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INSIDE AND OUTSIDE: "TRAUMA/DISSOCIATION/RELATIONALITY" AS A FRAMEWORK FOR UNDERSTANDING PSYCHIC STRUCTURE AND PROBLEMS IN LIVING[1] [2]

Elizabeth F. Howell, PhD

The Trauma/Dissociation Paradigm

As Bessel Van der Kolk has told us today so well, trauma changes and impairs not only how we think and what we think about, but also our very capacity to think. This new focus on trauma and dissociation is a paradigm shift. The emerging trauma/dissociation paradigm enables us to think differently not only about the structure of the human mind, how and why it becomes damaged, but also the processes by which it heals. The trauma/dissociation paradigm reorganizes our view of consciousness, of the unconscious, and of human motivation. It sweepingly restructures our understanding of all psychopathology that is not inherited.

In 1962 Thomas Kuhn published a groundbreaking book, *The Structure of Scientific Revolutions*. In this book, he proposed that rather than a linear progression toward more and better knowledge, it is paradigm shifts that allow for scientific progress. A paradigm is a theoretical model that can organize coherent thinking about a field of study. Kuhn described

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[1] The author wishes to thank The Analytic Press for permission to reprint sections of her book, *The Dissociative Mind* (2005).

[2] This paper was originally presented in response to a presentation by Bessel Van der Kolk at the annual conference of the National Institute for the Psychotherapies Training Institute entitled "The Trauma Dialogues: Body, Mind, Affect," on February 4, 2006.

different historical scientific shifts, noting that each hegemonic explanatory system always excluded some anomalous information. When the former anomaly became a cogent enough explanation to enough people, the paradigm would shift. What Kuhn (1962) said of scientific paradigms in general, is true of the trauma/dissociation paradigm: "As in political revolutions, so in paradigm choice—there is no standard higher than the assent of the relevant community" (p. 94).

However, this does not mean that the trauma/dissociation paradigm has never been "discovered" before. In her well-known book, *Trauma and Recovery*, Judith Herman (1992) notes that the study of psychological trauma is marked in history by episodic amnesia. She noted that the subject of trauma generates "such intense controversy that it periodically becomes anathema" (p. 7).

Does this mean that we are currently just on the end of the pendulum swing? One might ask this question because the topic of psychological trauma has been anathema throughout history for the same reasons that it is to the individual person: it opens the doors to the experience of overwhelming affects. And often, in addition to being powerless, trauma victims are isolated, with few or none to turn to for stabilization; and who wants to go there? Many important theorists, including Janet, Freud, Sullivan, Fairbairn, Ferenczi, Jung, Klein, and Winnicott, to name a few, have written of traumatic affects and dissociative processes. For instance, Harry Stack Sullivan (1953), in his book *The Interpersonal Theory Of Psychiatry*, made a point of describing how the dissociated "not-me" is constituted by the awesome affects: awe, horror, loathing, or dread" (p. 163).

Why does the recognition of these powerful affects and their effects require a paradigm shift now? Why will we not just have another period of amnesia? And why won't the current trauma/dissociation paradigm just be absorbed into another paradigm, as it was absorbed into Freudian psychoanalysis in the early twentieth century (see Ellenberger, 1970; Hillgard, 1977)? I think that today's trauma/dissociation paradigm has more hold than it did in previous oscillations because today we have the neuroscience to document it—and here we have Bessel van der Kolk, quite notably, to thank. Trauma has now been sufficiently acknowledged and sufficiently integrated by the body politic that its processing can continue. At the very least, this acknowledgment of the power of trauma will be a basis for future synthesis.

Today, Van der Kolk has cogently and powerfully presented key information about the neuroscience of trauma, information that opens up valuable new ways of thinking about and doing psychotherapy. He has spoken and written of how unbearably intense affect overwhelms the cognitive

framework of the individual, resulting in the sequestration and sensorimotor coding of the traumatic experience. He tells us and shows us convincingly and conclusively how trauma cuts off the capacity for verbal thought. Indeed, his phrase "speechless terror" has become one that indexes a whole system of thinking about trauma.

This demonstration of the reality and power of trauma-induced dissociation is illustrative of the paradigm shift that involves a reorganization of our perspective in thinking about the structure of the mind and of psychopathology. But what are we going to do with this? What are the different facets of this new perspective, and how do we pursue the implications of the concept of trauma-induced dissociation? Here there are different perspectives regarding how we understand psychopathology or problems in living and how we approach psychotherapeutic treatment.

Today, and in some of his recent writings, the meaning of dissociation that Van der Kolk emphasizes is primary somatosensory dissociation. Of course, he has written in detail of the complexity of trauma, notably in his 1996 book. Today he is emphasizing primary somatic dissociation—yet, today, I would like to emphasize how trauma also creates dissociative partitions in the mind and parts of the self. Thus, we have not only dissociation of body from mind, but of mind from mind. Trauma operates to bring about dissociation in different ways. Trauma splits off pieces of living experience, such that parts of experience are no longer accessible to the person—because they are encoded somatically and cannot be spoken, because one part of the mind can speak but another can't, and/or this aspect of experience is so anxiously avoided that it can't be formulated. One useful framework for thinking about these issues, one that encompasses all three of these possibilities, is the construct of the Emotional Personality and the Apparently Normal Personality, which has been recently articulated by our colleagues Onno van der Hart, Ellert Nijenhuis, Kathy Steele & Daniel Brown (2004), in their Structural Theory of the Dissociation of the Personality (based in part on the work of Pierre Janet). The Emotional Personality (EP) is the part of the personality that reenacts the trauma. It has been split off during the trauma; and what remains in ordinary consciousness is the Apparently Normal Personality (ANP). This is the constricted, avoidant, often numb posttraumatic personality that we see. But the important thing to recognize is that we are already talking in a language of parts. This constricted person we see is not the whole person, but only a part of a person. Both EP and ANP are parts of the personality. In this simple schema, the Emotional Personality holds the memory of the trauma. So, we have one person, but two different parts of the person that are dissociated. Now, too, we have the rudiments of a dynamic psychology—for

these two parts are phobic of each other. The Apparently Normal part does not want to know about the trauma and avoids the EP. In turn, the rejected and avoided EP intrudes into the experience of the ANP in the form of flashbacks, upsetting and unwanted memories, and so on. The constriction and the numbing of the ANP is designed to avoid these intrusive memories and experiences, which include bodily experiences. This combination and alternation of constriction and intrusion characterizes posttraumatic stress disorder (PTSD) (Van der Hart, 2000). In this framework, we have the split of body from mind, the split of mind from mind, and the situation that each of these parts becomes so avoided by the other that the affects, intentions, and thoughts of either one cannot be formulated, or understood, by the other. But trauma not only divides and splits off experience; it also impedes the integration of experience. Frank Putnam (1997) has written of how, developmentally, trauma impedes the integrating abilities of the mind. His Discrete Behavioral States (DBS) model outlines how, starting in infancy, behavior is organized as a set of discrete behavioral states that become linked over time. Trauma and neglect impede this linkage. In environments of abuse and neglect, different affect states may not be labeled and linked by the attachment figures—such that people who have grown up in these environments may not know when they are angry, or they may not have learned the experiential meaning of the word "compassion." So, for me, these mind-from-mind aspects of trauma-induced dissociation are just as important as the body-from-mind aspects.

"Bottom-Up" And "Top-Down" Processing

Van der Kolk is counseling us to give more credence to the wisdom of the processing capacities of the body (and the brain), and to put less stock in our theories of mental structure, of psychotherapy, and in ourselves as agents of change. We need to pay more attention to the way the brain and the body work, and we should incorporate this knowledge into the ways that we work. He advocates the use of body-based psychotherapies that will activate the appropriate brain structures to bring us into the present.

Van der Kolk is deemphasizing the importance of merely verbal therapy because it relies on "top-down" processing. Instead, he emphasizes the importance of "bottom-up" processing, which involves attention to sensorimotor reaction, bodily states, sensations, and affects. In contrast, "top-down" processing involves memory and cognition as they influence perception. It focuses on the cognitive and cortical inhibition and attempts to override our bodily sensations. In the service of pursuing other interests, one suppresses one's physical and affective experiences, such as hunger,

anger, or mild fear, relying instead on thought and the neocortex. Yet, as Van der Kolk points out, the neocortex may attempt to override, but it does not abolish our emotions and what is happening in our bodies. One of the problems is that top-down processes often mask the things we need most to know, such as information from our bodies and about our emotions (Van der Kolk, 1992).

However, in practice, top-down and bottom-up processes are intertwined. Even in body-focused therapies, as in EMDR, both sensations and words, both bottom-up and top-down, are framed by one another. Indeed, if we are sensitive as therapists, we utilize "top-down" and "bottom-up" processing simultaneously: we, as talk therapists, modify the position of our bodies, either consciously or unconsciously, in accordance with our patients posture, expressing a need, perhaps for closeness or distance. We modulate our voices, and so forth. There is much *affective exchange* in these modalities. We may also use words and groups of words as imagery and metaphor, which "speak to" somatic and affective states, eliciting resonance and "bottom-up" processing, as Bucci (2005) has observed. Also, I am not sure that we can avoid these exchanges, even if we want to. Alan Schore (2003) and Daniel Siegel (1999) have written about how right-brain processes, including perception of facial expression and body posture, are millisecond processes, often bypassing the more time-consuming left-brain processes. Much of this out-of-awareness interaction is right-brain to right-brain, more specifically right orbitofrontal cortex to right orbitofrontal cortex; and if this goes well, according to Siegel, it promotes a secure attachment in the therapy relationship. The attunement and the attachment are embedded in interactive brain processes.

Van der Kolk tells us about how trauma activates the subcortical brain regions, and reduces blood flow to crucial areas of the frontal lobe, and to Broca's area, the area involved with speech. He has noted that traumatized people cannot put their experience into language, they may develop alexithymia, no words for emotions—or they are otherwise out of touch with their emotional states. Traumatized persons need to learn to *have* rather than to *be* their emotions. But for the emotion to become one's own and for it to become a part of narrative memory, the action must be completed in some way (Janet, 1925). Because trauma interferes with the modulation of the ventral vagal nerve, the traumatized person may be forced to fall back upon phylogenetically less advanced brain structures for action strategies, such as fleeing or fighting, or in many instances when that is impossible, a protective maneuver of last resort, is freezing. One thing we need to do, then, is to enable ventral vagal modulation, with activities such as yoga, breathing techniques, and body processing. Many of us have long been

recommending yoga and teaching breathing techniques to our trauma patients. Now, it is clearer why they are helpful.

A Few Differences

In some of his recent writings, Van der Kolk has hinged his viewpoints about trauma and the efficacy of psychotherapy on EMDR. He states that the "task of therapy is to help patients form new associations that do not lead to a reliving of the past . . . It consists of *physically* experiencing new possibilities by welcoming and allowing these split-off bodily feelings to run their course" (2002, p. 78–79). Yet, here our emphases differ: while Van der Kolk emphasizes primary somatosensory dissociation, I am emphasizing how trauma also creates dissociative partitions in the mind, parts of the self that are phobic for each other. In my experience, EMDR links dissociated self-states, including affect states. Thus, the vehemently avoided thoughts and emotions are brought out into the present real time and into the present relationship because the dissociative barriers are being eroded in a safe environment.

In addition to the primary somatosensory dissociation of speechless terror, I think that we are working in EMDR and in good psychotherapy, with dissociated parts of the self. Part of the "accelerated processing" of EMDR is that when people can feel compassion for themselves and the suffering that they have endured, then a formerly dissociated part of the self can be *allowed in* to join the suffering part. It is a crossing of intrapersonal dissociative barriers. When this happens, passive "victimhood" is no longer the only stance toward the world that can be allowed in by the suffering part. Now the self-concept, and indeed the self, can be more complex.

Here I want to express my appreciation for Van der Kolk's ability to go against the tide, especially to an audience of verbally oriented psychotherapists. What he says is very valuable. Yes, traumatized people need to have more attunement with their bodies. This will give them more resilience. And also, because traumatized people are often so needy of attachment, they are prone to reenact their trauma both *inter*personally and *intra*personally, and they can be easily wounded in an intense therapeutic relationship. I can't disagree with Van der Kolk about the benefits of body processing and the dangers of intense attachment relationships in psychotherapy. However, I think one way we, as therapists, can get a better handle on the latter problem is not necessarily to avoid intensity in the therapeutic relationship, but to strive to understand our patients' minds more thoroughly. This includes the issue of the dissociation of mind from mind, as manifested in personality structure and in treatment.

In addition to the primary somatosensory dissociation of speechless terror, I am emphasizing that with many trauma patients—and that's a lot of people—we need to work with dissociated parts of the self that have become sequestered, especially along the lines of affect and context. By its very nature, trauma disrupts and interrupts the distinction between the internal—what is inside our skin and is our own preserve—and the external. Trauma is affectively overwhelming—it is the affect, not the event itself, that is most of the time so overwhelming (Russell, 1998). For instance, shaming words can feel overwhelmingly painful and demoralizing, independent of physical pain.

Interpersonal trauma can have a particular effect on the structure of the psyche, creating a relatively closed system (Fairbairn, 1958), one that is closed off from the influence of real others. This mutes the power of overwhelming affect to destabilize and derail us. Thus, it is a form of affect regulation. But because these affect states are dissociated, we are vulnerable to their intrusion. This means that the solipsistic stopgap attempt at affect regulation leads eventually to dysregulation.

The Closed System and Affect Regulation

Ideally, the infant-mother dyad and other intimate relationships, such as the psychotherapy dyad, are characterized by mutual regulation: they are open systems. All living organisms are open systems. They maintain their complex form and functions through continuous exchanges with the environment. An open system assumes interaction with, and influence from, the outside. A whole is more than the aggregate of its parts because it is in constant interaction with, and thus continually transformed by, the environment. It is on the basis of their interchanges with the environment that living systems are nourished.

Psychopathology that is not inherited represents the attempt to self-regulate alone. When things go wrong, whether by overt trauma, massive neglect, or overwhelmingly intrusive control and misattunement by the attachment figure, the child becomes overly self-reliant and approximates more and more a closed system to prevent destabilization by sudden, surprising intrusion, or abandonment by the other, and by intense affects that can be overwhelming if there has been little success in learning to regulate them.

No system can be both complete and consistent. The mathematician Kurt Gödel (Nagel & Newman, 1958) proved that an arithmetical system cannot be both complete and consistent. If it is complete, it cannot be

consistent, and vice versa. Arithmetical systems rest on a group of axioms from which the rules of processing the data are derived. Likewise, dissociated self-states are internally consistent. Each self-state excludes information that is not consistent with its unique organizational structure. Because there is such a massive partitioning of information, memory and affect—and because the ability to contextualize is poor—each self-state fallaciously claims to possess the whole truth. Mirroring the "isolated subjectivity" of these dissociated self-states, the system, which is the aggregate of these self-states, is closed. It cannot be complete without influence from the outside. People who rely largely on closed mental systems are relying heavily on dissociation as a defense. What happens with early, repeated trauma is that, without benign and meaningful interchanges with others, the mind attempts to be consistent and complete within itself. When affect is overwhelming and there is no outside source of safe support, then the psyche will of necessity become more and more self-referential and closed.

In contrast to the closed system, the healthy infant is Janus-faced, looking inward toward personal experience and outward toward regulation by others—and doing so simultaneously. In less than optimal development, the inward looking is a stagnant, concretized bootstrap operation; and the outward looking is intensely hypervigilant, so as to avoid regulation by the other, rather than to encounter it. Here the inward and outward looking are separate, dissociated processes each of which has a different purpose than *mutual* regulation.

Attachment

How does psychological trauma operate to create the closed system? Perhaps, most importantly, trauma damages the attachment system. Today, Van der Kolk is de-emphasizing attachment relationships in therapy, on which transference and countertransference work are based. Here, I would like to quote from some of his earlier work (forgive me, but I hope that one day I will have as many seminal articles, portions of which may come back to haunt me): along with Onno van der Hart and Jennifer Burbridge, he said in 1995, "After intense efforts to ward off reliving the trauma, therapists cannot expect that the resistances to remember will suddenly melt away under their empathic efforts. The trauma can only be worked through when a secure bond is established with another person; this then can be utilized to hold the psyche together when the threat of physical disintegration is reexperienced." In his 1987 book, Van der Kolk wrote a chapter on attachment in which he said,

following John Bowlby,[3] "In both children and adults, severe stress, such as illness and other situations involving loss of control, dramatically increase the need for attachment and protection. In fact the most powerful influence in overcoming the impact of psychological trauma seems to be the availability of a caregiver who can be blindly trusted when one's own resources are inadequate" (p. 32). (How beautiful!) Later in the same chapter he notes research indicating that the capacity to reduce arousal is the major maternal quality that reinforces the early infant's attraction or attachment. He was prescient here, for this is entirely consistent with the views of some current researchers in the field of attachment—such as that of Karlin Lyons-Ruth (2001), who sees the attachment system as similar to the immune system in that it buffers stressful arousal. She says that the attachment system can be understood as a psychological system for combating stress and modulating stressful arousal.

The attachment system cannot work adequately in traumatic attachments, in which the attachment figure fails to provide a protective shield against the dangers of the environment, or is herself, or himself, dangerous. Since the attachment system functions as a buffer against extreme fearful arousal, the effects of its failure will be profound, potentially attacking the linkage of states and creating dissociated self-states.

When a child must dissociate parts of the self as a way of maintaining attachment to a frightening, neglectful, or abusive caretaker, as when significant memories or systems of memories must be closed off from current experience in order to prevent destabilization and protect sanity, this forecloses open self-expression as well as an open vulnerability to the real behaviors of the other. As this progresses, the self becomes more and more a self-contained system. Genuine responsivity to another (originally, the attachment figure) is replaced by a set of expectations and responses that reflexively and self-protectively "manage" the other person while at the same time perceptions of the person are laundered of more problematic information and feelings. What is left in consciousness is a set of beliefs and strategies that allay terror and "work" interpersonally. The true vulnerability of a real relationship has been replaced by the "internal object," which predicts and, in a way, provides a defensive buffer against the psychic

[3] The three patterns of attachment initially identified by Bowlby and his followers were secure attachment and two insecure attachment styles: anxious-avoidant and anxious-resistant attachment. The insecure styles are ways of dealing with grief pertaining to attachment loss and its threat and are understood to be internally consistent, or coherent. A fourth, later-discovered category of attachment—disorganized (D) attachment (Main & Solomon, 1986)—is associated with maltreatment and gross insensitivity on the part the caretaker.

impact of the behavior of the frightening attachment figure. In psychoanalytic psychotherapy we often work with transference and enactments in which partially or fully dissociated self-states come forth and the patient sees the other "as if" (or "as") the other were the traumatic figure. Resolving these dilemmas in the work often results in deeply moving recognitions and insights that further integration.

The self-sufficiency of the closed system depends upon pathological dissociation. In dissociative psychopathology the mutuality of relationships, both interpersonal and intrapersonal, has collapsed in significant ways. Intersubjective failure in primary interpersonal relationships is at the root of this intrapersonal dissociation: when severe dissociation severs internal links, interpersonal ones are blunted as well. Lack of awareness of one's impact on others characterizes the closed system. By definition, a closed system precludes interpersonal intersubjectivity, the mutual recognition of separate, self-reflective selves that have agency.

Although many other kinds of problems in living are also trauma/dissociation-based, dissociative identity disorder, or DID, is an extreme version of the kind of dissociativity that ultimately becomes highly problematic for the individual. DID generally represents a very high magnitude of traumatization. We all know that a single rape for an adult can be a very traumatic experience, requiring many months or even years to recover from. Thus, the word, "recovery" is a misnomer, for one is never the same afterward. Now, let us apply what Richard Kluft calls the multiplication factor. Imagine a child raped two or three times a week for eight or nine years, or more, of her life. This is more than 800 rapes; and the victim is a child.

I will discuss the closed system in the following vignette from an ongoing treatment with Brenda, a person with dissociative identity disorder. As a child, from the age of five or younger, until she was about twelve, Brenda had been raped at night, night after night, by her father, while her mother was asleep in bed, knocked out on pills. Until recently, Brenda has not herself remembered most of these incidents, but other child parts of her have. They remembered horrifying things—bloody underwear, terrible pain, not being able to sit down, wetting her pants, and other strategies to try to deter her father's violations. These child parts have only been able to tell of their pain bit by bit because what they had to say would have been too destabilizing and painful to bear in large doses to Brenda herself, as well as to the adolescent and other adult "parts" of Brenda. Needless to say, these child parts still had much more to communicate at the time I received an alarming phone call from Brenda's husband. He called to cancel that day's session because she was in the hospital from a frightening drug overdose.

The odd thing about this incident was that Brenda had no memory of taking any pills and had always insisted that she was not suicidal. Later on, when we met, in the process of Brenda's and my discussion of the possible antecedents of this event, I asked to speak to Sarah, a very precocious child part, who at times takes a managerial role with respect to younger child parts, and who accordingly thinks of herself as "the Lifesaver, who has a hole in the middle." It turned out that Sarah had gotten sick and tired of hearing the constant, excruciating crying of a younger child part, Bob. Sarah knew Bob was in terrible pain, but she did not know why he was crying so much more than usual now. She just couldn't bear to hear Bob's crying anymore, and she decided to take matters into her own hands. She decided to give him pills to shut him up and knock him out. There were reasons that the younger part, Bob, was in so much grief. Brenda was about to take a trip back to the town where she grew up, and Bob thought the father, who was in reality dead, was still alive, still there, and capable of raping him again.

It was the one-sided domination, not a negotiated conflict between Bob and Sarah, which yielded this incident. A child part that had always had to fend for herself and that had to take too much responsibility for her young age, made a decision unilaterally, without consulting anyone. It was a decision that she was too young to make. When we were able to talk about Bob's and Sarah's feelings and fears, Bob could talk about why he was frightened and why he was crying, and Sarah could talk about hating to hear Bob's crying. After these interactions, Sarah knew why Bob was crying so much. She also understands now that she is too young to give anyone pills, and she has agreed to call me rather than undertake any unilateral action if she is in severe distress. Brenda has now been able to articulate a conflict, and she knows how to get help to deal with it. (To speak of Brenda's parts as she experiences them is not to incorrectly reify them, for she already experiences them as distinct and separate parts of herself. Furthermore, finding out in detail why different parts feel as they do helps Brenda to articulate aspects of her conflict and that all of these parts are, after all, aspects of her.) In this way it facilitates the integration of the parts.

In this vignette, Sarah, the child part, saw no recourse but to take control without communication or negotiation with other parts, and in a way that was hidden to Brenda. Similarly, Brenda, as a child, had had little power to negotiate with her father about his abuse of her. Here we see how dissociation ensues from traumatic attachment. This reliance on internal grandiosity is a consequence of the absence of a reliable and trustworthy caregiver to turn to when in the vortex of psychological trauma. The resulting feeling is of powerlessness to have an effect on the other. As a result of

the failure of attachment figures, there is a failure of the attachment system. Since there was no one, no attachment figure available to help, her overwhelming terror, shame, and pain could not be mitigated. This little girl was completely isolated. And she was a captive. Just as Brenda the child was isolated, so were her parts. As Chefetz (2004) notes, describing his concept of "isolated subjectivity," "What is not so obvious is that when we use a word like 'subjectivity' we are thinking on a level of abstraction that involves the confluence of multiple self-states. [When] affect . . . is isolated, the self-state[s] ha[ve] a quality of not being known. This is isolated subjectivity" (p. 431).

The grandiosity of Sarah, "the Lifesaver," was demanded by the system. Yet, she had an important recognition of the deficiency of this maneuver, as her very name indicated the knowledge that her center was missing. (She [the Lifesaver] has a hole in the middle.) We can see how the enormous need for her to be self-sufficient fed her grandiosity and how the closed system was invaluable in her original environment—although it is problematic now.

In order for the covert conflict to become overt, parts of the internal organization of the system need to be in a meaningful relationship to, and capable of being influenced by, someone outside the system. Without meaningful influence from the outside, there is a closed system of various collusions and hostile interactions among parts. These relationships among the parts, when they are dissociated, can only be seen from a point outside the system. Even then, for the pattern to be intelligible, the subjectivity of each of the constituent parts must be known to a person outside the system.

However, the organizational form of constituent parts, taken as a whole, may not be immediately intelligible to the outside observer. For instance, Brenda's apparent suicide attempt made no sense, since she admitted to no suicidal ideation. For the action of Brenda to be intelligible, I needed to contact Sarah and Bob, among others. However, when the parts were consulted, the emergent understanding of the concepts of suicide and homicide, silencing another's unbearable crying, and enacting the solution that she had observed in her mother was quite different. The way that this emergent understanding was achieved was by my getting to know the parts. This link to the outside is what Philip Bromberg (1998) refers to as a "relational bridge." However, what is also needed to heal and bridge the dissociation of the parts is an *internalization* of the relationship of the separate parts with the outside knower, often the therapist. Once this is accomplished, the parts begin to become less phobic of one another's memories and feelings. For the dissociation in Brenda to begin to be healed, I had to

know Sarah and Bob, and each of their own fears and desires. Then Brenda had to learn to know what I knew, now being able to learn it within a safe relationship. In Murray Bowen's (1985) family therapy terms, one could say that in the process of my engaging in relationship with Sarah and Bob, they became more differentiated. Alternatively, one may say that the parts, Sarah and Bob, became more formulated (Stern, 1997) to Brenda and to each other, which means that they became less dissociated.

I am not suggesting an absolute isomorphism between dissociative identity disorder and less severe personal problems that are dissociation-based. In DID, the internal dissociative barriers between parts are often much stronger, and the parts are more narcissistically invested in their own "pseudodelusional" (Kluft, 1984) sense of separateness. However, I believe that the basic model is the same, specifically insofar as the degree of dissociation of self-states may be understood to exist on a continuum.

This vignette illustrates how the patient's psychic structure mirrors the early family social structure. Dominant/subordinate relationships usually do not permit open conflict. When the subordinate is a child, one result of abusive dominant/subordinate relationships is that the covert conflict may be internalized, becoming part of the child's psychic structure, with the result that the family/social structure becomes mirrored in a collusive psychic structure. This means that dissociated dominant/subordinate self-states will be highly present in the personality organization. However, it is the very interrelationship and intense attachment between these self-states that makes it hard to break into the closed system. For instance, a dominant, aggressive self-state may keep the person in a subordinate external relationship—for old-time safety's sake. This aggressive self-state may be a protector and a persecutor at once (Howell, 1997). As Fairbairn (1958) noted, what keeps the patient mired in the closed system is that early experience induced in the patient "a sense of hopelessness over the possibility of obtaining satisfaction in relationships with external objects on whom he is dependent" (p. 92). Thus, the therapy relationship needs to offer an invitation to contradictory possibilities.

Traumatic attachment breeds the closed system. In contrast, what I call generative attachment can facilitate the healing of the closed system. What contributes to generative attachment? One factor is what Constance Dalenberg (2000), a prominent traumatologist, calls "anger in connection." Dalenberg conducted a substantial study of trauma patients' responses to the expression of anger in the psychotherapy relationship. An important issue was how to insure safety in the therapeutic relationship, an issue that Van der Kolk addressed. Dalenberg found that the therapists whom the patients found the most helpful were those who could accept their client's

anger and who were emotionally disclosing of some of their own, without blaming the client. What the clients learned was that they could be angry and stay in the relationship. The expression of anger meant neither abandonment nor imminent physical danger. The therapists who rarely expressed anger were more likely to explode at some point, having a highly distressing effect. The therapists trauma patients found the least helpful were the "blank-screen" psychoanalysts.

Another factor is the child's experience *of having an effect*. Karlin Lyons-Ruth (2001, 2004), in her many studies of disorganized attachment in children, has found that it is not overt trauma in childhood that correlates most highly, as one might expect, with dissociation later on. Contrary to expectation, she found that disrupted mother-child communication, and behavior that overrides the infant's attachment cues (that is, the threat is not having any influence on the caregiver), is most predictive of dissociation at age nineteen. This harkens back to the importance of completing the action, in a body sense, that Van der Kolk was discussing. The child with disorganized attachment, which Lyons-Ruth has written about so extensively, cannot safely approach the dangerous caregiver, but cannot safely flee either; often they are immobilized, and exhibit stilling and freezing behaviors. They cannot complete the attachment-based action of approach, and they cannot flee. They are left in a dilemma of "fear without a solution" in which workable behavioral strategies collapse (Hesse & Main, 1999, p. 484).

Both of these factors, anger in the relationship and the experience of having an effect, are relevant to Winnicott's concept of "object usage." Winnicott (1971) described how the patient's experience and expression of aggression toward the therapist, who in turn does not retaliate, can enable the therapist to become "real in the sense of being part of shared reality and not just a bundle of projections" (Winnicott, 1971, p. 88). This transformation involves a very important psychological shift away from a relatively primitive form of interacting "that can be described in terms of the subject as an isolate," in which the object is experienced primarily in terms of projection and identification (Winnicott, 1971, p. 88). The object (the other person) becomes real by virtue of having been killed in fantasy, surviving, and not retaliating, withdrawing, or submitting. The experience of unfettered and unpunished aggressive feelings toward an attachment figure has often been absent in people whose internal world is a relatively closed system.

The Trauma/Dissociation Paradigm Redux

Now, I would like to say a little more about the new trauma/dissociation paradigm. The closed system is a general model of a particular kind of trauma

response that stands in the way of positive psychotherapeutic change—not only with dissociative patients, but with many other groups of people. I believe that all environmental-based "psychopathology," or problems in living, can be understood in terms of this paradigm. A model of the mind, understood through the lens of trauma and dissociation, is potentially transformative of the way we conceptualize mental processes. Viewed in this way, many of our "household word" concepts in psychoanalysis, have a differently organized meaning. For instance, the structural model (which posits a tripartite unity of the ego, the id, and the superego, all in dynamic conflict, implies a unified, cohesive self) can be considered in a different way: ego and superego are dissociated, that is, the connection between them is severed, as are "the" conscious and unconscious (Putnam, 1997).

Trauma that occurs early in life has profound effects on personality development. Typically, we have understood child development in the last century as involving a fairly linear progression of increasing independence from mother as accomplished by the mastery of developmentally relevant tasks, whether we call these psychosexual stages, psychosocial stages, or the developmental epochs of infancy, childhood, preadolescence, and adolescence. As we know, the impact of trauma does much more than arrest a particular phase of development. It blanks out certain areas of experience from consciousness, it numbs the self, it increases stress hormones, it changes brain structure, it makes the world unsafe, and interferes with attachments, to name just a few features of this stress response.

Psychic fragmentation tends to occur along the fault lines of affect and context. The dissociated self-states characteristic of DID often "hold" different affects and feelings, such as shame, rage, disgust, sexuality, attachment need, and so on. Furthermore, particular self-states are often triggered by events reminiscent of an earlier trauma. Consider the Vietnam veteran who suddenly almost punches the man next to him in the face when an automobile backfires, triggering dissociated memories along with associated affects about gunfire in combat. As mentioned earlier, in my view, DID is simply an extreme version of the dissociative structure of the psyche that characterizes us all. The dissociative structure of the psyche may also result in personality disorders (Bromberg, 1998), psychotic thinking, and a host of symptoms such as anxiety, depression, eating disorders, substance abuse, and dissociative disorders.

Consistent with the paradigm shift regarding trauma and dissociation studies, our views of psychoses are modified. The hallmark of psychosis is not only poor reality testing, but more specifically, the inability to distinguish the internal from the external. It is exactly this distinction that trauma disrupts.

Few of us still use the word "neurosis." In that more and more problems in living are being understood as trauma-generated, much of what used to be seen as neurosis can now be understood in terms of posttraumatic stress and dissociation. The concept of neurosis requires the operation of a punitive superego, enforcing repression of dangerous wishes. Even here, it is not so much the wishes themselves that are problematic, but that the overwhelming affects brought on by the anticipated consequences foster fragmentation. "Uncivilized wishes can be forgotten [repressed] in an overall sense of the continuity of personal history . . . whereas overwhelming terror seems more likely to lead to a segmentation of self-experience [dissociation]" (Howell, 1997, p. 234).

In contrast to neuroses, which involves so-called structural conflict and depend on repression as the primary defense, personality disorders, especially borderline personality disorder, were thought to be in between neurosis and psychosis. Thus, "borderline," meant "borderline psychotic," until the mid to late 1960s. Judith Herman (1992) and Bessel van der Kolk (1996) have contributed to the reconceptualization of personality disorders in terms of trauma and dissociation with the concepts of "complex PTSD" and "disorders of extreme stress not otherwise specified" (DESNOS). Both encompass a constellation of symptoms resulting from long-term psychological trauma. Among these are emotional dysregulation, amnesias, damage to identity and relationships, and the potential for revictimization.

Otto Kernberg (1975, 1984) reformulated borderline personality disorder and most other personality disorders as encompassed within borderline personality organization (BPO). He emphasized that BPO was a stable, but pathological personality organization, with underlying rage and "oral" neediness, that was characterized by certain patterns of primitive defense in which splitting, and other related defenses of projective identification, denial, primitive idealization, devaluation, and omnipotence heavily predominate. As Kernberg (1984) noted, splitting is a primitive form of dissociation.

According to Kernberg, the primary purpose of splitting, the hallmark borderline defense, is to preserve the libidinal (positive) from contamination by the aggressive or the bad (negative). I am not disagreeing with Kernberg's important observations about splitting and the related defenses in borderline personality organization. I am suggesting that a trauma/dissociation perspective is also needed in understanding these processes. In relation to this suggestion, I (2002) have proposed that we might also understand splitting and BPO as involving alternating, partially dissociated victim and abuser self-states. Their oscillation appears to be a continual reenactment of the traumatic violation of the relational boundary. In a

chaotic, neglectful, and abusive familial environment, the child may focus intently on the abuser's postures, motions, facial expressions, words, and feelings in hopes of calming or pleasing the aggressor and preventing harm. I have suggested that as a result of being intensely attached to a person who is both an attachment object and an abuser (generally, more attached than if there had been no abuse, because threat and fear activate the attachment system), the child mimics the aggressor's behavior as a form of enactive, procedural dyadic learning. This may help to explain the isolated rage, contempt, and omnipotence that is often termed "identification with the aggressor." This way of thinking is consistent with the other defenses that Kernberg sees as related to splitting (primitive idealization, devaluation, omnipotence, projective identification, and denial). Indeed, the first three apply specifically to the victim or perpetrator states. Primitive idealization is felt only from the perspective of victim-identified states. Omnipotence refers to the abuser-identified states. It describes the traumatic nature of the way that the victim experiences the abuser—omnipotent and overwhelming—and often the self-experience of the aggressor. Devaluation is usually the attitude with which the abuser treats the victim, but it also often becomes the attitude that the survivor later takes toward the self. These aggressor-identified states alternate with the victim states.

Daniel Stern (1985), who did not disagree that splitting is characteristic of borderline patients, or, indeed, of all of us to some degree, criticized Kernberg's concept of splitting as being out of step with the observed developmental timetable. He emphasized that, based on systematic observation of the developmental capacity of infants, splitting "is not a likely experience of the infant as observed" (p. 252). Again, I am not disagreeing with the basic psychodynamics of splitting that Kernberg proposes. However, I believe that the trauma/dissociation perspective is closer to experience. In addition, the model of splitting presented here as deriving from a Ferenczian view of "identification with the aggressor," proposes a relational explanation for the excess aggression presumed to lead to splitting.

Last but not least, the "culpability factor" in psychopathology is reassessed in trauma theory. As we know, self-blame is a big problem of many trauma survivors. Freud's first theory about the origins of psychopathology, the seduction theory, was a trauma theory—and one that correctly placed the blame for the psychopathology on the perpetrators. In contrast, Freud's later views of psychosexual development blamed the child as "guilty" on account of having incestuous wishes. Trauma theory recognizes the victim's helplessness at the time of the trauma. Despite the fallacy of self-blame, in a certain sense, blame itself is irrelevant, the posttraumatic

problem is now one's own. As a patient of mine said recently, he felt "remorse" about the abuse he endured. The survivor's acknowledgment of how relationships to the abusers have been internalized and replicated can make self-responsibility much more thinkable. The past lives on in the present, but the buck stops here. Ironically, it is the acknowledging of one's self-responsibility as well as one's helplessness and pain that promotes self-forgiveness, and healing.

This brings us back to the constructs of the EP and the ANP as a model of the mind. This is a dynamic construct and it includes a model of the unconscious in that the EP is not known to the ANP. You saw how this was illustrated in the case of Brenda, where Sarah and Bob both contain emotional memories. Van der Hart's, Nijenhuis and Steele's model of the Structural Dissociation of the Personality was largely derived from the thinking of Pierre Janet (1907, 1925) and it can be understood as Janetian dissociation. Another model of trauma-based dissociation is attachment-based dissociation—also operative in the case of Brenda, in that the host Brenda was very positively attached to both of her parents (and other parts hold the pain and the rage). Fairbairn (1952) had an exemplary model of attachment-based dissociation in his design of the schizoid psyche, with the exciting object and the libidinal ego and the rejecting object and the antilibidinal ego, all as potent unconscious forces.

Finally, we have the model of unformulated experience, proposed by Donnel Stern (1997), which addresses how topics that make us too anxious may remain unformulated. This is supplemented by what I think of as an interconnecting puzzle piece, Philip Bromberg's (1998) understanding of how anxiety that is sufficiently intense to make something "unthinkable" is, by definition, traumatic. Here you can see how these three models of the dissociative mind set the stage for enactments, which are now considered by many to be an intrinsic aspect of our verbal psychoanalytic work. Enactments are very important here because they are endemic, occurring in psychotherapy as well as in all interpersonal relations. Therefore, they are going to occur in treatment relationships even where, in theory, the relationship as well as the enactment is avoided. And I cannot emphasize enough how traumatized patients will pull us, inexorably, into some version on an interpersonal repetition of their trauma. Conceptually, they also bridge the somatosensory and the psychoanalytic, in that procedural, dyadic learning is enacted, as Lyons-Ruth describes. If this aspect could be isolated, these would be *non-conscious* enactments. But we also have *dynamically* unconscious enactments in which some aspects of experience are so unbearable and unthinkable that they can only be enacted. Generally, these occur together. It is our relationships that we repeat, and sometimes the only

way we can stop these "everlasting re-recommencements," as Pierre Janet (1925, p. 663) put it, is in a psychotherapy relationship where the dissociative structure of the mind is accepted, understood, and can be worked with.

REFERENCES

Bowen, M. (1985). *Family Therapy In Clinical Practice*. Northdale, NJ: Jason Aronson, Inc.

Bromberg, P. (1995). Psychoanalysis, dissociation, and personality organization. In: *Standing in the Spaces: Essays on Clinical Process, Trauma, and Dissociation.* Hillsdale, NJ: The Analytic Press, 189–204.

Chefetz, R. & Bromberg, P. M. (2004). Talking with "me" and "not-me": A dialogue. *Contemporary Psychoanalysis*. 40, 409–464.

Dalenberg, C. (2000). *Countertransference and the treatment of trauma*.Washington DC: American Psychological Association.

Fairbairn, W.R.D. (1952). Psychoanalytic studies of the personality. London: Tavistock.

Fairbairn, W.R.D. (1958). On the nature and aims of psychoanalytical treatment. In E.F. Birtles & D. E. Scharff (Eds.), *From Instinct To Self: Selected Papers Of W.R.D. Fairbairn* (Vol. 1, pp. 74-92). Northvale, NJ: Aronson.

Ferenczi, S. (1949). Confusion of tongues between the adult and the child. *International Journal of Psycho-Analysis, 30,* 225–31.

Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

Hesse, E. & Main, M. (1999). Second generation effects of unresolved trauma in non-maltreating parenting: Dissociated, frightened and threatening parental behavior. *Psychoanalytic Inquiry, 19,* 481–540.

Howell, E. (1997). Desperately seeking attachment: A psychoanalytic reframing of harsh superego. *Dissociation, 10,* 230–239.

Howell, E. (2002). Back to the "states:" Victim and abuser states in borderline personality disorder. *Psychoanalytic Dialogues, 12,* 922–958.

Howell, E. (2002). Dual Visions, Dual Voices: Reply to Commentary. *Psychoanalytic Dialogues,12(6)*, 971–986.

Howell, E. (2005). *The Dissociative Mind*. Hillsdale, NJ: The Analytic Press.

Janet, P. (1907). *The Major Symptoms Of Hysteria*. New York: MacMillan.

Janet, P. (1925). *Psychological Healing*. New York: MacMillan.

Kernberg, O. (1975). *Borderline Conditions and Pathological Narcissism.* New York: Jason Aronson.

Kernberg, O. (1984). *Severe Personality Disorders*. New Haven, CT: Yale University Press.

Kluft, R. (1984). Treatment of multiple personality disorder. *Psychiatric Clinics of North America.* 7, 9–29.

Kuhn, T. (1962). *The Structure Of Scientific Revolutions*. Chicago: University of Chicago Press.

Lyons-Ruth, K. (2001). The two-person construction of defenses: Disorganized attachment strategies, unintegrated mental states and hostile/helpless relational processes. *Psychologist Psychoanalyst, 21(1)*, 40–45.

Lyons-Ruth, K. (2005), Plenary 1: Dialogue and dissociation: Clinical implications of longitudinal research. Presented at the 22nd Annual Fall Conference of the International Society for the Study of Dissociation, November 6, Toronto, Ontario, Canada.

Main, M. & Solomon, J. (1986). Discovery of a new, insecure-disorganized/disoriented attachment pattern. In T.B. Brazelton & M. Yogman (Eds.), *Affective development in infancy* (pp. 95–124). Norwood: Ablex.

Nagel E. & Newman, J. (1958). *Gödel's Proof.* New York: New York University Press.

Putnam, F. (1992). Discussion: Are alter personalities fragments or figments? *Psycholanal. Inq, 12*, 95–111.

Putnam, F. (1997). *Dissociation in Children and Adolescents.* New York: Guilford Press.

Russell, P. (1998). The role of paradox in the repetition compulsion. In: J. Teicholz & D. Kriegman (Eds.), *Trauma, Repetition & Affect Regulation: The Work Of Paul Russell* (pp. 1-22). New York: The Other Press.

Schore, A. (2003). *Affect Regulation And Disorders Of The Self.* New York: Norton.

Siegel, Daniel. (1998). *The Developing Mind: Toward A Neurobiology Of Interpersonal Experience.* New York, NY: Guilford.

Stern, D. B. (1997). *Unformulated Experience: From Dissociation To Imagination In Psychoanalysis.* Hillsdale, NJ: Analytic Press.

Stern, D. N. (1985). *The Interpersonal World Of The Infant.* New York: Basic Books.

Sullivan, H. S. (1953). *The Interpersonal Theory Of Psychiatry.* New York, NY: W. W. Norton & Co.

Van der Hart, O. (2000). Dissociation: Toward a resolution of 150 years of confusion. Plenary address given at the 17th International Fall Conference of the International Society of Dissociation, Nov. 14, San Antonio, TX.

Van der Kolk, B. (1987). *Psychological Trauma.* Washington, DC: American Psychiatric Association.

Van der Kolk, B. (1996), The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development. In B. A. Van der Kolk, A. McFarland, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects Of Overwhelming Experience On Mind, Body, And Society* (pp. 182-213). New York, NY: Guilford Press.

Van der Kolk, B. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 57–84). Washington DC: American Psychological Association.

Van der Kolk, B., Van der Hart, O. & Burbridge, J. (1995). Approaches to the treatment of PTSD. http://www.trauma-pages.com.

Winnicott, D. W. (1971). Use of the object and relating through identifications. In: *Playing and Reality*. New York: Tavistock.

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