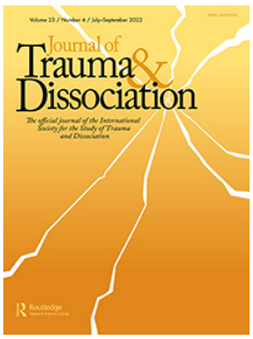

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Journal of Trauma & Dissociation

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wjtd20

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Vedat Şar MD

To cite this article: Vedat Şar MD (2022) The Dialectical Dynamic Therapy of Trauma, Journal of Trauma & Dissociation, 23:4, 339-355, DOI: 10.1080/15299732.2022.2079110

To link to this article: https://doi.org/10.1080/15299732.2022.2079110

JOURNAL OF TRAUMA & DISSOCIATION
2022, VOL. 23, NO. 4, 339–355
https://doi.org/10.1080/15299732.2022.2079110

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EDITORIAL

The Dialectical Dynamic Therapy of Trauma

Trauma as a Prolonged Inner Process

Once upon a time in psychiatry, before the so-called neo-Kraepelinian era, schizophrenic "reaction" was not an awkward phrase in the daily jargon of a psychiatric unit. Reaction to what? To life tasks the patient was mentally too weak to deal with? Was this reaction a symbolic-communicative uprising of an over-sensitive person to something wrong in the environment such as a dysfunctional family or maybe injustice of the universe? "Neurotic" conditions were considered even more chronic than schizophrenia because the hypothesized developmental "fixations," "rigid/immature defenses," and an "enduring personality structure" were taken as long-term traits distorting one's perception of internal and external realities to keep them in a window of tolerance. Acute or chronic traumatic stress as merely "toxic agents" were expected to influence formation of symptoms to the extent that the "premorbid personality" allowed such stress to penetrate the system. It took some time for mainstream psychiatry to recognize that trauma was more than a stressor, i.e., a long-term inner process and not just an external event. Even the so-called acute reaction to traumatic stress is usually embedded in a chronic process when contextualized in the biographical narrative of the affected individual. Here is the place to present my motto as an "experienced clinician": *There is (almost) no (such thing as) acute !*

Nevertheless, the intriguing dynamics of coping with childhood trauma and the interplay between acute (crisis) and chronic posttraumatic phenomena (process) continue to raise inspiring questions. For example, what should the demarcation line be between a so-called "personality disorder" and a "proper" psychiatric disorder? This question is a critical one in that I further contend that while personality may be defined as a construct also determined by environmental influences, the distinctness of the prolonged inner process of trauma needs to be recognized in order for the trauma to be psychotherapeutically resolved. Achieving such clarity of vision about the blurred boundaries between one's "constitution" and the acquired deviations may raise challenges for patients who were exposed to suboptimal environments in early life that the ability to initiate meta-awareness of their trauma-related functioning is impeded. This is the basic dissociation. What such patients need is the capacity to look at their own detachment from a distance which frequently triggers a joyful *Aha-Erlebnis* if obtained in a safe environment. This is an empowering insight (on condition that the clinician does not turn it to a fearful one) which is also experienced emotionally. Thus, recognition of this process by both the clinician and the affected person is the first step of effective treatment, which

requires close collaboration between two participants. This interpersonal resonance is based on the dynamic synchronization of mutual communicative capacities in a dissociated sphere.

Transdiagnostic Dimensions of Dissociative Psychopathology

Some type of psychological and/or neurobiological disintegration is a phenomenon, which may apply in any psychiatric disorder including "schizo-phrenia." Thus, it is of high interest to identify the dynamics of the intrapersonal and interpersonal mental operations involved with dissociation, which become manifest through partially overlapping nosological categories.

Differential diagnosis of borderline personality disorder (BPD) and dissociative disorders (DDs) is one study area suitable for such inquiry. This is due to the large diagnostic overlap between these two categories, and because their relationship to childhood trauma has been demonstrated both in clinical and community settings (Şar et al., 2006, 2003). Analyses of the data collected in stepwise (self-report and blind structured clinical interview) assessments of a college population on DD, BPD, and reported childhood trauma led to insights summarized in a group of previous papers (Şar et al., 2006, 2017a, 2014, 2017b). A concurrent diagnosis of BPD and DD (dual diagnosis) has led to more *identity confusion, derealization*, and *overall severity of dissociation*. The latter was also correlated with the total number of DSM-5 BPD criteria met. A more detailed inquiry of this spectrum was found to be necessary in order to identify whether this relationship was only a matter of severity.

A set of self-report questionnaires (Steinberg & Schnall, 2000) administered in this large-scale (n = 1301) study provided opportunities for dissecting core areas of dissociation into further subdimensions through factor-analyses (Şar et al., 2017a, 2014, 2017b). The domain of dissociative amnesia was subsumed under three factors: dissociated behavior & generalized amnesia, memory gaps, and intrusive memories. Depersonalization-derealization was represented in four dimensions: cognitive-emotional self-detachment, perceptual detachment, detachment from external reality, and bodily self-detachment. Finally, the domain of identity alteration and confusion was composed of three factors: intrusions from within, being perceived as acting like a different person, and having imaginary friends and angry outbursts. Taken together, these 10 subdimensions inspired various cross-cutting perspectives of subjective experiencing: internal versus external world, cognition-emotion versus body, detachment from oneself versus detachment from environment, forgetting versus remembering, self-perception versus perception of others, and last but not least, *intrusion versus avoidance*: the distance to pain and fear.

Knowing and Not Knowing: Awareness and Coping

One challenging outcome of these studies was the discrepancy between scores obtained by self-report and clinician-administered standardized assessments. These differences between the data collected in personal and interpersonal settings were too consistent to be considered as merely a sign of psychometric weakness of the instruments. In fact, they reflected the real condition, i.e., perceptual differences and alterations that are aspects of dissociation. These discrepancies seemed to represent individual dynamics of coping with developmental traumatization including awareness about both current subjective psychopathological experiences and memories of traumatic antecedents. The influence of the interpersonal setting on clinical interview should also be considered. The "inner world" of the disintegrated individual which is organized to cope with (emotional) pain and fear requires self-courage to be shared with an interviewer who represents the "external reality." Namely, mental content, when conveyed to someone else, effectively transmutes to the status of external reality. This can be threatening to the subject with a fragmented internal world, and poses challenges to the productive work of the intervening therapist. Indeed, a fantasy turning to reality may be a frightening rather than pleasurable experience.

Somewhat paradoxically, the opposite is expected to occur in effective psychotherapy despite the truthfulness of trauma! This occurs through sharing the inner experience in a safe environment which is itself transforming. Such transformation of the patient's subjective reality is the prerequisite of integration, i.e., accepting one's biography and the truth as they are. The disintegration rooted in the effort of minimizing the traumatic impact of the event by establishing other inner perspectives should end in unification. The reversal of the disintegration can be achieved via the acceptance of the patient that this "hand-made" inner world does not reflect external reality.

Internal or psychological "realities" constitute a virtual presence compared to the actual external world. Rather than a cause of psychological detachment, "alternate" personality states may emerge as a response to it. Precocious merger of the two worlds is not adaptive. This is why DDs usually remain hidden, i.e., not only because of consciously experienced shame or voices which forbid sharing of their presence. Nevertheless, confiding a secret in a safe environment may strengthen the bond with the therapist.

Awareness of the experience of trauma may impede integration unless paced therapeutically as in treatment which is phase-oriented. "Untamed" awareness may lead to post-traumatic stress disorder (PTSD); that is, individual dissociative barriers are both dissolved and subsequently re-

created. This describes and comprises the basic dynamics of any posttraumatic condition: avoidance and intrusion of mental content and overmodulation and undermodulation of emotions (Lanius et al., 2010).

Analogically, childhood trauma itself may also be divided into omission (neglect) and intrusion (abuse) types. Nevertheless, the terms are interchangeable. This is because omission may involve (hostile) rejection and intrusion may also lead to the experience of loneliness and abandonment. Another division may be between bodily (sexual and/or physical abuse and neglect) and cognitive-emotional (emotional abuse and neglect) types of adversities, which may initiate different coping mechanisms. While both omission and intrusion refer to a threat to personal and interpersonal *boundaries* in contrasting ways, bodily and cognitive-emotional maltreatment refers to a threat to the *self-control* on (or self-regulation of) one's internal (i.e., mind and emotions) and external (i.e., the body and behavior) presence; both being most important and stressful consequences of cumulative traumatization to be monitored and dealt with throughout every treatment until recovery.

The combination of overprotection-overcontrol (intrusion presented as love and care) and emotional neglect, on the other hand, represents a double-bind in the relationship with a caretaker. This is a kind of "betrayal" (Freyd, 1994), a phenomenon which leads experiences to be traumatic by disrupting the subject's perception of reality (Şar et al., 2021).

Overprotection-overcontrol is, in fact, a type of intrusion presented as normative careful caretaking. Typically, these parents are oppressive-restrictive and prone to boundary violations. Different than the verbal emotional abuse, the relatively invisible quality of this type of emotional abuse creates both anger and guilt. Such interpersonal interference may have started "very early" (Şar, 2020) in life, affecting the developmental period of mirroring by the primary caretaker (Fonagy et al., 2002).

Interestingly, overprotection-overcontrol together with emotional neglect predicted depression among young adults (Şar & Türk-Kurtça, 2021). The betrayal aspect of this confusing caretaking style was mirrored by the preoccupied and fearful attachment styles of the participants as additional predictors of dissociative depression. Such combination represents an ambivalent relationship which historically has been a well-known psychodynamic cause of depression (Freud, 1917).

Differentiating Personality from Disorder in an Era of Estrangement

Additional details of the empirical output of the above-mentioned college population study (Şar et al., 2006) are illuminating. In the second phase of the project, a subgroup with BPD and/or DD and controls (n = 191) were assessed through blind semi-structured clinical interviews. This was in

addition to the self-report measures of the first phase to address the perceptions of the subjects' and clinicians', respectively. Although both BPD and DD diagnoses were associated with dissociative amnesia in clinical interview, DD patients underreported this in self-assessment (Şar et al., 2014). Thus, they were less aware of their amnesic gaps compared to those with BPD in relation to which the concept of "amnesia to amnesia" (Kluft, 1988) is apposite.

Subjects with DD possibly experienced complete switching between personality states, while those with BPD suffered from more awareness about their discontinuities. This may be due to the co-presence/co-consciousness of "parallel-distinct personality states" (Şar, 2017) or a more effective pursuit of memory trace by at least one (host?) of them. This is a situation in which the subject with DD tries to terminate contact to (i.e., avoid) her inner disturbance. The person with BPD, however, strives to catch and express the origins of this. The question of what this observation reflects admits of several possibilities: (1) clinicians' considerations when differentiating BPD from DD, (2) patients' changing attitudes in personal and interpersonal settings, (3) different pathways of coping with developmental traumatization, or (4) consequences of diverse types of childhood trauma.

In this college study (Şar et al., 2017b), denial or minimization of trauma history (i.e., idealization of the perpetrator) was a predictor of *mental intrusions from within*. Not surprisingly, as an internally experienced type of identity disturbance, intrusions from within was *a predictor of both BPD and DD*. However, *externally experienced identity disturbance* such as being perceived as a different person, expressed anger, and having imaginary friends was associated with the BPD rather than DD diagnosis. Among four components of depersonalization-derealization, *detachment from external reality* also predicted BPD (Şar et al., 2017a). Thus, the main difference between BPD and DD was in *introtensitivity and extratensitivity* of experiencing, i.e., the detachment was experienced in the interpersonal domain in BPD more readily in addition to the intrusions from within. Interestingly, depersonalization was under-assessed in clinical interview among those participants with BPD despite affirmative self-reports. This is the opposite of what occurred with dissociative amnesia in DD.

Apparently, both BPD and DD are related to avoidance of fear and pain while representing desperate attempts to gain the lost unity and connectedness back at the same time. The phenomenon of BPD is, predominantly, about distancing from the external "reality" while claiming to participate in it "extratensively." The opposite seems to be valid for DD: Distancing from (and surprisingly finding an "enemy" in) oneself while claiming to take contact with the internal "world", i.e., the town of "expectedly limitless possibilities."

Escape from Inner Reality and Return of the Dissociated

Although mental intrusions from within (e.g., interference of alternate personality states) may be unlimited in their capacities to escape from reality as an activity of the inner world, nevertheless, they are restricted in agency. This is due to the partial control still maintained by the host and other personality states of the internal system. The opposite is valid for an externally experienced mental content unless a culture or subculture enables liberty to some of these deviations from normative. They are aberrations over which there is a collective consensus in the community regarding shared agreed upon realities. An example of this might be possession by shared external entities which operate like "currencies" it is possible of exchange, i.e., in contrast to private alternate personality states, they can move from one person to another. This is the reason why working individually and "inside" of the patient provides fertile opportunities for therapeutic change. Extension of inner experiences to the external world, on the other hand (unless approached and engaged specifically and accurately), may elicit resistance and thereby impede therapeutic interventions.

Clinical phenomenology pertaining to this study was possibly influenced not only by the assessment setting but also by a traumatic past and the ability of respondents to report it. For example, reported sexual abuse was the trauma type which was associated with memory gaps and BPD criteria. It was also associated with identity alterations which, alongside dissociative amnesia, constitute the main two diagnostic criteria of DID in DSM-5. Here, an opportunity emerges to obversely speculate about a further discrepancy in the data as the conditions associated with *lack of report of childhood sexual abuse* were characterized by *intrusive memories, dissociated behavior*, and *generalized amnesia*. The latter pattern suggests the presence of inaccessible memories among individuals who are close to embarking on a trauma-related enactment (*return of the dissociated*), i.e., an acute crisis superimposed on a chronic post-traumatic process. *Absence* of sexual abuse was also associated with bodily self-detachment, detachment from external reality, and experiencing identity disturbance in the outside world. This composite pattern which was related to both ways of leaving oneself (body and/or identity) seemed to comprise mental avoidance overall.

At the Cross-Roads of Avoidance: Two Ways of Leaving Oneself

Might *identity alteration* be a way of coping with awareness of sexual abuse? And could *bodily self-detachment* indicate a burden of amnesia to sexual abuse? Namely, reported childhood sexual abuse was associated with cognitive-emotional self-detachment and perceptual detachment but not with bodily self-detachment. Apparently, awareness of sexual abuse led to dissociation in the type of BPD and/or DID. The combination of bodily depersonalization and dissociative amnesia, however, constituted a type of DSM-5 Other

Specified Dissociative Disorder (OSDD) with less than marked presence or lack of distinct personality states but mixed and enduring dissociative symptoms.

Bodily self-detachment was predicted by physical and emotional neglect but not by any type of abuse, albeit the latter was underreported due to denial or amnesia (Şar et al., 2017a). Indeed, this pattern of disowning the body (Ataria, 2016) was associated with dissociative amnesia but not with other dissociation measures.

Alongside bodily self-detachment, detachment from external reality had the highest correlations with self-mutilative behavior. What do they have in common? Might this have something to do with turning the body to an enemy (Ataria, 2016) onto which evil is projected as well? Could this be because the body is perceived as an "exogenous" entity compared to one's "internal world" too? For example, it is vulnerable to physical diseases which seem to come out of nowhere and unexpectedly. A physical disease can even be experienced as an insult to the person who may feel *betrayed* by her own body (Şar et al., 2017c). It can also be captured by malevolent others via physical control. One's willpower may be restricted unless the individual decides to vacate the body, e.g., through an attempt of suicide. The latter is the most radical option reserved for unbearable situations when there is no other perceived way of escape. Might somatoform dissociation (functional neurological symptom or conversion disorder), pertain to the fear of being kept under control which paradoxically results in loss of control of the body? Namely, depersonalization and amnesia are the most frequent dissociative symptoms in patients with conversion disorder (Şar et al., 2004). Depersonalization-derealization is one of the most resistant dissociative symptoms if experienced in the absence of other dissociative symptoms (an observation which likewise applies to somatoform symptoms). Apparently, their adaptive function as a way of escape from oppression is the cause of resistance and persistence.

An interim summary may be helpful at this point. In the study being discussed, BPD, DID, and bodily self-detachment constitute a triangle and amnesia was their common ground. While identity disturbance was common to BPD and DID (pathway 1), bodily self-detachment was more associated with OSDD (pathway 2). Identity alteration and amnesia (the two main diagnostic criteria of DID in DSM-5) were not the main differences between BPD and DID either. Both were characterized by enduring instability in daily life regardless. Rather, identity alteration and amnesia both served as an avoidance type of coping mediated by the type of childhood trauma (intrusion or omission). Namely, BPD was predicted by total childhood trauma score, all types of abuse, and physical neglect (Şar et al., 2006). The latter may also be perceived as a type of overt abuse due to its drastic quality. Thus, BPD was

associated with the intrusion type of trauma. Minimization of trauma (denial of abuse, idealization of the perpetrator) and emotional neglect (omission), however, were related to DDs.

The *second important result* derived from the empirical data of the study is that the alternative to the disturbance of identity (BPD and/or DID) is the more subtle chronic dissociation, which may lead to transient crises and reenactments on a spectrum between acute reaction stress to dissociative psychosis in its most severe form. Bodily self-detachment, amnesia and a history of both emotional and physical neglect are the main characteristics of such an OSDD, which represents, in fact, the "pathway 2" of coping mentioned above.

Coping with abuse and neglect seems to lead to different types of "identification with the aggressor." While abuse would more readily lead to *projective identification* (close to BPD phenomenology), emotional neglect boosts *introjective identification* (close to DD phenomenology). Aggressive-rejecting-conflictual and narcissistic-identificatory-fusionary types of object relationships have different consequences in terms of the experience of belonging to a larger context or greater whole, whether this is family, community, or any conception of what that wider context might look like or comprise.

Boundaries of Internal World and External Reality

The American Psychiatric Glossary (Stone, 1988) defines reality testing as the ability to evaluate the external world objectively and to differentiate adequately between it and the internal world. Impaired reality testing is one of the major hallmarks of psychosis. Patients with DID or related types of OSDD usually have cognitive insight overall (Şar et al., 2012) and into their illness except during an episode of dissociative psychosis (Şar, 2022) which can be prolonged as seen in some cases of severe maladaptive daydreaming with limited meta-awareness. For example, one such breach between internal world and external reality in DDs is known as "internal homicide" (Putnam, 1989). This is an annihilating act driven by an alternate personality state when a patient succeeds in completing such self-destruction by targeting her own body. Given that, some criminal acts may be "enactments" (Şar et al., 1990), in fact, *an actual murder is an extended suicide and any suicide is an internal murder.*

Regulation of reality perception requires consideration of the mutuality between internal and external world. Childhood abuse, neglect, and insecure attachment disrupt this balance in such a way that internal reality becomes more compelling. Developmentally, a balance between the external and internal world is optimally established via the caregiver's adequate mirroring. The caregiver's responses should accurately match the infant's mental state (Şar, 2020). In the thinking of toddlers' and preschoolers', internal and external

world is equated: "psychic equivalence" (Fonagy et al., 2002). Alternative perspectives of reality are scarcely considered in this condition such that a fantasy may be experienced as potentially real. In "pretend mode," however, thoughts and feelings can be expressed in the absence of objectively real presentation. The opposite of the pretend mode is known as the "teleological mode" which is characterized by a black and white perception of reality which focuses on what is physically apparent.

In DDs, internal reality is experienced both in psychic equivalent and pretend modes. This occurs in a dialectical fashion described as the "dissociation paradox" (Şar et al., 2012). Namely, cognitive insight is empirically defined as the difference between self-reflection and self-certainty. Individuals with a DD have elevated self-certainty to a scope unusual for non-psychotic disorders. If combined with diminished self-reflection, elevated self-certainty would lead to delusional thinking. But, self-reflection is not disturbed in DD, such that he increased self-certainty does not undermine the cognitive insight.

A helpful construct for understanding the developmental and interpersonal origins of perception of reality is mentalization. Mentalization is the ability to understand the mental state of oneself or others (i.e., basic prediction of motivation that underlies their overt behavior). Development of mentalization capacity and experiences of mirroring with primary caregivers are interrelated. The caregivers should be able to express an affect while indicating that they are not expressing their own feelings. This is the so-called marked (in contrast to the unmarked) mirroring which helps the child to differentiate their (the child's) mirrored emotions from those which are not theirs. Otherwise, the caregiver's expression may seem to mirror the child's own emotion and, consequently *externalize* (as a first example of extratensive processing) the infant's experience and may overwhelm the infant due to the mismatch with the origin. Additionally, a predisposition to experience emotions through other people might be established by this early interpersonal template. This is the first step leading to emotional dysregulation which further shapes perception of reality (Fonagy et al., 2002) and is one example of *the combination of intrusion and omission* types of traumatization in the cognitive-emotional sphere early in life (Şar, 2020).

Types of Childhood Adversities and "Endogenous" Psychoses

Notwithstanding epigenetic influences in their pathogenesis, schizophrenic and bipolar disorders are considered as psychiatric conditions with robust biological-constitutional-genetical roots; hence, they were formerly called "endogenous" psychoses. Yet, in an outcome study on bipolar disorder, the total severity of childhood trauma (including all types of abuse) predicted

lifetime general psychiatric comorbidity, use of antidepressant medication, and psychotic features (Cakir et al., 2016). While physical neglect predicted average severity of mood episodes and psychoticism, emotional neglect predicted suicide attempts.

In a study on schizophrenic disorder, subgroups with and without dissociative symptoms both had their highest scores on emotional neglect among all types of childhood trauma. As with BPD, however, dissociative schizophrenia patients had significantly higher scores on all types of childhood abuse and physical neglect compared to the non-dissociative group (Şar et al., 2010). They also had higher scores on BPD criteria alongside somatoform and Schneiderian symptoms, extrasensory perceptions, and general psychiatric comorbidity. In an other study, "dissociative depression" (Şar, 2011) also covered BPD symptoms alongside Schneiderian experiences, possession and suicidality (Şar et al., 2014). The common ground for the latter pattern was childhood trauma, while symptoms of BPD were transdiagnostically at the crossroads of clinical phenomenology. In schizophrenic disorder, unlike dissociative experiences, childhood trauma did not directly correlate with Schneiderian symptoms and number of general psychiatric comorbidity (Şar et al., 2010). Thus, dissociation seems to be the mediator between childhood trauma, nosological fragmentation and diminished sense of self-agency in schizophrenic disorder.

These clinical outcomes seem to represent expressions of different types of childhood trauma. While intrusion leads to *a polymorphous clinical phenotype*, omission leads to *bodily self-detachment* and *detachment from external reality* which have been shown as significant correlates of self-mutilation (Şar et al., 2017a, 2017b). While related to the intrusion type of trauma, BPD also has a parallel association with the omission pole through one symptom dimension: detachment from external reality. This is possibly the junction at which different post-traumatic pathways meet.

What about chemical treatment? Response to lithium treatment (the ultimate chemical to prevent mood disorder episodes) was not related to childhood trauma in bipolar disorder. However, a concurrent diagnosis of PTSD determined insufficient response to lithium and, consequently, antidepressant use was more frequent. Anticonvulsants operated differently: presence of a concurrent PTSD did not have any effect on the response to them, however, childhood emotional and physical abuse predicted insufficient response to anticonvulsants in terms of preventing new episodes of bipolar disorder. These findings seem to represent different effects of *early (childhood)* and *later trauma (PTSD)*. As far as I am aware, a similar study (i.e., the influence of childhood trauma on treatment response) for antipsychotic medication in schizophrenia has yet to be conducted.

Somatization: Body as Container of Negative Emotions

Among patients with fibromyalgia or rheumatoid arthritis (two chronic psychosomatic disorders which cause bodily pain), all types of childhood abuse (intrusion type of trauma) predicted cognitive-emotional dissociation, while emotional neglect predicted somatoform dissociation (Kılıç et al., 2014). Cognitive-emotional dissociation was associated with current severity of depressive disorder, while somatoform dissociation was associated with a lifetime diagnosis of depressive disorder, i.e., coverage of a more subtle process. Indeed, in a study on an endemically disadvantaged group of women with somatization disorder, childhood trauma was related to all indirect signs of early traumatization in the form of trauma-related psychiatric comorbidities including possession states, a direct significant relationship between reported childhood trauma and dissociation scores did not appear (Taycan et al., 2014). Suggesting the role of actual environmental conditions in ongoing dissociation, similar observations on such a missed correlation were made on male prisoners (Şar & Akyüz, 2002). Interestingly, both populations were exposed, albeit for different reasons, to some type of *systemic restriction (or oppression)* in their present life.

Among patients with fibromyalgia or rheumatoid arthritis (Kılıç et al., 2014), current severity of depression predicted expressed anger. The latter was associated with loss of control, number of BPD criteria and dissociative amnesia. Loss of control was predicted by all types of abuse, identity fragmentation, and dissociative absorption (narrowing of consciousness). This pattern indicates a crisis state (nervous breakdown) which seems to do with an outburst of the previously overmodulated anger possibly related to "reminiscences" of trauma. Thus, such a dissociative depression may represent emergence from a closed inner system through a window which should be both diagnostic and therapeutic.

Thus, somatoform dissociation reflects rather overmodulation of emotions, while cognitive-emotional dissociation accompanies emotional expression (undermodulation) which leads to phenomena of BPD and loss of control. The intrusion type of childhood trauma seems to lead more readily to overt crisis in the form of emotional outbursts, while the omission type establishes fertile ground for chronic hidden psychopathology. Nevertheless, overmodulated anger may enable such a severe cognitive rigidity that even a *somatoform type of dissociative psychosis* emerges which may become chronic. The latter is characterized by quasi-delusional thinking and hallucinatory experiences about perceived disturbances of bodily functions.

Narcissism: A Defense Against Fragmentation?

A college study (Şar & Türk-Kurtça, 2021) is suggestive of a new description of dissociation in that the Dissociative Experiences Scale (DES) was positively correlated both with grandiose narcissism and depression scores despite negative correlations between the latter two. Indeed, grandiose narcissism and depression can coexist only in a dissociated (inner) world. This discrepancy resembles the rather narcissistic flavor of most alternate personality states which tend to be vulnerable, grandiose or both. The host personality usually suffers from depression and/or PTSD. The vicious cycle between "traumatic narcissism" (Şar & Türk-Kurtça, 2021) and "dissociative depression" (Şar, 2011) may even take the form of a *dissociative mood disorder*. The latter is relatively common among dissociative adolescents and children who insidiously switch between alternate personality states carrying different emotions.

The narcissistically created inner world is a way of coping with the imagined (ideal) individual psychosocial growth which can only be achieved to a limited extent. This is a dilemma between "growth panic" (DeMause, 2002) and the wish to overcome the discrepancy between one's ideal and actual selves. The limits of the lifelong psychosocial growth of an individual are partly predetermined by the parenting style to which she has been exposed. The latter factor is sensitive to intergenerational transmission of trauma including cultural evolution of the childrearing modes over centuries. Interestingly, alongside sexual abuse, women with dissociative depression reported more educational deprivation which was rationalized by gender-biased traditions and conservatism in a non-industrialized geography (Şar et al., 2013). Educational deprivation was a predictor of current severity of depression among women with fibromyalgia-rheumatoid arthritis too (Kılıç et al., 2014).

The compensatory grandiose narcissism requires a "folie à deux" with "self-objects" to transiently bridge the discontinuities about reality. Indeed, vulnerable narcissism was predicted by preoccupied attachment but not any other type of childhood trauma and neither by dissociation scores. This position seems to reflect a situation of dependency on self-objects in order to confirm the fantasies of excellence and completeness. Namely, the only other predictor of vulnerable narcissism was the disappointment in an allegedly secure relationship resulting in depression and defensively recursive grandiose narcissism subsequently maintained by dissociation.

Interestingly, sexual abuse and physical neglect, the most severe and overt types of intrusive trauma targeting the body, were predictors of grandiose narcissism (Şar & Türk-Kurtça, 2021). This most concrete type of traumatization in childhood seems to initiate an attitude of pseudo-autonomy and readiness to fight any threat of dominance. An "as if" personality emerges which is "reversible" on encountering and is easily directed by an external

power. This is due to the dominance of one's "sociological self" detached from her more unitary, authentic, and compassionate "psychological self" (Şar & Öztürk, 2007). Such narcissism is susceptible to manipulation of individuals and masses by abusive powers even against their own interest; e.g., by "quasi-leaders" who themselves are nothing more than puppeteered sociological figures or "false-pulpits."

Unfortunately, one method of coping with pain is utilization of others (individuals, groups, or communities) as proxies, i.e., as extended victims. Hence, the need to develop awareness about and obtain courage and strength to recognize and accept the truth and one's vulnerabilities in this regard, i.e., difficult tasks which effective psychotherapy can facilitate (unfortunately, only on an individual basis and limited to those heroic individuals who see a merit in it).

Foundations of a Dialectical Dynamic Therapy

The leitmotif of these thoughts has been the dialectic dynamics of transdiagnostic dimensions of coping with derivatives of childhood trauma. Here is, finally, the place to put forward the implications of this way of thinking for an effective interventional psychotherapy of trauma which I wish to subsume under one rubric: the "Dialectical Dynamic Therapy."

Dialectical thinking is dealing with thesis and antithesis (accepting coexistence of the opposites) to achieve a creative-integrative *synthesis*; i.e., without falling into "trans-logic." This is the core principle of understanding psychotraumatology (Fischer & Riedesser, 1999) and in fact, the highest step of the individual cognitive development (Basseches, 1980). Thus, it is not a surprise that dialectical thinking is a facilitator of both true science and effective psychotherapy.

Why dialectics? Lacan (1966) referred to the most universal betrayal of the "civilized" human society once saying that: "for centuries, knowledge has been pursued as a defense against truth." In a world of power ("master's discourse"), the sole scientific attitude was, for him, asking questions ("scientific discourse") but not replacing the truth, directly or indirectly, with "master's" reality as seen in "academic discourse" (Fink, 1998). Thus, science would be possible only in the "hysterical (dissociative in today's terminology) discourse" where the subject is divided to challenge the reality by asking questions of themself.

Clinical phenomena of "hysteria" have inspired clinicians, theoreticians, and researchers for centuries in turn producing contrasting "scientific" paradigms with some blind spots in the bigger picture. These explanations by mainstream thinkers hardly facilitated the effective treatment of traumatized patients and those with DDs in particular. And the symptomatic phenocopies

provided by these patients (e.g., functional neurological symptoms) continued to challenge mainstream knowledge about other psychiatric and even general medical disorders, i.e., the science and practice of medicine over centuries.

What is required, in contrast, is a Dialectical Dynamic Therapy different in its discourse from the currently known modalities. Neither asking questions nor challenging (hysterisizing) "the master signifiers coughed by the analysand" in the form of "analytic discourse" (ironically, the chosen word "analysis" itself refers to an antithesis of synthesis) is sufficient for an effective treatment of a traumatized client. Namely, the internal world (the focus of any dynamic treatment) of a dissociative patient is a power-driven sphere; little different from the camouflaged truth of the external reality of a still power-driven world (its aspirations to civilization notwithstanding). In master's discourse, it is slave who collects and produces knowledge which master orders and appropriates. The relationship between patient and clinician is necessarily asymmetrical due to the professional responsibility and also officially being trained and approved for this purpose of the latter (the master) in this dyad. To address the *power paradox* involved, the therapist should *dialectically reverse the roles in the master's discourse* and challenge (i.e. "hystericize") the "master signifiers" they (the therapist) has incorporated-internalized by previous learning (and which have thereby become mindsets). In an other conceptual context, this is the way of harmonizing the sociological (main seat of the master's discourse) and psychological self of an individual in her inner world to achieve a rather integrated self capable of dialectical thinking (Şar & Öztürk, 2007).

This operation should occur through utilization of the knowledge obtained from the "slave". Alleviating the tension of the patient via the transfer of information flow toward the therapist would export the subject's initial dividedness to the therapist who should be sufficiently courageous to utilize this for their own coping. As a *shaman* (Winkelman, 2010) *of modern times*, the master themself is divided and should cope with their own dividedness without an expectation or attempt to obtain individual healing on their part. Nevertheless, the dialectical style should involve not only knowledge, thinking, perceiving, and emotional experiencing but how the *relationship* and *communication* between the therapist and the patient evolve. Following the order of "intellectual honesty" (Metzinger, 2014), any emerging "surplus value" should be deposited to the common spiritual treasury of humanity as a biopsychosocial heritage accessible to both masters and slaves and inclusive of all genders, ethnicities, cultures, and markers of social diversity. Experienced clinicians and researchers (but also any newbie medical student when exposed to the universality of the human body while exercising dissection in anatomy practices) would agree that *there is (almost) no (such thing as) local!*

The phenomenon and coping strategy of dissociation confirms that the human individual is a social creature in that detachment from environment disturbs the coherence of one's internal world. The "comradeship" of master and slave is a declaration of respect to the mere existence and life. Validation of the impacts of traumatic memories by the therapist alleviates posttraumatic structures. As a source of inspiration, therapist (master) delivers several formulae to the patient who chooses which of them to utilize in achieving solutions for individual impasses and for those arising in therapy. This is a process of proposing and ratification which can also operate in the opposite direction. In fact, *there is (almost) no (such thing as) master or slave* but the process of ratification does! Nevertheless, the invitation to initiate assists acquisition or regaining of a sense of agency and, subsequently, a sense of self. This empowerment boosts the wish of recovery in the patient, reduces fear and pain, initiates creative learning additional to modeling, and nurtures hope, conviction, and belief as wisely expressed in the phrase: "we (I) shall overcome."

Acknowledgments

I wish thank to my "silent partners" including but not limited to several of my colleagues, students, and last but not least, *my patients* for their valuable inspirations and comments which nicely "glimpse" in various places of this text.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Vedat Şar, MD
Professor and Chair, Department of Psychiatry, Koç University School of Medicine, Istanbul
vsar@ku.edu.tr