42 Multiple Self-States, the Relational Mind, and Dissociation: A Psychoanalytic Perspective

Philip M. Bromberg, PhD

OUTLINE

The human personality possesses the extraordinary capacity to negotiate stability and change simultaneously, and will do so under the right relational conditions. I believe that this attribute is what we rely on to make clinical psychoanalysis, or any form of psychodynamic psychotherapy, possible. How we understand this remarkable capability of the mind, and what we see as the optimal therapeutic environment for it to flourish, are, I suggest, the most fundamental questions that shape the theory and praxis of psychodynamic psychotherapy.

In discussing these issues I will explore the central role of dissociation in normal personality functioning, in psychopathology, and in the process of psychotherapy. I will try to show why psychotherapeutic personality growth is, at its core, an intersubjective-interpersonal engagement between human beings, each possessing a mind organized as a nonlinear configuration of multiple self-states. *I contend that the mind is inherently relational in both its normal process of developmental maturation and in its subsequent ability to usefully participate in a psychotherapeutic process.*

Beahrs (1982, pp. 65–66) said that "we are advised to ask when dissociation is useful and when it is not." I would add to this that in each *individual* treatment we are well advised to ask how dissociation is useful. We should assess the degree to which that usefulness has been enlisted in the formation of a dissociative mental organization that is so rigid that it defines its own pathology.

42.1 HYPNOID STATES, DISSOCIATION, AND PSYCHOANALYTIC HISTORY

The constraint on the inclusion of dissociation in the development of psychoanalytic theory began with Freud's

break with Josef Breuer. Following the publication of *Studies on Hysteria* (Breuer & Freud, 1893–1895), Freud sharply disagreed with Breuer about hypnoid states and splitting of consciousness (see Bromberg, 1996b). Breuer essentially supported Charcot (1882, 1887), Binet (1892), and Janet (1889), by stating in his theoretical chapter in *Studies on Hysteria* (pp. 185–251), that "what lies at the centre of hysteria is a splitting off of a portion of psychical activity" (p. 227). Breuer then took this view still further by insisting that this was "a splitting not merely of psychical activity but of consciousness" (p. 229). In brief, Breuer claimed that traumatic hysteria is mediated by a process that can "be classed with autohypnosis" and that "it seems desirable to adopt the expression 'hypnoid,' which lays stress on this internal similarity" (p. 220).

But, while Breuer asserted that the basis of hysteria was the existence of hypnoid states that had the power to create an amnesia, Freud rejected Breuer's concept of self-hypnosis and later contended that he had never encountered a self-hypnotic hysteria, only defense neuroses (Bliss, 1988, p. 36). After *Studies on Hysteria*, Freud tended to be openly contemptuous about the theoretical usefulness of dissociation, hypnoid states, or alterations in consciousness (Loewenstein & Ross, 1992, pp. 31–32). Berman (1981) characterized Freud's position as a "one-sided anti-Janet stand" (p. 285) that led psychoanalysis, for the next century, toward an "emphasis on repression at the expense of dissociation" (p. 297).

Nevertheless, there has always been a small coterie of independent thinkers representing different schools of analytic thought who contended that the quality of the analytic relationship is necessarily shaped by dissociation because dissociation is a key aspect of mental functioning. Several major theorists (Ferenczi, 1928, 1930, 1931, 1933; M. Balint, 1935, 1937, 1952, 1968; Sullivan, 1940, 1953, 1954, 1956; Fairbairn, 1929, 1940, 1944, 1952; Bion, 1957, 1965; and Kohut, 1971, 1977) argued that severe dissociation was etiologically linked to an early history of psychological trauma. Each of these theorists was struggling, in his own way, with the question of how dissociation shapes the analytic relationship and its effectiveness.

The longevity of the term *dissociation* in psychoanalysis, however, is due largely to Sandor Ferenczi (1930, 1933), a debt that cannot be overestimated. In opposition to Freud, Ferenczi believed that dissociation is a normal aspect of routine human development, and because of this, the quality of the analytic relationship takes on special significance. Ferenczi saw the etiology of *defensive* dissociation as linked to an inevitable aspect of personality development designed to protect the mind, at almost any cost, against the reactivation of traumatizing affect. "To Ferenczi the dissociated state included more than a set of associatively isolated traumatic memories; he described the dissociated state as a whole person, a child, and the delirious quality of that child as a reactivation in the treatment setting of the traumatically overstimulating situation" (Davies & Frawley, 1992, p. 12). Ferenczi pioneered the contemporary analytic view that regressive reliving of early traumatic experience in the analytic transference is to some degree curative in itself because it encourages active mastery of the traumatic "past" through use of the here-and-now analytic relationship.

Today, increased attention is being paid to the normal multiplicity of states of consciousness. This is evoking a conceptual shift toward a view of the mind as a configuration of discontinuous, shifting states of consciousness. These states are understood to have varying degrees of access to perception and cognition because many domains of dissociated self-experience have only weak or nonexistent links to the experience of "I" as a communicable entity. It should be noted, by the way, that this is true not only of patients with a history of *massive* traumatization. Before these hypnoidally inaccessible self-states can be taken as objects of cognitive reflection, they must first become "thinkable" by becoming linguistically communicable through enactment in the therapeutic relationship. Until this happens, neither repression nor even the experience of intrapsychic conflict can take place because each state of consciousness holds its own experientially encapsulated "truth," which is repetitively enacted. The difficulty for psychoanalysts is that they have lacked a strong theoretical model that could deal with the implications of this. When Freud dismissed the phenomenon of dissociation, he formulated a belief system that posited that (except for the most seriously disturbed patients) his concepts of "repetition compulsion" and "interpretation of resistance to unconscious conflict" constituted sufficient foundation upon which to build a theory of clinical technique.

42.2 THE RELATIONAL MIND, MULTIPLE SELF-STATES, AND DISSOCIATION

42.2.1 The Relational Mind

Mitchell (1991), in developing his now seminal view of the mind as relationally organized, writes the following:

> The key transition to postclassical psychoanalytic views of the self occurred when theorists began thinking … of the repressed not as disorganized, impulsive fragments but as constellations of meanings organized around relationships, and they began to conceive of the id as

> involving a way of being, a sense of self, a person in relation to other persons. M. Klein, Fairbairn, Jacobson, Loewald, and Kernberg, each in their own way and in their own language, portray the id as a person or collection of persons in passionate relationships to other persons or parts of persons. Fairbairn's ego and object units are … versions of the person himself, and they embody active patterns of experience and behavior, organized around a particular point of view, a sense of self, a way of being, which underlie the ordinary phenomenological sense we have of ourselves as integral. Because we learn to become a person through interactions with different others and through different interactions with the same other, our experience of self is discontinuous, composed of different configurations, *different selves with different others.*… [E]ach actual relationship may contain multiple self-organizations; and there may be many such relationships. (pp. 127–128, emphasis added)

> The result is a plural or manifold organization of self, patterned around different self and object images or representations, derived from different relational contexts. We are all composites of overlapping, multiple organizations and perspectives, and our experience is smoothed out by an illusory sense of continuity.… Thus, the portrayal of self as multiple and discontinuous and the sense of self as separate, integral, and continuous are referring to different aspects of self. The former refers to the multiple configurations of self patterned variability in different relational contexts. The latter refers to the subjective experience of the pattern making itself … represented as having particular qualities or tones or content at different times; however, at every point, it is recognized as "mine," my particular way of processing and shaping experience. (p. 139)

42.2.2 The Relational Mind and Multiple Self-States: The Domain of Dissociation

Beahrs (1982) writes that "state of consciousness, schema, mood, role, system, ego state and alter personality all refer to some level of … mental unit. Separated by a boundary from others, each unit has characteristic features defining its identity and finite persistence over an extended period of time. Dissociation, then, is *the process of forming and maintaining the boundary of said unit"* (pp. 61–62, original italics). I believe that this definition would be considered by most researchers and clinicians to be empirically useful. The term *dissociation*, "first coined in psychology by William James, was developed to explain various phenomena of altered consciousness, such as somnambulism, fugue states, and conditions of double consciousness. Personality was considered a plurality of states ranging from pathological to transcendent, with waking consciousness being only one possible state among many" (Taylor, 2000, p. 1030). Slavin and Kriegman (1992) discussed this same issue in terms of evolutionary biology and the adaptive design of the human psyche:

> Multiple versions of the self exist within an overarching, synthetic structure of identity … [which] probably cannot possess the degree of internal cohesion or unity frequently implied by concepts such as the "self" in the self psychological tradition, the "consolidated character" in Blos's ego psychological model, or "identity" in Erikson's framework. … [T]he idea of an individual "identity" or a cohesive "self" serves as an extremely valuable metaphor for the vital experience of relative wholeness, continuity, and cohesion in self-experience. Yet, as has often been noted, when we look within the psyche of well-put-together individuals, we actually see a "multiplicity of selves" or versions of the self coexisting within certain contours and patterns that, in sum, produce a sense of individuality, "I-ness" or "me-ness." (p. 204)

As clinicians, we try to find within our patients a self we can talk to who can simultaneously talk to us: in the process, we find ourselves traversing states kept apart from one another by dissociation. This means that there are important ways in which the seemingly "unitary self" that we meet in our patients is incapable of true dialogic engagement and, in other important ways, incapable of the experience of intrapsychic conflict. When the acquired, developmentally adaptive illusion of being a unitary self is traumatically threatened with unavoidable, precipitous disruption, its very cohesiveness becomes a liability because that cohesiveness is in jeopardy of being overwhelmed by a trauma that it cannot process symbolically. In such situations, the mind, if able, will enlist its normal dissociative ability as a protective solution, to assure continuity and coherence of selfhood—its own survival.

In other words, when emotional experience is traumatic (more than the mind can bear), it remains unprocessed symbolically, leaving the person vulnerable to its *unanticipated* return if "triggered." To minimize the possibility of its *unexpected* repetition, a dissociative "early-warning system" develops—a self-curative dynamic that, in the long run is "worse than the disease" because the dynamic rigidifies into a dissociative mental *structure*. As an "early-warning system," this structure is designed to *anticipate* the triggering before it happens. It serves to gain some control over the shock of what cannot be regulated—the "triggering" of hypnoidally isolated emotion schemas that hold the affective memory of ungovernable hyperarousal.

In this context, the therapeutic goal of helping a patient to access and process unsymbolized experience is integral to any successful psychoanalytic process. It allows a patient's ongoing personality structure to safely accommodate new experience that leads to mutative growth. The traditional Freudian psychoanalytic focus on transference is based on two interrelated assumptions: (1) that the mind is organized by conflict and repression, and (2) that unconscious conflicts are objectively revealed when the patient transferentially "projects" his repressed unconscious conflicts onto the analyst. According to this Freudian model, the analyst's interventions should accurately interpret the patient's transference (and his resistance to the interpretation) in order to provide "insight" into the conflict being repressed. The problem with this formulation, however, is that it does not explain why interpretation of unconscious conflict and its "resistance" produces treatment failure or treatment impasse in such a large number of patients. It is now fairly clear that the dynamic conceptions of Freud participate in an ongoing dialectic with a complex latticework of psychic structure, one central organizing principle of which is dissociation.

42.2.3 Dissociation and Postclassical Psychoanalytic Thought

Dissociation was a pivotal concept in the birth and development of interpersonal psychoanalysis (Sullivan, 1940, 1953, 1954, 1956) and the "independent" school of British object relations theories (Fairbairn, 1929, 1940, 1944, 1952; Winnicott, 1945, 1949, 1960, 1971). Today, dissociation continues to receive its most active clinical and theoretical attention from contemporary analysts whose sensibilities represent one or both of these schools of thought (e.g., Bromberg, 1984, 1991, 1993b, 1994, 1998, 2000a, 2000b, 2001a, 2001b, 2003a, 2003b, 2003c, 2006; Chefetz, 1997, 2000, 2004; Chefetz & Bromberg, 2004; Davies & Frawley, 1992, 1994; Davies, 1996a, 1996b, 1998, 1999; Frankel, 2002; Grand, 1997, 2000; Harris, 1992, 1994, 1996; Howell, 1996, 2002, 2005; Mitchell, 1991, 1993; S. Pizer, 1998, 2002; Reis, 1993; Schwartz, 1994, 2000; B. L. Smith, 1989; D. B. Stern, 1983, 1996, 1997, 2003, 2004; S. Stern, 2002). Dissociation has also found its way into the work of analysts with a self-psychological orientation, particularly those interested in the phenomenology of self-states (e.g., Stolorow, Brandchaft, & Atwood, 1987; Ferguson, 1990).

Dissociation has begun to gain acceptance among postclassical Freudian analysts as well (e.g., I. Brenner, 1994, 1996, 2001; Faimberg, 1988; Gabbard, 1992; Goldberg, 1987; Lyon, 1992; Roth, 1992). Not insignificantly, some *classical* Freudian conflict theorists have begun to acknowledge dissociation as an intrinsic dimension of mental functioning, but they tend to minimize their conceptual departures from Freud by retaining his conceptual language (e.g., Gottlieb, 1997, 2003; Kernberg, 1991; Marmer, 1980, 1991; Shengold, 1989, 1992; H. F. Smith, 2000, 2001, 2003a, 2003b, 2003c, 2006; Waugaman, 2000).

All told, the shift within psychoanalysis toward recognition of dissociation is leading away from Freud's (1915) topographical stratification of unconscious-preconscious-conscious layering. The shift is leading toward a view of the mind as a configuration of discontinuous, shifting states of consciousness with varying degrees of access to perception and cognition. In this view, some self-states are hypnoidally unlinked from perception at any given moment of normal mental functioning—lending support to some of Freud's ideas in his *Project* (Freud, 1895) and *The Interpretation of Dreams* (Freud, 1900), while other self-states are virtually foreclosed from such access because they are either developmentally prelinguistic or unsymbolized as a response to trauma.

Freud believed that the "perceptual system" was circumvented or compromised during sleep and dreaming. More recent thinking about the mind argues that the perceptual system can also be circumvented by the mind's response to trauma. This is considered to be a normal developmental response to trauma and a basic defense against its recurrence. In broad terms, the older conception of psychodynamic therapy (i.e., that the therapist helps a patient to change a unified but unadaptive self-representation to a more adaptive one) is being replaced with a new understanding (i.e., that self-states of the therapist and patient relate to one another in a process that helps the boundaries between the patient's self-states to become more permeable).

Foundational to this view are two ideas: (1) every human being has a set of discrete, more or less overlapping schemata of who he is, and (2) each schema is organized around a core self-other configuration (Sullivan, 1953) that was shaped early in life. Wolff (1987), for example, sees the self as nonunitary in its very *origin*. Wolff's study of infants led him to see the self as (1) a structure that originated as a multiplicity of self-other configurations (i.e., "behavioral states"), (2) that developmentally attains coherence and continuity, and (3) that subjectively comes to be experienced as a cohesive sense of personal identity—an overarching feeling of "being a self."

According to Kihlstrom (1987) [quoted from LeDoux, 1989, p. 281], "in order for unprocessed subjective experience to become symbolized in conscious awareness, a link must be made between the mental representation of

the event and a mental representation of the *self* as the agent or experiencer. These episodic representations … reside in short-term or working memory." Kihlstrom's identification of the need for this link focuses our attention on an essential question: What makes it so *difficult* to link the unsymbolized affective experience from the past with a mental representation of the self as the agent or experiencer of the event? In my view, the answer to this question is *dissociation*. The human self is a configuration of multiple states as well as a functional unit (Bromberg, 1996a; Mitchell, 1991); the more intense the unsymbolized affect, the more powerful the dissociative forces that prevent isolated islands of selfhood from becoming linked within working memory.

42.2.4 Current Research in Cognition, Neuroscience, and Attachment Theory

Wilma Bucci's cognitive research (2001, 2002, 2003, 2007a, 2007b), Joseph LeDoux's neuroscience research (1989, 1994, 1995, 1996, 2002), Allan Schore's research in Interpersonal Neurobiology (1994, 2003a, 2003b, 2007), and my interpersonal/relational view of psychoanalysis (Bromberg, 1994, 1996a, 1998, 1999, 2000a, 2000b, 2006) converge in their focus on the interface of dissociation, conflict, and self-state communication.

Bucci has studied the centrality of dissociation to normal human cognition and its relevance to the psychoanalytic process. She writes:

> The basic forms of emotional communication that operate in the analytic context also underlie all interpersonal interaction. In normal functioning as in pathology, we are constantly sending out and receiving subsymbolic signals; these often occur without accompanying verbal messages and are difficult to make explicit. A fundamental difference between normal and pathological functioning is that *in the former, the subsymbolic communication is connected, or readily connectable to the symbolic components … whereas in pathology the subsymbolic representations are largely dissociated from the symbolic modes that would provide meaning for them*. (Bucci, 2001, p. 68, emphasis added)

Bucci (2002) concludes that Freud's *repression-based* conception of the therapeutic action of psychoanalysis is in need of serious reconsideration and that "concepts such as regression and resistance need to be revised as well" (p. 788). Quite matter-of-factly, she offers the view that "the goal of psychoanalytic treatment is integration of dissociated schemas" (p. 766) and that *this requires activation of subsymbolic bodily experience in the session itself, in relation to present interpersonal experience and memories of the past.*

From different vantage points, both Bucci (2003) and I (Bromberg, 2003a) focus on Kihlstrom's (1987) crucial observation that in order for dissociated material to become symbolized and available to participate with other self-states in internal conflict resolution, a link must be made in the here-and-now between (1) the mental representation of that dissociated event and (2) a mental representation of the self as the agent or experiencer. In therapy, the more intense the fear of triggering unprocessed traumatic affect, (1) the more powerful are the dissociative forces, (2) the harder it is for working memory to cognitively represent the here-and-now event that (in the therapy itself) is triggering the affect, and (3) the harder it is to access long-term memories associated with it.

Similarly, LeDoux (2002) proposes in neurobiological terms that the enigma of brain processes is related to the enigma underlying multiplicity of self:

> Though [the self] is a unit, it is not unitary.… The fact that all aspects of the self are not usually manifest simultaneously, and that their different aspects can even be contradictory, may seem to present a complex problem. However, this simply means that different components of the self reflect the operation of different brain systems, which can be but are not always in sync. While explicit memory is mediated by a single system, there are a variety of different brain systems that store memory implicitly, allowing for many aspects of the self to coexist. As William James (1890) said, "Neither threats nor pleadings can move a man unless they touch some one of his potential or actual selves." Or as the painter Paul Klee (1957) expressed it, the self is a "dramatic ensemble." (LeDoux, 2002, p. 31)

This configuration of meaning develops early in life through reciprocal patterns of interaction with significant others that establish the internal templates for attachment behavior. These internal templates are core ways of being with an other that come to organize the self-meaning of "who one is." They provide the basis of self-continuity that assures stability and sometimes sanity in the face of psychological stress. Because continuity of self-meaning is the underpinning of mental stability, each human mind is dedicated to preserving its pattern of attachment at any cost. From this frame of reference, *psychological trauma can be defined as the precipitous disruption of self-continuity through the invalidation of these early attachment patterns of interaction that give meaning to "who one is."*

Attachment researchers are currently studying the relationship between disorganized/disoriented attachment

and adult dissociative pathology (cf. Barach, 1991; Liotti, 1992, 1995; and Main & Morgan, 1996). Barach (1991, p. 118) contends that Bowlby's concept of detachment "is actually a type of dissociation." Although Bowlby described children's response to abandonment in terms of detachment, Barach insists that Bowlby was really describing a dissociative process.

42.3 WHAT CAUSES DISSOCIATION?

42.3.1 Nonlinear State Changes as a Developmental Paradigm

In a seminal paper discussing nonlinear state changes as a developmental paradigm, Putnam (1988) emphasizes the most central property of states—that they are discrete and discontinuous. Asserting that "states appear to be the fundamental unit of organization of consciousness and are detectable from the first moments following birth," Putnam says that states are

> self-organizing and self-stabilizing structures of behavior. When a transition (switch) from one state of consciousness to another state of consciousness occurs, the new state acts to impose a quantitatively and qualitatively different structure on the variables that define the state of consciousness. The new structure acts to reorganize behavior and resist changes to other states.… [S]witches between states are manifest by *non-linear changes* in a number of variables. These variables include: 1) affect; 2) access to memory, i.e., state-dependent memory; 3) attention and cognition; 4) regulatory physiology; and 5) sense of self.… *[C]hanges in affect and mood are, however, probably the single best marker of state switches in normal adults.* (p. 25, emphasis added)

Putnam's assertion, that nonlinear switching among discontinuous states of consciousness is a normal process, has profound implications. For one thing, it shows that dissociation is an essential part of the process through which human beings maintain personal continuity, coherence, and cohesiveness of the sense of self. But how can this be? How can the division of self-experience into relatively unlinked parts contribute to self-integrity? The most convincing answer to this question was previewed in the previous discussion: (1) self-experience originates in relatively unlinked self-states, *each coherent in its own right*, and (2) the experience of being a unitary self (cf. Hermans, Kempen, & van Loon, 1992, pp. 29–30; Mitchell, 199l, pp. 127–139) is an acquired, developmentally adaptive illusion. When threatened with unavoidable traumatic disruption, the illusion of unity becomes too dangerous to maintain; a defensive dissociative reaction will then occur that preserves continuity and coherence by abandoning the need for cohesiveness.

42.3.2 Normal Dissociation: The Capacity to Feel Like One Self While Being Many

A human being's ability to live a life that allows both authenticity and self-reflection requires an ongoing dialectic between the separateness and unity of one's self-states; crucially, this dialectic must allow each self to function optimally without foreclosing communication and negotiation between them. When all goes well, a person is only dimly or momentarily aware of the individual self-states and their respective realities because each functions as part of a healthy illusion of cohesive personal identity—an overarching cognitive and experiential state that is felt as "me." Each self-state is part of a functional whole, informed by a process of internal negotiation with the realities, values, affects, and perspectives of the others. Each aspect of self has its own degree of access to the various domains of psychic functioning (e.g., capacity to feel and tolerate the pressure of one's needs and wishes, capacity to judge what is adaptive social behavior, capacity to act from a sense of one's values as well as from a sense of purpose, capacity to maintain object constancy, and capacity to mentally bear the experience of intrapsychic conflict). Despite collisions and even enmity between aspects of self, it is unusual for any one self-state to function totally outside of the sense of "me-ness"—that is, without the participation of the other parts of self.

In a relatively coherent personality, dissociation is a healthy, adaptive function of the human mind. Dissociation is a basic process that allows individual self-states to function optimally (not simply defensively) when full immersion in a single reality, a single strong affect, and a suspension of one's self-reflective capacity is exactly what is called for or wished for. I am referring to times requiring concentration, single-mindedness, task orientation, or full surrender to a pleasurable experience. "Under normal conditions, dissociation enhances the integrating functions of the ego by screening out excessive or irrelevant stimuli" (Young, 1988, pp. 35–36). As a normal process, dissociation also includes the ability to defend against trauma by disconnecting the mind from its capacity to perceive that which is too much for selfhood and sometimes sanity to bear. It reduces what is in front of someone's eyes to a narrow band of perceptual reality that lacks emotional relevance to the self that is experiencing it ("whatever is going on is not happening to *me*").

42.3.3 Pathological Dissociation: The Transformation of a Flexible Dynamic to a Rigid Structure

When used defensively, dissociation is unlike any other defense; it bypasses cognitive modulating systems. As neuroscience research has shown, defensive dissociation is part of an evolutionary response whose survival priority is equivalent to certain genetically coded response patterns of lower animals to life-threatening attack by a predator. *Because of its survival priority, dissociation not only defends against immediate trauma, but it is then subverted into a nonrelational mental structure that is constantly anticipating a recurrence of that trauma. It is the non-negotiability of this mental structure that makes dissociation pathological. As I've described earlier, pathological dissociation is an inflexible "early-warning system" designed to proactively prevent mental destabilization associated with the unanticipated return of unprocessed traumatic affect.* I conceive of this structure as a conglomerate of discontinuous self-states that are vigilantly "on-alert" to preempt trauma by holding a perception of reality in which potentially unbearable psychic pain is always around the next corner.

Putnam (1992, p. 104) has called dissociation "the escape when there is no escape," to which I would add that dissociation then begins to take over as "an escape *before* there is no escape"; a dissociative structure with a life of its own. *The key quality of pathological dissociation is the state of readiness that is afforded by the hypnoid separateness of self-states, so that each can continue to play its own role, unimpeded by input from other self-states (or other people). The protective readiness of hypnoidally separated self-states is the difference between normal dissociation and pathological dissociation.*

42.3.4 Standing in the Spaces

I've written (Bromberg, 1993, p. 186) that "health is the ability to stand in the spaces between realities without losing any of them—the capacity to feel like one self while being many." *Standing in the spaces* is a shorthand way of describing a person's relative capacity to make room at any given moment for subjective reality that is not readily containable by the self that he experiences as "me" at that moment. This capacity is what distinguishes creative imagination from both fantasy and concreteness, and distinguishes playfulness from facetiousness.

Some people can't "stand in the spaces" at all. In these individuals we see a psyche that is organized more centrally by dissociation than by repression, so that each shifting "truth" can continue to play its own role without interference by the others, thus creating a personality structure that one of my patients described as "having a whim of iron."

But built into the personality of *every* human being are some dissociative areas of mental structure that were shaped by traumatic intrusions that were simply too disjunctive with ongoing selfhood to be held and processed as internal conflict. In those dissociated areas of mental structure, the illusion of unity (between the disjunctive aspects of self) was abandoned, and the tolerance for bearing intrapsychic conflict was either weakened or foreclosed. As a result, for all individuals, not only those who have suffered *pervasive* trauma, there are areas of the psyche in which discontinuous constellations of self are defensively kept apart by the autohypnotic process of dissociation.

The gaps between dissociated aspects of self must be linked by human relatedness in order for the experience of intrapsychic conflict to be possible. The hermeneutic process of interpretation in psychoanalysis *depends* upon this. Conversely, it should be understood that the ability to experience intrapsychic conflict does not always exist. When patients are unable to contain an experience of intrapsychic conflict, the immediate goal is to use the therapeutic relationship to help them turn self-experience into something more than islands of "truth." To utilize interpretation, a patient must be able to stand in the spaces between self-states so that reliance on the protection of dissociation is replaced by a capacity to feel internal conflict as bearable.

42.3.5 Dissociation, Nonlinear Dynamic Systems, and Growth of Self

In response to a major paradigm shift in psychoanalysis, most contemporary analytic theorists no longer consider the most relevant *clinical question* to be, What technique should be applied? but rather, What are the necessary and sufficient conditions to *support* an analytic process? The latter question is more rooted in gestalt field theory, chaos theory, and nonlinear dynamic systems theory than in the 19th-century positivism that shaped Freud's thinking. Barton (1994, p. 5) characterizes the new paradigm as a science without an implication of prescribed sequences. Barton postulates that complex systems (like the human mind) have an underlying order, but that simple systems (like a human interaction) can produce complex behavior. The old paradigm's conceptualization of personality growth (i.e., as being mediated by the lifting of repression and the uncovering of unconscious conflict) is being

reexamined in light of a nonlinear understanding of the human mind. This new understanding emphasizes self-organization, states of consciousness, dissociation, and "multiple self states that can change suddenly from one to another when a parameter value crosses a critical threshold" (Barton, 1994, p. 8).

Data supporting this understanding have been provided by independent clinical and scientific domains. Particularly significant are Edelman's (1989, 1992) neurobiological research, Thelen and Smith's (1995) writings on nonlinear dynamics theory and cognition, and Piers's (1996, 1998, 2000, 2001) work on character as self-organizing complexity, including its relationship to multiplicity and wholeness.

Piers (2001), for example, in addressing the issue of "character" in terms of Self-Organizing Dynamic-Systems Theory, supports my conception of personality disorder as inherently dissociative (see Bromberg, 1993, 1995):

> When it comes to complex systems such as the human mind, self-organization arises naturally, resulting in *emergent structures* that are self-generating and draw the components into their functioning in order to sustain the whole. Some emergent structures are "*softly assembled'*" making them more sensitive to fluctuations, which in turn allow the system to remain responsive or adaptive. Other systems are more restrictive or "*firmly assembled,*" and result in *less responsiveness and adaptability of the system*. (Piers, 2001, presented paper)

Piers then addresses my thoughts about the link between personality *style* and personality *disorder* (Bromberg, 1993, 1995). Piers considers both personality style and personality disorder to be nonlinear, self-generating emergent structures; from this perspective, personality disorder may emerge from personality style in order to sustain coherence of self-organization:

> *[P]athology* is conceptualized [by Bromberg] as the proactively defensive use of normal dissociative processes.… [S]uch a defensive deployment of dissociation provides the individual with the protection afforded by the separateness and discontinuity of self-states, while minimizing the opportunity for the multiple self-states to inform or influence one another. (Piers, 2001, presented paper)

In this context, a personality *disorder* is an "emergent structure" that results from the *rigid* consolidation of certain character traits in the service of dissociative protection. Independent of type, a personality disorder (narcissistic, hysteric, schizoid, borderline, paranoid, etc.) constitutes a *personality style* organized as a proactive, dissociative solution to the potential repetition of childhood trauma. The centrally defining hallmark of a personality disorder is that the *interpersonal* threat that is presented by the "other" is foreclosed before it can become traumatic; the patient's mental processes are designed to create an interpersonal "impasse" in which neither person can reach the other intersubjectively, and spontaneity is preempted by predictability. The price is emotional deadness and relational stagnation.

42.4 PERSONALITY DISORDERS AND DISSOCIATIVE DISORDERS

I have suggested (Bromberg, 1993, 1995) that the psychoanalytic understanding of character pathology needs to be revamped to take into account the inherent dissociative structure of the mind. I also urge analysts to rethink their traditional understanding of what we mean by *unconscious* and their traditional ways of looking at character structure and character pathology (especially what we call *personality disorders*). I propose that personality *disorder* might usefully be defined as the characterological outcome of the inordinate use of dissociation in the schematization of self-other mental representation, and that independent of type (narcissistic, schizoid, borderline, paranoid, etc.) it reflects a mental structure organized in part as a proactive protection against the potential repetition of early trauma. Thus, the distinctive personality traits of each type of personality disorder are embodied within a mental structure that allows each trait to be always "on-call" for the trauma that is seen as inevitable.

All personality disorders therefore entail *ego-syntonic dissociation*. Each type of personality disorder is a dynamically on-alert configuration of dissociated states of consciousness that regulates psychological survival in terms of its own concretized blend of characteristics. Within each type of personality disorder, certain self-states hold the traumatic experience and the traumatic affect; other self-states hold the particular ego resources that (1) proved effective in dealing with the original trauma and (2) ensure that the pain will never recur (e.g., hypervigilance, acquiescence, paranoid suspiciousness, manipulativeness, deceptiveness, seductiveness, psychopathy, intimidation, guilt-induction, self-sufficiency, insularity, withdrawal into fantasy, pseudomaturity, conformity, amnesia, depersonalization, out-of-body experiences, trance states, compulsivity, substance abuse, etc.).

42.4.1 Dissociative Symptomatology and Dissociative Character Traits

When faced with a reminder of past trauma that threatens affective hyperarousal, the mental structure of a person with a *dissociative disorder* is usually not stable enough to successfully prevent *symptoms* from being triggered. This vulnerability to symptoms causes a person with a dissociative disorder to appear "sicker" than a person with a personality disorder (an individual whose dissociative mental organization is evidenced in the rigidity of ego-syntonic character pathology). But in *both* cases (dissociative disorders and personality disorders), mental functioning is mediated by the adaptive effort of a dissociative mental structure that is designed to prevent the intrusion of unbearable trauma. The dissociative structure is a bulwark against retraumatization, but it also creates an existential illness. It plunders both the present and the future on behalf of the past.

In a personality disorder, each personality configuration has its own characteristic pathologies of cognition, impulse control, affectivity, and interpersonal functioning. Each specific personality configuration represents a dissociative solution to trauma that has been preserved and perfected because it balanced safety and need satisfaction, characterologically, in a fashion that "worked" for that person. The subsequent cost of this solution, however, is always identical regardless of personality *type*—to one degree or another, an unlived life.

The dissociative disorders (i.e., Dissociative Identity Disorder, Dissociative Amnesia, Dissociative Fugue, or Depersonalization Disorder) are, from this vantage point, touchstones for understanding the personality disorders even though, paradoxically, dissociative disorders are defined by symptomatology rather than by personality style. *The symptoms of the dissociative disorders are direct manifestations of discontinuities between states of consciousness that the personality disorders are designed to mask*. In the personality disorders, discontinuities between states of consciousness are expressed only indirectly and "characterologically" as a relationally impaired but relatively "enduring pattern of inner experience and behavior that … is inflexible and pervasive across a broad range of social situations" (American Psychiatric Association, 1994, p. 275).

Each type of personality disorder has its own characterological configuration of dissociated self-states that are on-call to preempt the traumatic input of "otherness." For example, the obsessive-compulsive personality disorder neutralizes otherness by engaging in covert power operations that are designed to undo the impact of the therapist's words. The purpose of these power operations is to prevent the therapist's subjectivity from allying with dissociated "not-me" aspects of the patient's self, and thus risking the creation of mental confusion, if not chaos. In this dynamic, the therapist is always potentially dangerous because the therapist's subjectivity holds the potential to wipe out the patient's mind by trying to replace the patient's experience with something the therapist deems "better." Dangerous, "not-me" aspects of self become controllable *interpersonally* only when they are externalized as part of "the other." Thus, by pulling the therapist into covert power operations, an obsessive-compulsive patient helps keep the "not-me" aspects of self dissociated by making the therapist, at least temporarily, the sole proprietor of those unwanted aspects of self.

Ultimately, the ability of a patient to allow dissociated "self-truth" to be altered by the impact of the therapist depends on the development of a paradoxical relationship. By paradoxical, I mean a relationship in which the therapist can be experienced as someone who both accepts the validity of the patient's self-state "truths" and participates in the here-and-now act of constructing a negotiated reality broader than any of the individual truths. It should be added, however, that the ease or difficulty in the development of such a relationship is influenced by the history of a patient's attachment-based procedural memory and the *degree* to which its non-negotiability has been shaped by the dread of psychic trauma.

Just as the obsessive-compulsive patient uses words to magically make the potentially impinging other believe that the patient is "agreeing" while dissociating the here-and-now present from the ongoing interchange, the *hysteric* personality disorder uses affect and pain to keep the other at bay. "You won't let me be myself." "You don't understand what I am feeling." "No, that's not what I feel." The hysteric, by the way, is the only type of personality disorder that has already been acknowledged as "most likely" to be dissociative. Why? Probably because the hysteric has organized into the personality structure, the use of rapid switching of self-states as a proactive response to potential affective overload. This character trait, which we know as affective "lability," has more of the aroma of a dissociative disorder than do many of the character traits we find in other types of personality disorders.

I also have hypothesized (Bromberg, 1993, p. 179) that *paranoid* personalities are labeled "delusional" because the extreme dissociative isolation of the self-state that holds paranoid "truth" creates an immovably fixed self-narrative that is virtually *immune* to modification through

relational negotiation. That is, paranoid personality disorders rely almost exclusively on a self-state that is designed to be *seamlessly* vigilant and to not only mistrust, but to actively *look* for reasons to mistrust.

There are different likelihoods that a dissociative personality structure will "fail." To some degree, the likelihood is determined by the type of personality style in which it is embedded. Sometimes the failure is seen in the development of *symptoms*; sometimes in a flooding of affect as in hysteria; sometimes in a bizarreness of obsessive thinking or compulsive behavior; sometimes in a loosening of a schizoid person's hold on reality; and sometimes in a paranoid person's "delusional" thinking. Some people with schizoid personality disorders have become so weakened by profound isolation that they risk loss of selfhood while trying to stay untouched by the annihilating presence of others. Others, whose dissociative structure is more "successful," simply "die before they have lived."

With personality-disordered patients, the therapist's overarching task is to facilitate a safe reorganization of self-structure into one that feels sturdy enough to withstand input from another person's mind without dissociating. This requires the gradual transformation of an ego-syntonic dissociative rigidity into something that feels ego-alien; the transformation of "This is who I *am*" into "This is what I *do*." The success of the process depends on whether the therapist does not *unreflectively* compromise the patient's here-and-now experience of selfhood by triggering a flood of shame and panic associated with early trauma that feels irreparable. When I say "not unreflectively," I am speaking about a process in which the unavoidable "collisions between subjectivities" are *negotiable*—what might be called the process of "negotiating otherness." Negotiating otherness is mediated in part by the therapist's ability to comprehend the particular personality style of a given patient. This requires that the therapist understand both the unique configuration of dissociated self-states that is distinctive of that personality type, as well as the uniqueness of the particular person that embodies it. The patient's capacity to open an internal negotiation between his hypnoidally isolated self-states depends on the therapist's ability to participate in a process of external negotiation through *enactment*—a process in which the patient's own otherness (his *not-me* self-states) is played out with the *actual* other (i.e., the therapist). In other words, the patient's affective safety is not something that is "delivered" to the patient through the analyst's unilateral judgment of what is "safe." A therapist cannot make the process feel "safe" by trying to minimize his presence and believing he can do so by avoiding active participation in the ongoing relationship. Allan Schore (2003b, 2007) in fact stresses the *dual role* of the therapist as *simultaneously* psychobiological regulator and co-participant, and that this simultaneity is especially vital during heightened affective moments in working with dissociated self-states. That is to say, the therapist's role is therapeutic *because* the analyst's regulating function is *not independent* of coparticipation, which means being a human being in a very human relationship.

42.5 MULTIPLE SELF-STATES, DISSOCIATION, AND ENACTMENT

I am not suggesting that addressing dissociation is all there is to psychoanalysis. What I *do* believe is that for some patients characterologically, and for all patients in certain areas of their personality, an analysis that is enduring and far-reaching is best achieved by working with dissociative processes as an intrinsic part of working with conflict. "Working in the transference" is inherently "working with dissociation" because *transference is inherently an enacted dissociative process that includes both patient and therapist.*

Transference and countertransference are simply aspects of enactment, a dyadic dissociative cocoon. Through enactment, patient and therapist play out together an externalization of the patient's communication with internal objects. The patients feel this dialogue *affectively*, and as they attempt to express respective "unformulated experiences" (Stern, 1983, 1997), they are given a chance, jointly, to arrive at language that gives this enacted dialogue relational meaning and intrapsychic meaning. But to do this, the analyst has to come to grips with the dissociated parts of *the therapist's* self that are contributing to the enactment. By using self-awareness as a source of therapeutic data, the therapist can make the patient's experience less shameful, less dissociated, more *real,* and thereby more accessible to an immediate sense of "me." The therapist's feelings and the patient's feelings, during an enactment, are part of a shared configuration of experience that must be processed linguistically within the immediacy of the therapeutic relationship in order for the multiple realities *within* the patient to become linked via cognitive symbolization by language. As this happens, the clinical process increasingly shifts from working with dissociation to working with conflict.

Every clinician knows that it is never a simple matter for a patient to confront dissociated self-experience, including memories. Even when an interpretation may seem to be successful, the resulting "awareness" of something from the past (or the present) does not in itself signify a personally relevant *experience* of what has been "confronted."

An experience that is available to self-reflection is often not created because the "awareness" is still organized around a dissociated structure that remains more powerful than the "interpreted" evidence of reason. Thus, what the therapist is *saying* often remains dissociated from the patient's here-and-now experience of the relational context that holds the personal impact of what is being said.

In other words, when self-states are islands of "truth" that are held in place by dissociative mental structure, they remain immune to the evidence of reason.

Under these conditions, dissociated experience is rigidly unyielding to cognitive processing and self-reflection. Apropos of this, Lyons-Ruth and the Boston Change Process Study Group (2001, pp. 13–17) have focused their attention on what arguably may be the next step in the growth of psychoanalysis—"a non-linear enactive theory of psychotherapeutic change," whereby "the process of psychodynamic therapy can usefully be thought of as the pursuit of more collaborative, inclusive, and coherent forms of dialogue between the two therapeutic partners."

> If clinical process is *affect-guided* rather than cognition-guided, [then] therapeutic change is a process that leads to the emergence of new forms of relational organization. New experiences emerge but they are not created by the therapist for the benefit of the patient. Instead, *they emerge somewhat unpredictably from the mutual searching of patient and therapist for new forms of recognition, or new forms of fitting together of initiatives in the interaction between them.* (Lyons-Ruth et al., 2001, p. 17, emphasis added)

Specifically, they argue that enlarging the domain and fluency of the dialogue is primary to enduring personality growth in treatment; it is this that leads to increasingly integrated and complex content. This does not mean that content is unimportant; rather, *it is in the relational process of exploring content that the change takes place, not in the discovery of new content per se.* The "content" is embedded in relational experience that embodies what they call "implicit relational knowing"—an ongoing *process* that is itself part of the content. This unsymbolized relational experience is relived by being enacted repeatedly between patient and therapist as an intrinsic part of their relationship.

Lyons-Ruth (2003, pp. 905–906) has emphasized the major contribution of relational theory to this new understanding of the source of therapeutic action. She urges that work continue toward developing "a language and structure that moves beyond a narrow focus on interpretation to encompass the broader domain of relational interchanges that contribute to change in psychoanalytic treatment." In my view, the concept of working with enactment and "not-me" experience provides the structure of which she speaks because it encompasses the essence of relational interchange—interpersonal and intersubjective—without losing the focus on the intrapsychic.

As an experiential process, enactment takes place *between* patient and therapist. As a concept, enactment is anchored in the view of a "relational mind." Moreover, it is more consistent with contemporary understanding of mental functioning than is the bifurcated conception of transference and countertransference.

From the perspective of the mind as relational, enactment does not take place *within* the patient. A relational concept of enactment considers both partners as an interpenetrating unit. Thus, enactment is a *dyadic* event in which therapist and patient are linked through a dissociated mode of relating, each in a "not-me" state that is affectively responsive to that of the other. In the language of enactment, this shared dissociative cocoon has its own imperative; it enmeshes and (at least for a time) traps the two partners within a "not-me" (Sullivan, 1953) communication field that is mediated by dissociation. In short, *enactment is an intrapsychic phenomenon that is played out interpersonally.*

42.5.1 Dissociation, Affective Safety, and Human Relationship

One might view the unconscious communication process of enactment as the patient's effort to negotiate unfinished business in those areas of selfhood where affective regulation of past traumatic experience has been insufficient to allow symbolic processing by thought and language. *In this light, a core goal of the therapeutic process is to increase competency in regulating affective states without pointlessly triggering the dread of retraumatization.* But this is not a simple matter. The problem is that the dissociated horror of the past fills the present with such powerful affective meaning that it often precludes any sense of safety. No matter how "obviously" safe the current situation may appear, patients cannot *perceive* themselves to be safe unless they allow themselves a moment of consciousness during which they can decrease their reliance on dissociative hypervigilance. But, often, that is simply too dangerous to the patient's felt stability of selfhood.

Even in routine analytic work, telling "about" oneself leads with surprising frequency to the dissociated reliving of an overwhelming experience that had been encapsulated as an unprocessed affective and somatic "memory." This experience cannot be therapeutically utilized unless the patient feels sufficient relational safety to have access

to working memory during the reliving. I have proposed that safety and growth are part of the ongoing negotiation of the therapeutic relationship itself. The negotiation of safety and growth entails what a given patient and therapist do in an unanticipated way that is safe, but not *too* safe—namely, a replaying of the patient's past relational failures in the form of safe surprises. Patients are optimally released from the crippling effects of their traumatic past when they are simultaneously released from the grip of their own self-cure (i.e., *what they continue do to themselves and to others in order to cope with a past that continues to haunt them).* This is why the processing of enactments is so powerful. It simultaneously frees the patient from the nightmare of the past and the prison of the self-cure; it frees the patient from the grip of the dissociative personality structure that has been compulsively plundering both the present life and the capacity to imagine a pleasurable future.

42.5.2 Enactment and Shame

When unprocessed traumatic affect is relived with one's therapist, the reliving is almost always accompanied by a dissociated shame experience. The shame is, in part, shame that is relived from the past, but it is also *new* shame that is being evoked by the therapist-patient relationship *while* the reliving is taking place. As Lynd (1958, p. 42) puts it, "a double shame is involved"; the person is shamed by the original episode and shamed by the strong need to be understood about an event that the patient has come to believe is, in Lynd's words, "so slight that a sensible person would not pay any attention to it." As with the original trauma, the patient hungers for recognition of the pain from the person (in this case the therapist) who is least likely to offer it because he is also the person who is *causing* the pain (in this case, inadvertently). Consider this clinical vignette paraphrased from Fridley (2001, p. 5):

> After many years and much anger, your patient is finally able to tell you that the phone message they left two days ago was actually a request for you to call them back. While you have some patients whom you know *always* need a call back, this person's subtlety takes you by surprise. The alliance is wounded. They were distressed, they called, and you did not answer. Their cry for help, which would in infancy, lead to attachment behaviors, was ignored. You are able, eventually, to say: "When I didn't call you back I ignored you." You have then owned your contribution to the "negative transference." Now your patient says: "I sat by the phone for hours, hoping you would call, but nothing happened." You ask: *"What did you imagine I was doing while you were waiting?"*

Often, this question will lead to the creation of a "safe surprise" because it addresses a patient's unprocessed experience of what is in the mind of a person who does not take an interest in them. Sometimes, however, the question is, at that moment, too much for the patient to think about. If that happens, the therapist must be attuned to that occurrence and must acknowledge it to the patient. In other words, the therapist must not assume that the patient has a capacity for mentalization (i.e., the ability to represent a representation—to think about another person thinking about them). The question of what the patient thought the therapist was thinking is always valid to consider. But when actually asked, the question can be therapeutic *only* if the therapist is alert to the fact that this inquiry may be shame-inducing. Trying to think about what was in the mind of a needed "other" who failed to fulfill a need may flood the patient with shame, and trigger an automatic dissociative isolation of the shamed part of the self.

Put most simply, a patient's transition from "not-me" to "me" is not easy or neat. Typically, it is a process of messy, nonlinear spurts, closer to *lurching ahead* than the more euphemistic term *growth*. During this process, therapeutic action flows from the therapist's ability to do two things simultaneously: (1) to relate fully to whatever aspect of self the patient is experiencing and presenting as "the real me," and (2) to let the other, more dissociated parts, know that the therapist is aware they exist. As words are found and negotiated between them, the traumas of the past become "safe surprises" in the present that facilitate the patient's growing ability to symbolize and express in language what previously had not been voiced. The goal is for the patient to move, slowly and safely, from a mental structure in which self-narratives are dissociatively organized, to a mental structure that allows the patient to cognitively and emotionally hold the self-narratives as part of a coherent, self-experience that allows for finding new solutions that are more flexible, and though not totally satisfying to any *one* part of the self, are more *me* to the *total* personality.

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