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Return of the Repressed: Revisiting Dissociation and the Psychoanalysis of the Traumatized Mind

Author: Michael J. Diamond

Abstract

Psychoanalytic treatment is often indicated when trauma and its psyche/soma companion, dissociation, severely disrupt symbolic functioning and associative linking. After Freud's initial thinking on these matters, repression replaced rather than supplemented dissociation (which occasions segregating units of experience) as the primary defensive response to severe trauma. Because psychoanalysis had “repressed” the salience of dissociation as *actively* motivated (though *passively* experienced), an unnecessary schism has occurred between trauma theories and mainstream North American psychoanalysis, and within psychoanalysis itself. To fully restore dissociation's role in primitive mental states and provide a more integrated approach to technique, it is necessary to comprehend the triadic nature of trauma, which entails economic/drive, structural conflict and deficit, and object-relational factors. For a treatment model that addresses defensive dissociation in the here and now, primary and secondary dissociation must be distinguished, with each differentiated from splitting and repression. Technique requires addressing unconscious, repressed fantasies associated with the “trauma,” object-relational patterns that interfere with linking, and psycho-economic issues that have disrupted ego functioning. A clinical example illustrates both the analyst's persistence in suffering the dead, eerie space of dissociated trauma and efforts to find language that helps structure the patient's somatic and enacted expressions (and accompanying dissociative and repressive processes) by which traumatic experiences are registered and conveyed.

Keywords:

dissociation | Freudian theory | trauma | unconscious | transference | symbolism | countertransference | memory | post-traumatic stress disorder | representation

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Training and Supervising Analyst, Los Angeles Institute and Society for Psychoanalytic Studies.

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> "*A most remarkable thing about psychoanalysis is its checkered response to trauma-generated dissociation.*"
>
> —*Howell and Itzkowitz (**2016**, p. 7)*

My title suggests, somewhat ironically, that what psychoanalysis has "repressed," or at least neglected, is the salience of dissociation as a motivated, more actively dynamic operation. Thus, until recently, there has been a tendency to diminish the relevance of trauma theorists while polemicizing theoretical issues within mainstream psychoanalysis. As a result, dissociation was often bifurcated from more dynamic unconscious processes entailing conflict, fantasy, symbolization, and the role played by actively motivated defenses. I wish to offer here a more inclusive psychoanalytic perspective on trauma and its psyche/soma companion, dissociation, that conveys their impact on the mind and suggests a more integrative treatment model that incorporates both dissociation and repression. Moreover, I hope to repair a notable yet unnecessary schism whereby the nonrepressed part of the unconscious **(Freud 1915)**—or "unrepressed unconscious" **(Mancia 2006)**—has been kept split off from the repressed unconscious.

In short, I hope to reconcile dissociation, splitting, and repression in contemporary, pluralistic approaches to psychoanalysis while furthering how we might think about dissociations occurring in the "here and now" of the analytic dyad with patients suffering from severe early trauma. The viewpoint I offer distinguishes primary from secondary dissociation. To clarify what happens in the analytic setting, I will show how both forms of dissociation operate to attack linkages and disrupt symbolization, and how this can be countered by integrating primitive mental states (often including disturbing somatic states) lying within the psychotic register of experience. I will discuss a clinical case that illustrates my way of working to reestablish weakened symbolic capacities in a patient who was severely traumatized in early childhood and whose mind was riddled with oscillating repression-based and dissociative mechanisms.

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In using both a repression-based model of conflicted mental functioning and a model that incorporates dissociatively produced, segregated units of experiencing, treatment is geared toward *reestablishing*, as well as developing, the representational capacities that dissociation has disrupted and weakened. Moreover, whether the trauma incurred was acute or cumulative, of child or adult onset, suffered at the hands of another or due to one's own actions, or induced interpersonally or through natural catastrophes, the analyst must vicariously experience the patient's traumatic anxieties, defenses, and internal object relations—largely through projective identification—as well as persistently analyze negative transferences and unconscious fantasies occurring both before and after the trauma.

Before exploring these ideas, I wish to contextualize my argument by revisiting the topic of dissociation and its complex links with trauma theory and repression. I begin by considering the historical basis within psychoanalysis for having essentially replaced dissociation with repression.

Historical Perspective on the Psychoanalytic Theorizing of Trauma

Recall that psychoanalysis emerged from Breuer and Freud's observation **(1893)** that the major reactive mechanism to trauma is “severely paralysing affect … during a modified state of consciousness” (p. 110). This affect can be introduced into normal consciousness only through speech. Four years before Breuer and Freud's observation, Janet **(1889)** similarly described unconscious automatic activity in response to trauma. All three agreed that dissociation involves the splitting of consciousness, designed to exclude unpleasant memories or ideas **(Gullestad 2005)**. However, both Breuer, the main proponent of “hypnoid hysteria,” and Freud, more focused on “defense hysteria” as a forerunner of repression-based theory, stressed a dynamic, *actively* motivated defense (subsumed under repression) originating from internal *conflict*. In contrast, Janet focused on *deficit* produced by disorganized cognitive processing, a disaggregation of the personality that he erroneously interpreted as the result of *passive* constitutional weakness.

Freud and Janet soon became bitter rivals, with psychoanalysis starkly opposing the French view of psychopathology. Freud essentially erased (i.e., repressed) “Janet's memory” (Ellenberger **1970**, p. 409; see also **Makari 2008**)

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by replacing dissociation with the new concept of repression (while ingeniously incorporating its consciousness-splitting aspect). Freud called his system *psycho-analysis* as distinct from Janet's *psychological analysis*. Thus was "the restless ghost of Pierre Janet … banished from the castle by Sigmund Freud" (Bromberg **1995**, p. 189).

Despite Ferenczi's interest in Janet's work and his departure from classical technique when working with exogenous, trauma-induced trance states (i.e., dissociation), including multiple personalities (**1932**, **1933**), Freud (in contrast to Breuer) made a "primal category mistake" (O'Neil **2018**, p. 266) by failing to conceive of dissociation itself as an actively motivated, autohypnotic or "hypnoid" defense. Consequently, dissociation was omitted from the "venerable 'list' of psychoanalytic defense mechanisms" (p. 267). This produced an ongoing and regrettable rupture—a "dissociative gap in theory" (Howell and Itzkowitz **2016**, p. 27)—that deprived us of essential insights concerning how the human mind functions in response to severe trauma and how to treat its failings **(Kluft 2000)**. Whereas during its formative era, psychoanalysis emphasized unconscious conflict and complex internal object relations, dissociative mental states were largely overlooked until quite recently and their "significance … [in]adequately addressed" (Bohleber **2010**, p. 131). In fact, for most of the twentieth century, mainstream North American psychoanalysis considered theories based on dissociation beyond the pale **(Berman 1981)**, while many analysts worldwide deemed the notion "unsavoury" **(Chase 1991)**.[1]

This dismissive tendency, however, has been recognized by many analysts; for example, Bion's unique thinking about primitive mental states involves forceful defenses mounted against the self that experiences the unbearableness of trauma, ideas that emerged from his own

1. Because of the setback to psychoanalysis following the Freud-Janet split, and despite Janet's influence on both Ferenczi and Fairbairn **(Cassullo 2014)**, some analysts were led to disregard the traumatic reality of sexual abuse and incest, as well as dissociation itself, for various reasons, clinical and methodological, as well as reasons rooted in identity politics. In accordance with the primary categorical defense of failing to recognize the traumatized individual's active, motivated role that incorporates psychic conflict, Spivak **(2020)** suggests that "professional guilt" stemming from a long history of misunderstanding the "reality" of sexual abuse may have led to a compensatory focus on the other end of the spectrum—namely, a one-dimensional perspective in which the patient is simply a *passive* "victim" of external reality shorn of the role played by actively unconscious processes including libidinal and aggressive urges.

traumatic wartime experiences **(Brown 2011)**. In addition, more than sixty years ago, in reflecting on Freud's method, the prominent North American ego psychoanalyst Bertram Lewin **(1954)** bemoaned that "we may … have erected an unconscious defense … so as to live down our suspect history as hypnotists, … [and thus] … not be aware of all the traces of hypnotism and

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anesthesia we have unwittingly carried along with us" (p. **502**). In contrast, trauma theorists, less impacted by the "checkered" response within psychoanalysis, retain an interest in dissociative processes though largely excluding the dynamic unconscious, so that the "who"—the agent that *decides* to dissociate—is all but omitted **(Gullestad 2005)**. Consequently, even among psychoanalysts, dissociation has often been reduced solely to an automatic, psychobiological response to overwhelming excitation (e.g., **Purcell 2019**); moreover, what I will discuss as *secondary dissociation*, particularly when defensively founded largely on intrapsychic conflict, remains poorly understood.

Notwithstanding its disappearance for the most part from psychoanalytic vocabulary until the last two or three decades, the phenomenon of dissociation and related autohypnotically fueled, defensive altered states of consciousness, with their segregated units of experience, remain unmistakable. Although the language of dissociation often went underground, analysts of varying schools used "splitting" as code for trauma-generated dissociation **(Howell and Itzkowitz 2016)**. Apart from their frequently incompatible frames of reference within psychoanalysis, consider Ferenczi's concept of *trance states*, Fairbairn's *endopsychic ego structures*, Klein's *splitting of the self*, Federn's *ego states*, Steiner's *psychic retreats*, and Kohut's *self states*. While all of these concepts entail vertical splitting, including what Freud **(1938)** would call "splitting of the ego," little distinction was made between the concepts of splitting and dissociation, especially by Klein and her followers (**Brierly 1953**; **Blass 2015**). In addition, confusing terms were used to depict pathological dissociation by two of the most significant twentieth-century analysts seeking to maintain the phenomenon's significance. Thus, Ferenczi (**1932**, **1933**) used "fragmentation" and Fairbairn **(1944)** employed "splitting" (and "splitting of the ego"), with neither positing that it leaves experience largely unformulated.

Since "psychoanalysis began as a theory of trauma" (Bohleber **2007**, p. **329**), however, it is not surprising that theorizing about trauma has continued to develop (notwithstanding the deemphasis of dissociation).

For instance, Freud (**1913**, **1915**, **1923**) privileged pathological, primary process ego functioning and an object relations-based deficiency in protective shielding that accesses primal repression. Ferenczi **(1933)**, Fairbairn **(1943)**, Balint **(1969)**, Winnicott **(1974)**, and Khan **(1974)** furthered the view that the relationship with the object is the traumatogenic factor (including the role played by introjection and identification), whereas Bion (**1959**, **1962**) emphasized the containing object's

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failure to symbolically elaborate the deepest anxieties. Neo-Freudians, including Fenichel **(1945)** and subsequently Rothstein **(1986)**, Shengold **(1989)**, Busch **(2005)**, and Sugarman (**1994**, **2008**), focused on ego regression to passive coping mechanisms, as well as developmental conflicts and a libidinization of traumatic repetition that furthers sadomasochistic object relations. Analysts of varying schools have also described the psychic damage caused by prolonged, complex trauma including disruptions of affect regulation, attachment patterns, self-esteem, and developmental competencies **(Fonagy and Target 2003)**.

Contemporary analysts focusing on primitive mental states have become more explicit about interpersonal trauma and the prominence of dissociative processes. There is an extensive literature within the North American interpersonal/relational school strongly influenced by Sullivan **(1953)** according dissociation special status, while drawing on attachment and trauma theory, as well as psychoeconomic and neuroscientific factors. For instance, Philip Bromberg (**1998**, **2011**) has played a pivotal role in expanding on Janet, Ferenczi, and Fairbairn by placing dissociation at the center of his clinical theory, Donnel Stern **(1997)** has helped return psychoanalysis to trauma theory, and three European analysts **(Craparo, Ortu, and van der Hart 2019)** have recently published the first comprehensive reassessment of Janet's complex relationship to Freud, Ferenczi, Fairbairn, and Bromberg.

In addition, psychoanalytic infant researchers have explicitly used the concept of dissociation in presymbolic contexts (**Beebe and Lachmann 2002**; **Lyons-Ruth 2003**), while British neo-Kleinians and contemporary Bionians (**Steiner 2000**; **Hinshelwood 2008**; **Bronstein 2016**) discuss dissociation, though largely using it interchangeably with splitting, distinguishing the two only quantitatively (**Grotstein 2009**: **Blass 2015**). Still, as Bromberg **(1995)** noted twenty-five years ago, most major analytic schools “have become … more responsive to the phenomenon” (p. 189), while in more recent years Janet has been rediscovered **(Lingiardi and McWilliams 2017)**.

Though I welcome the many concepts that have helped to fold dissociation back into mainstream psychoanalysis, several essential tenets of unconscious mental processing (pertaining to primitive endogenous fantasy, impulse, somatic experience, and conflict) have unfortunately been *replaced* rather than *supplemented* by more mechanistic ideas pertaining to the revival of intolerable experience.[2] This perpetuates the long-standing schism, though now often within psychoanalysis itself, particularly between neo-Freudian and relationally oriented analysts. In

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brief, when one side limits the role played by intrapsychic dynamic processes and agency, polarizing splits between various psychoanalytic camps are perpetuated, and useful technical ideas pertaining to dissociation and autohypnotic altered states more closely aligned with trauma theory too often remain detached from indispensable, foundational psychoanalytic understandings that have been misconceived and associated with Freud's renunciation of the "seduction theory" (**Gullestad 2005**; see also **Bohleber 2010**). One of my fundamental aims here is to lessen such rifts and build bridges between unnecessarily segregated units of theoretical (and technical) understanding.

The Triadic Nature of Trauma: The Basis for Dissociation

Whereas an overbroad concept of trauma (and dissociation) is evident today, external traumatizing conditions, environmental object-relational failures, and identification-based internalizations, along with the roles played by unconscious narcissistic collusions and après-coup phenomena, remain central. The word *trauma* comes from the Greek word for "wound," itself derivative of "to pierce," and psychic trauma always involves a certain breach, a *too muchness* signified by its intensity and by an incapacity to respond adequately. This produces mental upheaval with

2. For instance, I find it regrettable that analysts like Boulanger **(2007)** reductively locate drive theory and even object relations in opposition to the relational turn, while seeming not to include preexisting internal conflict and the role of the intrapsychically structured mind in their clinical theory (see **Smith 2003**; **Busch 2005**; **Sugarman 2018**; **McBride 2020**; **Spivak 2020**). Similarly, others suggest that dissociation is "entirely automatic," rendering personal agency and intentionality irrelevant **(Purcell 2019)**. However, as hypnosis researchers know well (**Hilgard 1977**; **Kluft 2018**), there is no equivalence between automaticity and lack of agency (though the latter may be far removed from conscious experience).

lasting consequences to the ego's construction of meaning (**Shengold 1989**; **Bohleber 2010**; see also **Freud 1920**).

Events are made traumatic by a specific interaction—namely, a "sudden and brutal encounter between an unconscious fantasy and external reality" (Bokanowski **2005**, p. **256**)—that, especially in early childhood, can often access life-preservative survival instincts. In more classical, drive-based terminology, the self-preservative drive is besieged by the acute fear of being annihilated, ripped apart, and/or no longer existing. Depending on the individual's

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developmental level, unconscious fantasies may include the illusion of complete security, blessedness, and normal (healthy) omnipotence, as well as oedipal illusions about the seduction of the abuser. The traumatized individual personalizes the *too muchness* and unconsciously, though actively, crafts defenses for both the threat to existence and the breaching of innocence—for instance, by taking responsibility for the breach through identifying with the aggressor and/or forming the “moral defense” **(Fairbairn 1943)**. This interaction between psyche and environment is apparent in psychoanalytic work with *cumulative trauma* (Khan), *developmental trauma* (van der Kolk), *strain* or *shock trauma* (Kris, Sandler), *silent trauma* (Hoffer), and *deprivation trauma* (Bowlby).

To repeat, I suggest that far too often, at least until very recently, the focus on unconscious fantasies and libidinal wishes has all but been *replaced*, rather than more usefully *supplemented*, by privileging trauma's quantitative impact on ego functioning and symbolizing capacities, as well as object-relational failures in appropriate responsivity (e.g., the “negative” or “absent” external object). To some extent, this *pars pro toto* fallacy continues to restrict our work, and the active agent—the *I* doing the dissociating—is frequently omitted. Thus, in order to treat trauma psychoanalytically **(Diamond 2020)**, I recommend following a clinically based, dynamic tripartite model of analytic metapsychology grounded in *economic* (i.e., trauma's *too muchness* and its somatic sequelae), *topographical/structural* (intrapsychic) *conflict and deficit*, and *object-relational* understandings—what I call *the triadic nature of trauma* that incorporates dissociation.

Throughout what follows, I elaborate these ideas while making clearer that whenever the manifestations of trauma appear as dissociative mechanisms within the analytic frame, intrapsychic conflict and repressive processes are likely to be present as well. Moreover, with the severely traumatized patient, each comes to the fore, though in varied fashion.

Representation, Unconscious Fantasy, and Conflict

Reducing dissociation to solely a psychobiological “shutdown” mechanism restricts work in the transference-countertransference field. It bears repeating, then, that trauma always reflects an interaction with the preexisting, overdetermined internal world constructed in accordance with self-preservative drives and unconscious fantasies antecedent to, simultaneous with, and/or subsequent to single-incident as well as cumulative trauma. Because cognitive functioning,

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including symbolization, thinking, and integration, is compromised or suspended during traumatic experiences, unconscious fantasies—as well as archaic fantasy structures established during or soon after massive trauma, particularly in infancy or early childhood—are less likely to be verbally represented and typically more weakly symbolized **(Rosenbaum and Varvin 2007)**. I will clarify this when discussing memory and representation in the analytic situation.[3]

Analytic treatment with traumatized patients is particularly challenging because their unconscious conflict and fantasy are often difficult to access. Moreover, despite significant technical advances in the treatment of patients restricted in their capacity to symbolize and represent (see, e.g., Killingmo **1989**, **2006**; **Levine 2012**; **Civitarese 2013**), difficulties remain due to the fact that traditional interpretive methods rely primarily on freely associative, verbalizable material, whereas archaic fantasy structures associated with trauma tend to be expressed somatically or acted out nonverbally, often in the patient-analyst relationship. Consequedntly, the analyst must struggle with enactments of the trauma (**Davies and Frawley 1994**; **Varvin 2003**).

It is increasingly apparent that a psychoanalytic treatment model that addresses only linguistically represented conflict is destined to fail because the weakly symbolized traumatic material accompanying dissociative states resides primarily in somatic experience. Instead, a wider, more inclusive analytic approach, addressing both repression-based and dissociative mechanisms, is necessary—an approach increasingly offered

3. Memories of early trauma tend to operate largely in the procedural, implicit memory system and consequently function more unconsciously when “traumatically” triggered, which manifests in behavioral, emotional, and sensory/motoric experience (**Gaensbauer 1995**; **Schacter 1996**; **Diamond 1997**). Nonetheless, even preverbal traumas are often capable of being remembered in both procedural (implicit) and declarative (explicit) memory systems, as for instance through an analytic process **(Gaensbauer 1995)**.

to nontraumatized patients as well **(Schmidt-Hellerau and Busch 2006)**. In work with more primitive mental states, there seems to be an increasing convergence in technique among analysts of many schools, despite their often mutually incompatible theoretical positions. This technical commonality includes British and North American independents, contemporary ego psychologists, London neo-Kleinians and contemporary Bionians, Italian and South American field theorists, and authors influenced by French analysts and psychosomaticians (see Diamond **2011**, **2020**).

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I next discuss key facets of dissociation that impact clinical practice and whose nature and functioning must be recognized in working with traumatized patients. Considerable time and effort is needed before the secondary dissociative defenses alive in the transference can be contained, as well as the unconscious fantasies and conflict-laden material associatively linked to the primary dissociative mechanisms.

Dissociation

Dissociation as a defensive operation entails keeping psychic clusters segregated in order to avoid mental distress. Moreover, the segregated clusters are available only in part and in specific, typically altered states of mind. Winnicott (**1945**, **1974**) was among the first neo-Freudians to posit dissociation as a healthy, natural capacity—a "queer kind of truth" (**1974**, p. **105**)—as well as a defensive response to trauma. He viewed dissociation as a natural capacity that precedes defensive repression; like Bromberg (**1998**, **2011**), who sees it as essential for maintaining internal continuity of self and identity, he believed that unlinked dissociated states lie at the root of all self-experience (see Goldman **2012**, **2013**).

Not all dissociation is indicative of psychopathology (though it may be defensively motivated), and humans have an innate capacity to become dissociatively absorbed for creatively adaptive purposes, as well as for self-protective defensive reasons. Accordingly, dissociation exists on a continuum ranging from a healthy capacity to maintain a sense of unity within multiple self states to more pathological, rigid defenses against acute and cumulative trauma that impairs self-cohesion (Bromberg **1998**, **2011**; see also **Hilgard 1977**).

Adaptive, healthy dissociative experience is evident, for instance, in splits between the observing ego and the experiencing ego, splits that are

part of the analyst's "therapeutic dissociations" **(Sterba 1934)**. Similarly, quotidian dissociative experience resting on autohypnotic ability **(Butler 2006)** is apparent in creatively imaginative play; in states of artistic immersion; when absorbed in reading, music, cinema, or theater; when watching or playing sports; in spiritual experiences, intoxicated states, hypnosis, or "highway hypnosis" while driving; and in other consciousness-altering experiences or states of mind

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(Hilgard 1977). This comports with Bromberg's description of psychic health as “the ability to stand in the spaces between realities without losing any of them” (**2011**, p. 51).

Dissociation, Splitting, and Psychopathology

Though the term *dissociation* and its ancestral term, *splitting*, have multiple meanings, *dissociative splitting* can be distinguished from other forms of splitting **(Blass 2015)**. A useful distinction is that dissociation tends to be a discrete phenomenon that impacts mental processes or consciousness in relation to bodily experience per se, whereas splitting affects psychic structures more accessible to verbalization (e.g., splitting of the ego or splitting of internal objects) and is accompanied by severe distortions in object relations and other pathological defensive processes **(Auchincloss and Samberg 2012)**. In dissociation, somatic experiences are kept relatively unformulated verbally **(Stern 1997)** and, as suggested by the Paris Psychosomatic School, are split off from psychic representation **(Aisenstein 2006)**. In contrast, splitting primarily operates on what has already been formulated linguistically.

The link between severe trauma and dissociation is generally well established (**Hilgard 1977**; van der Kolk **1987**, **2006**; **Diamond 1997**; **Bohleber 2010**). More extreme dissociative experience designed to protect a nascent sense of self tends to remain weakly symbolized or, particularly when relegated to the body, persists as linguistically unformulated and is therefore unrepresented in the “symbolic register” **(Quindeau 2013)**. In other words, traumatic messages and experiences tend to persist as somatic memories largely devoid of symbolic form and are not representable in a more explicit, conscious way. Nonetheless, I believe it important to note that even when not formulated in symbolic mode, some weaker, nonlinguistically structured representations may remain present and can become accessible in analysis (as illustrated in the clinical example).

Dissociation and Neuroscience

Neuroscientific research indicates that such integrative failure is mediated by stress-related alterations in brain regions that serve major integrative functions; thus, traumatized individuals are more apt to react to sensory input with irrelevant, often harmful subcortically mediated

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responses that further impair symbolic formulation of experience (see, e.g., **Krystal 1988**; Schore **1994**, **2009**; **van der Kolk 2006**).[4] Because of the consolidating function's failure, heightened affect and sensory impressions are repetitively processed by the amygdala, thereby producing a confusing “disconnect between the cognitive and affective spheres” (Boulanger **2018**, p. **65**).

Regardless of ongoing controversy within analytic circles apropos a neuroscientific approach, it seems useful to recognize that dissociation appears to reflect the inability of the right brain's cortical-subcortical system to recognize and integrate exteroceptive information from the environment and interoceptive information from the bodily-mind self (**Krystal 1988**; Schore **1994**, **2011**; **Meares, Schore, and Melkonian 2011**). Unfortunately, however, some neurobiologically oriented writers (e.g., **van der Kolk 2006**) misrepresent psychoanalysis as a left brain-dominated, “rational, executive” form of treatment that fails to address right-brain pathology. This characterization is blatantly inaccurate—consider, for example, the influence of Winnicott and Bion, as well as that of many child analysts (typified by **Sugarman 2008**)—although psychoanalysis itself has contributed to the fallacy by its long-standing failure to more directly address the impact of dissociative mechanisms (Brenner **2009**, **2014**; **Howell and Itzkowitz 2016**; **Kluft 2018**).

The Phenomenology of Dissociative Experience

Unlike repression, which keeps formulated but conflicted mental experience unconscious **(Freud 1915)**, dissociation does not produce a

4. For example, early relational trauma is imprinted on developing limbic and autonomic nervous systems in the maturing right brain, producing hemispheric dysregulation that interferes with the ability to maintain a coherent, continuous, and unified sense of self **(Schore 1994)**, as well as with the capacity to communicate experience in words and to integrate sensory input with motor output **(van der Kolk 2006)**. In short, an integrative failure occurs in which the right brain cortical-subcortical implicit self-system becomes dysfunctional in its response to trauma (**Schore 2011**; **Porges 2011**). From a neurochemical perspective, during traumatic experiences of sustained terror, excess norepinephrine is released that overwhelms the part of the brain that functions to consolidate verbal memory—namely, the hippocampus **(Boulanger 2018)**.

forgetting of threatening mental content, but instead keeps such content segregated and available only in part and in specific states of mind. This is accomplished by severing connections between linked self state processes, between cognitive and affective/somatic spheres, and/or between subsymbolic and symbolic components within emotion-based schemas

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(Bucci 2011). In psychoanalytic terms, there is an “unconscious refusal to allow the possibility that full-bodied meaning [can] be created” (Goldman **2013**, p. **11**), which becomes a “matter of avoiding the *interpretation* of [one's] experience” (Stern **1997**, p. xii)—a veritable refusal to be curious. When used to safeguard survival, the potential space required to feel alive is collapsed **(Winnicott 1971)**, causing the individual to be “cut off from authentic human relatedness” (Bromberg **1991**, pp. 405-406).

Dissociation is experienced by the subject as a *passive* process that “just happens,” partly due to a failure of the cohesive function normally exercised by the ego **(Fairbairn 1953)**. In this respect, dissociative experience is both known and unknown, simultaneously **(Bohleber 2010)**; it becomes a veritable “queer kind of truth” for the traumatized individual who “was not there for it to happen to” (Winnicott **1974**, p. **105**). Nonetheless, analysts beginning with Freud who are familiar with hypnosis can appreciate that these altered self states, reflecting a disconnection between one's imaginative and adaptive capacities, can be more easily activated through hypnotic, imagistic, drug-induced, and bodily based interventions.

Primary and Secondary Dissociative Defensive Functioning

As I have said, it is important to distinguish *primary* from *secondary* dissociation, though in their defensive functioning each expresses an overwhelmed ego's often quite adaptive altered state that serves to protect against the shock of incapacitation by a real or perceived threat arising from the blending of external and internal reality **(Reik 1936)**. Consequently, despite operating under conditions of failed synthesis and integration, dissociation forecloses psychic contents and severs connections between mental contents in order to modulate unbearable internal states (particularly intense impulses and emotions) and thereby salvage minimally needed mental functioning (**Gullestad 2005**; see also **Janet 1889**; **Davies and Frawley 1994**).

I propose that in primary dissociation the traumatic event's excessive influx of excitation (combining too much stimulation and too little protective shielding) activates the individual's annihilation anxieties. This

“original experience of primitive agony” (Winnicott **1974**, p. **105**), which Freud **(1926)** took up vis-à-vis traumatic (automatic) anxiety reflecting the dread of ego collapse, annihilation, and

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imminent breakdown, produces unconscious protective autoregulation that keeps psychic experiences separated from consciousness while obliterating the sense of personal agency. An experienced “unbearableness” causes the “I” to leave the scene (via a hypnoid state) in order to maintain personhood or sanity in the face of breakdown (**Diamond 1997**; see also **Winnicott 1974**; **Goldman 2012**). This is “the escape when there is no escape” (Putnam **1992**, p. **104**) that abolishes (at least temporarily) the existence of the self to whom the trauma would occur. Representing the “most primitive defense against traumatic affect states” (Schore **2003**, p. 246), primary dissociation serves to create a death-like state that is experienced as a passive happening (Bromberg **1995**, **1998**; **Diamond 1997**; see also **Ferenczi 1933**).[5]

In contrast, secondary dissociation, when functioning defensively (rather than creatively), and often experienced in the analytic setting, reflects a motivated defensive operation originating in unconscious experiences of internal conflict, particularly when unacceptable object representations and fantasies are activated. Rather than *forgetting* threatening mental content, as in repression per se, this form of dissociation still involves *segregating* units of mental content and requires interpretive acumen, inasmuch as both passive and active ego defenses are in play. Because linguistically structured representations are more developed and tend to be more accessible, the physiological effects are less intense than in primary dissociation (though often more intense in contrast to the splitting of psychic structures or internal objects). However, in both forms of dissociation, there is a persistence of the defense of turning away from threatening stimuli (such as the analyst in the negative transference, as will be apparent in the clinical example to be presented). Cumulative reliance on secondary dissociation can become structurally organized in complex character patterns originating in intrapsychic conflict—for example, in dissociative identity disorders (e.g., multiple personality) as well as in dissociative defensive structures evident in eating and addictive

5. Using different terminology, Tustin **(1981)** referred to severe environmental impingement or psychological catastrophe **(Bion 1962)** that produces an innate defensive mechanism—an autistic withdrawal or encapsulation against bodily/somatic pain. This process involves “shutting out from the mind” internal mental experience that cannot be handled, resulting in an almost complete inability to integrate physiological and psychological responses **(Bucci 2011)**.

disorders, psychosomatic reactions, borderline personality disorder, schizoid states, and post-traumatic stress disorder.

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Distinguishing between primary and secondary dissociation, as well as between dissociation and repression, is far less clear-cut in treatment because dissociative processes inevitably connect themselves to other defensive maneuvers and because repressive processes indicative of conflict may be present in any dissociative event. Patients use both secondary dissociation and repression against any undesirable intrapsychic material (**Gullestad 2005**; **Bohleber 2010**); moreover, a consequent diminution in the sense of *I-ness* often reflects dissociative mechanisms having become secondarily linked with conflictual material. For example, a young adult patient whose psychic conflict owed much to oedipal issues, when required to expand upon transcribed depositions in his work as an attorney, would often "space out" when returning to his computer and become "lost for hours" in internet pornography, stock market tracking, and daydreaming with little sense of time or agency until "rudely awakened" by someone entering his work space.

To help recover the severely traumatized patient's lost sense of agency in the analytic setting, generally the analyst must carefully validate the psychic state associated with annihilating anxieties before interpreting the conflictual fantasies and object representations. For instance, when interpreting a patient's "psychotic" attacks on linking **(Bion 1959)**, it may be crucial to address the horrendously fragmenting states of mind that have become linked to seemingly more straightforward, conflict-based compromise formations resulting from unacceptable impulses, wishes, and affects arising from violent fantasies of projective identification.

Trauma, Memory, and Representation in the Analytic Situation

Because the psychic devastation of severe trauma overwhelms memory's integrative functioning and alters normative encoding, as well as linking among memory systems (**Schachter 1996**; **Diamond 1997**; **Mancia 2006**; **Bohleber 2010**; **Craparo and Mucci 2016**), the continuity of time is significantly disrupted. Rather than flowing continuously, the patient's sense of time seems to be stuck in a permanent *now*—the Lacanian *real*—that is experienced analogously to a succession of dangerous, jagged peaks **(Scarfone 2006)**. In Lacanian terms, what has not been allowed symbolic expression reappears in reality in the concretized form of hallucination.

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At the risk of slight overstatement, inasmuch as the capacity for representation lies on a gradient, the traumatized patient is somewhat lost to what lies outside verbal representability and, in being unable to penetrate the *imaginary* order to reach the *symbolic*, becomes stuck in the *real* **(Lacan 1966)**. The patient's traumatic experience of *primitive agony* **(Ferenczi 1933)**, *mental disaster* or *breakdown* **(Winnicott 1974)**, or *internal catastrophe* **(Bion 1992)**, as well as any accompanying unconscious fantasies, often remains split off and psychically undigested (see **Bion 1962**). In other words, as noted, because early-life trauma is often encoded in the body-mind system before becoming verbally signified, the associated memories are frequently not stored in the episodic memory system and instead remain in an earlier, more primitive memory form (**Mancia 2006**; **Meares 2009**; see also **Gaensbauer 1995**). Through dissociated self states, traumatic memories tend to remain encapsulated and isolated from the flow of affectively laden, associative linkages; consequently, such memories may be subject to little or no revision by present circumstances, although they are generally preserved with considerable precision (not necessarily accuracy) in the unconscious and thus over time can become amenable to verbal narration.[6]

In the analytic situation, we see that an individual's experience of trauma depends on what is made of impinging external events and corresponding endogenous, often predetermined stimulation. Trauma is no more one's destiny than anatomy is destiny. Quite the contrary: in viewing the experience of trauma analogously, destiny is determined by what one makes of the traumatic events. Nonetheless, traumatized patients often reveal how their psychic functioning is undone by self-protective dissociative mechanisms, which, as Freud argues in *Beyond the Pleasure Principle* **(1920)**, restores pleasure principle functioning while disrupting the continuity of time and identity and weakens symbolization (**Shengold 1989**; **Bohleber 2010**).

Potentially representable experience remains unintegrated, timeless, and ego-alien because the dissociated “raw data” stored as traumatic memory, typically rendered in somatic symptoms, is often left devoid of language-based symbolism. At the time, it cannot undergo further mental processing (**Bokanowski 2005**; **Bromberg 2011**; **Roussillon 2011**). Consequently, the absent or unknown source of pain often communicated

6. However, some analysts (e.g., Modell **2000**; **Faimberg 2007**) argue that the present relational field reconfigures memory and category formation, which potentially can transform the contours of dissociated self states.

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through enactments, requires transformation into a psychic presence through the analyst's interpretive provision of meaning that has been left uncreated (**McDougall 1974**; **Aisenstein 2006**). Many such patients are left haunted by emotionally charged, implicit traumatic memories yet to be expressed in words. However, when put into words and images, perhaps for the first time, forgetting through the work of repression can occur **(Loewald 1955)**.

This is easier said than done because disruptions in memory and representational functioning often force the analyst to *suffer with* the patient's terrified states of mind, contain highly charged enactive tendencies, and endure deadening dissociative defensive operations before representational interventions can be used. Vicarious traumatization experienced by the analyst often ensues and may become a necessary therapeutic tool for representing and interpreting the meaning that has been unconsciously repudiated (**Davies and Frawley 1994**; **Bromberg 2011**; **Diamond 2014**; **Boulanger 2018**; Craparo and Mucci 2018). I hope to clarify how successful treatment often rests on gradually developing the ego's capacity to represent such encrypted psychic experiences and to mentally process unbearable anxieties and psychic pain **(Birksted-Breen, Flanders, and Gibeault 2010)**.

Dissociative Functioning and Analytic Technique

The analyst must discern not only how the traumatization is represented—despite how tenuously its representational elements are connected to early trauma—but also how *accessible* the fragments of traumatic memory, affect, and fantasy are to the patient's consciousness and associative processes. Consequently, it is necessary to determine what sort of mind is being dealt with at any point—a mind capable of imaginative and metaphorical thinking, or perhaps a more somatically based one with a more limited capacity for symbol formation.

Because vital memories and experiences tend to remain segregated and are yet to be creatively imagined and represented in linguistic form, treatment becomes extremely challenging inasmuch as the actuality of trauma is stored in the body and resides in the procedural, implicit memory system. The key issue is how to transform these somatic memory traces into more “normal” memory—to find ways of translating what presents currently as pre-representable or perhaps only minimally representable and making it psychically figurable (**Botella and Botella 2005**; **Civitarese 2013**).

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This process typically commences when the analyst can address the trauma's impact on the patient's symbolizing capacities. Whether it is assumed that symbolization is disrupted by means of trauma's *too muchness* producing a lasting deficiency in psychic structure or as a by-product of underlying conflict and unconscious fantasy, I contend that representation is best understood as occurring in gradients—ranging from very weak, bodily based forms to stronger ones that are verbally and imaginatively encoded. Consequently, a dual-track technical approach seems advantageous, one that entails both *archeological* and *transformational* ways of working **(Levine 2012)**.[7]

The former addresses well-represented and symbolically invested psychic elements tangled in conflict, whle the latter is required to translate the semiotic, pre-representational, and sensual into the symbolic realm. Most analyses are characterized by oscillations between the two modes, and the central technical issue is the analyst's ability to discover what kind of mind the patient is operating from and to tailor interventions accordingly.

To disentangle the actuality of the trauma (i.e., traumatic reality) from unconscious conflict and fantasy, the patient needs to experience the analyst's sufficient validation of the traumatic events themselves. This entails discovering the “reality” of the trauma and its associated effects, however approximate. Of course, working with the patient's psychic reality in relation to actual, historical reality is a complex matter, though useful guidelines in the form of a cluster of converging material are available that help establish the likelihood of a history of actual trauma in contrast either to libidinally based fantasized trauma or to illusory, false memories of suggested trauma (see **Diamond 1997**). Though validation of historical reality cannot be provided with absolute certainty, the analyst treating severe early trauma is well advised to “believe skeptically and doubt empathically”(Brenneis **1994**, p. **1050**).

Sufficient validation in the realm of “actual” trauma helps the dissociative, traumatized patient become sufficiently available to the recognition and analysis of secondary revisions via unconscious fantasies, conflictual affects, and defensive constructions (often involving introjective and projective punitive impulses and feelings of guilt). Otherwise, the danger of

7. Archaeological work requires an investigative analytic attitude, with a more knowing analyst interpreting the patient's repressed unconscious in order to discern concealed meaning apropos of conflict pathology. Transformational work, by contrast, requires an affirmative mode to establish meaning (Killingmo **1989**, **2006**), and here the analyst is more of an “engaged witness to the ‘queer truth’ of dissociated experience” (Goldman **2016**, p. 105).

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iatrogenic retraumatization remains in the form of repeating the traumatic impact of nonrecognition by the “absent” (“negative”) caregiving object **(Ferenczi 1933)**.

The dissociated, more or less sequestered units of experience stored on a sensorimotor level are often elicited unexpectedly and reactivated in regressive transference states. In the face of such weakly symbolized trauma, patients unconsciously search for another mind to think what is as yet unthinkable **(Bion 1962)** in order to declare what remains implicit. Through a willingness to experience the patient's traumatic states countertransferentially, the analyst functions as a *transformational object* **(Bollas 1979)**, lending his or her mind as an auxiliary ego (i.e., alpha function) and emotional regulator to facilitate the patient's development of thoughts, feelings, and mental states (**Botella and Botella 2005**; **Diamond 2011**; **Bromberg 2011**; **Civitarese 2013**).

Consequently, an opportunity is provided for creating a new experience of the original trauma(s) wherein the events are endowed “with the feeling of a real experience” (Ferenczi **1932**, p. 14). This helps achieve an authentic, emotionally resonant rather than intellectually detached insight. Such therapeutic action results in part because the vicariously traumatized analyst allowed him- or herself to become “impregnated” by turbulent affect (**McDougall 1978**; see also **Davies and Frawley 1994**; **Bromberg 2011**; **Boulanger 2018**).

Given the analyst's likelihood of “falling ill” with the ailment affecting the patient **(Borgogno 2014)**, there is considerable potential for the analyst to enact, and particularly to assume a masochistic or sadistic stance in identifying with the patient's inner objects, rather than recovering in order to contain and subsequently to interpretively represent. The analyst's ability to work with enactments and projective identification demands a particular “maternal” attitude **(Ferenczi 1933)** or “way of being” **(Purcell 2019)** entailing a profound emotional engagement not so easily represented linguistically.

I also emphasize that when secondary dissociation appears—at times as an extremely varied, “weird” scenario, and at other times in more subtle ways (**Diamond 1997**; **Gullestad 2005**)—the analyst must both appreciate its function as a *motivated* defense implying an active though unconscious strategic agent, and recognize it as something that just “happens” to the passively experiencing patient through repetition compulsion, as the case to follow illustrates. However, like other forms of repetition

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compulsion, secondary dissociation expresses an archaic effort at mastery, which in the analyst's presence represents an active attempt to find in the analyst a containing object capable of making sense of what has remained weakly symbolized and often expressed somatically.

Because treatment entails a highly charged atmosphere of projective identification with the patient's unsymbolized terrors and unbearable states of falling apart, the analyst is faced with the responsibility of bearing disturbing and often excruciating countertransference reactions. In spite of feeling confused, overwhelmed, helpless, enraged, betrayed, guilty, powerfully protective, and driven to act, the analyst must discern the patient's negative transferences, which can easily remain disguised by compliant and/or defiant character modes **(Diamond 1997)**, as well as by one's own countertransference resistances toward facing the patient's hidden hatred and contempt **(Ferenczi 1933)**. Although such transferences reflect the patient's sadistic attacks on the self rather than simply replicating past external relationships, nonetheless, as the case example will suggest, it is necessary to feel and suffer with the patient's states of traumatic anxiety, as well as dissociated terrors of fragmenting and falling apart that underlie defensive identifications, as with a sadistic abuser.

In sum, the analyst's recognition, containment, and skillful interpretive work allows the dissociated aspects of the patient that cannot yet speak—the dissociated *not me* state possessing the patient—to be experienced as a presence the patient is able to own and thus to represent (initially, together with the analyst). The patient's unconscious fantasies and conflicts often become more accessible when the analyst, through reconstruction, labels an experience traumatic, based on the patient's secondary dissociation, and affirmatively links it to the here-and-now transference by interpreting what may be occurring “at the same time and on another level” (**Grotstein 2009**; see also **Killingmo 2006**).[8]

The following clinical material depicts the complexities of analytic work with dissociation, the transference-countertransference, symbolizing processes, and the role of unconscious fantasy, repression, and

8. Because of the likelihood of iatrogenic retraumatization, the timing of such here-and-now transference-based interpretations is crucial with patients who have experienced severe trauma (see **Ferenczi 1933**). Thus, in addition to determining whether the patient is operating from a mind capable of functioning in the symbolic realm, the analyst is required to sufficiently safeguard the patient's psychic survival over time and in rare cases may even need to remain present in relative silence, without interpreting for years, in order to establish the necessary safety (see, e.g., **Grossman 2014**). Although it is beyond my scope here to more fully discuss timing and “readiness,” as well as the requirements for safeguarding psychic survival, I hope to encourage further discussion of this vitally important issue when working with severe trauma.

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conflict, subsequent to the patient's having achieved verbal access to severe childhood trauma that still involves partly unformulated remnants expressed through the body. The single-session vignette illustrates the impact of the patient's oscillating states of mind and the persistence required of the analyst both to suffer with and find the words to build bridges between segregated units of experience.

Case Example

Ms. A., a forty-year-old woman, initially entered treatment suffering from an acutely severe post-traumatic stress disorder that kept her from returning to work for six months or so. The trauma had apparently resulted from a botched abdominal surgery performed without anesthesia due to a misplaced catheter. However, it wasn't until well into the second year of psychoanalytic treatment that it became clear that she was profoundly traumatized throughout her childhood by chronic sexual abuse by her maternal grandfather (along with several more distant relatives).

Before beginning analytic treatment, her focal psychotherapy had ended several months after her PTSD symptoms abated, and she had resumed working and could function socially. Nonetheless, Ms. A. experienced considerable anxiety and reported having had multiple depressive episodes, including having been hospitalized following a suicide attempt in her early twenties. She soon resumed treatment, and we began meeting two or three times weekly to address the impact of her troubled childhood history and persistent struggles with anxiety. Within a few months, she became quite depressed and actively suicidal (though no specific memories had yet surfaced). Operating within a more psychotic domain, she described feeling “invaded” by intrusive and terrifying bodily sensations and partial images of early violent abuse, all before recalling her extensive experiences of sexual abuse between the ages of five and eight. As we would eventually learn, and despite subtle signs of ongoing abuse, including selective mutism for two years, both of her parents responded with disbelief and denial (although her mother too was sexually abused by her own father).

In the sixth month, we began a three- to four-times-weekly psychoanalysis on the couch that lasted five years.[9] During the second year of treatment, she had become more stabilized and we began analyzing her

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9. Portions of this case have been presented in a discussion of the “unbearable agony” of cumulative early childhood trauma (see **Diamond 1997**).

secretive self-cutting and its relation to her wish to have her inner pain and torment “seen” as well as “believed” by a mother (analyst) who would intervene and protect her. Still, as noted, only later in the second year of analytic work, mainly through a series of dreams and transference enactments, could Ms. A. develop a verbal narrative in which her trauma could be more coherently recalled and linguistically represented, including its transference manifestation in a workable form.

For instance, during a session in which she had become more able to think about her impulse to cut herself, she surmised that it had something to do with her being able to “picture” me as someone calm inside her who didn't want her to be hurt. She suddenly became visibly disturbed by the repetition she experienced concretely in the transference. Grimacing in agony, she said: “I'm afraid. I see you turning into him [her grandfather]. I don't want you to get in. He was nice too, then … I can't talk about it. I'm falling apart … the darkness. I must get out of here right away.”

Ms. A. looked terrified and held herself tightly while sitting up in a rote manner with a faraway look in her eyes. Escaping from inhabiting her apparently reviled body, she was present yet not present for what seemed like several minutes. I felt suddenly pushed far away and though taken aback, an unbidden feeling of amusement came to me as if we were playacting. I struggled to stifle my peculiar (and very uncomfortable) desire to laugh, while she remained motionless, like an automaton. Soon my unwelcome amusement gave way to intense anxiety. I felt an urgency to reach her, to find words to make contact and bring her back to life.

At the same time, I felt encased in a sort of plaster cast, and my mind was shutting down from thinking thoughts or even having images. Though feeling increasingly “impregnated” by disturbing, turbulent affect and my own mental shutdown, I couldn't make sense of what was happening. Then I remembered that she had spoken recently of “spacing out” on other occasions, so without thinking I found myself saying, “You seem to be spacing out now after picturing me as someone calm inside you.” I then added, in a quasi-dissociative, yet rather traditional, reconstructively oriented way of interpreting the transference, that she seemed to experience me as like her grandfather, who used kindness to seduce and betray her.

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Because neither of us could yet be fully engaged emotionally, she remained motionless while ignoring my comments; my own feelings of disturbance were mounting in what seemed like a force field of heavy, inhibiting silence. The time seemed endless as my feelings continued to

mount. I was trapped in the anguish that seemed to be enveloping us (perhaps it was only my own). It no longer seemed clear who was doing what to whom or even who was who (enveloped as I was within the tentacles of a somatically impacted, traumatized, projective identification).

I felt increasingly helpless and ineffective while compelled to do, say, or figure out something. As she remained motionless in a trancelike state, an image of a zombie from a film came to mind. When I recalled that she had become selectively mute as a child, the force encasing my mind began to lessen. I realized that both of our minds had become frozen in zombie fashion, and we seemed to be disappearing together in a dissociative haze. Though I could not yet appreciate how necessary it was for me to be receptive to this kind of psychotic-like disturbance, I did sense that my position was shifting.

Still, I had no idea whether or not she was in a state of mind where she could make use of verbal interpretation and symbolic reality. I thought about the “I” in Ms. A., who at some level was actively dissociating to avoid experiencing the mental distress of whatever unconscious fantasies and conflicted feelings about me might have triggered her retraumatizing anguish in the here and now. Despite my uncertainty about her state of mind, I gave interpretation a try by noting once more how she was experiencing my recent comment that made her feel “loved” in a way that caused her to relive how she felt with her abusing grandfather, which led her “traumatized mind” to take over again.

She remained staring off into space, though seeming to be slightly more open to her feelings and anxieties, before replying, “It's better to just be abused, get it over with once and for all,” adding several times her forceful plea, “Do it … just do it now!” Once again I found myself drawn into what I would subsequently understand as the necessary enactive process, which required my being receptive to accepting my “bad object” role as an abusive victimizer. In my role-responsiveness (to her internalized object world), I felt a strange impulse to harm her, initially to shake her vigorously to get her to come out of her trance, and then, grappling with my own more sadistic, sexualized images to take control of her body.

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While struggling to contain these disturbingly sadistic impulses and fantasies during the lengthy silence, I recalled an image from a dream she presented at the outset of therapy. The image was of a child's face without a mouth—an abused child without a voice, obviously traumatized. As I regained my analytic voice (and symbolizing abilities), I began

to consider my very disturbing experience in the countertransference, linking my helplessness and sadism to Ms. A.'s unconscious world. Together we were enacting the need to turn passive into active (though fortunately as her analyst, only in my internal world).

While working to contain and metabolize my own experience in order to be present and helpful, I noticed that Ms. A. began to feel a bit safer, perhaps in preconsciously grasping that my effort was to understand what was occurring without needing to prematurely put it into words or action. In a sudden reappearance of her observing and symbolic functioning, she mentioned a recent session in which I had offered her a glass of water during a bout of coughing. We were working together again in our dyad, and yet, as is common with patients who have had to protect themselves from deep emotional engagement, she again turned away and huddled on the corner of the couch, mumbling, “I can't be sure you're not like him.” By now, I had more of an emotional understanding of the oscillating dance between us marked by dissociative and repressive defenses and hence, seeking clues to the “danger” she was experiencing, I asked, “What is it about *me* making you feel that I would lead you on and then betray you?” She replied, “You're a man, that's all,” as she again became visibly afraid, curling herself up in silence.

The air again became impregnated with tension, and once more I struggled with my discomfort with being considered a rapist, and feeling like one, by virtue both of my sadistic projective identification and the simple fact that I am male. The seemingly endless, traumatic, persecutory repetitions took hold once more, Yet again I began to feel rather helpless to do anything for this fragile, unreachable woman-child, though perhaps it might help if I could name—that is, give voice to—what seemed so obviously the preconscious source of Ms. A.'s reaction—that she is afraid of me because I am a man and therefore must be like her seductive and exploitative grandfather. She might then recognize that I was serving as an external representation of her sadistic, self-hating internal object.

“You are and you will [abuse me],” she declared without hesitation or thought as she remained motionless and then, a few minutes later, touched her face while staring at me in a lifeless

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fashion. Her secondary dissociation was active, and she stated in a weirdly detached manner, “I'm concerned … something very bad is happening now. I'm being taken over. A mask is on my face, covering the ‘real me’ that's so little.”

I wondered anxiously if somehow I had promoted a more permanent split, creating a multiple personality out of my analytic “failure.” I was

having thoughts of the multiple, switching “faces” of the cinematic Eve as her dissociative functioning had more fully come into the analytic space. The ambience became eerie in a demonic way, and I began to feel as though I couldn't use words to effectively clarify anything. Recognizing how locked into the concrete realm she was, lacking the ability or space to think, I struggled to help draw her back to her associative (rather than dis-associative) functioning. I then was able to speak rather haltingly of her fear of what might be “under the mask”—namely, what's inside her and part of the “real” her (including the more sadistic hatred she harbored toward her neediness and desire). She responded, “It's bad, it's awful. Please make it go away. I must hurt myself.”

I commented on how afraid she might be that I would be as rejecting and hateful as she was of her “needy” self that was depending on me. However, she seemed to be “upping the ante” in her sadomasochistic enactment as she boldly declared, “I really must hurt myself.” I realized that she not only needed me to protect her from harming herself; she also required that I understand how she used self-harm as a protective mechanism. So I conveyed that her hurting herself was her way of “trying to make her need for me disappear,” because to need someone, particularly an older man, was linked in her mind with being used and abused.

She looked at me strangely and started to laugh somewhat demonically, before declaring, “I want you to hurt me … now, hurt me … hurt me please!” I replied again that she was terrified that I would exploit her need for me and indeed hurt her, before adding that she wanted me to hurry up and get it over with so she wouldn't have to sit helplessly and wait passively for the pain.

Perhaps my persistent efforts to find my way back to and stay present with her deep anxieties and dissociative defenses were helpful; she finally appeared somewhat relieved and began elaborating on how afraid she was of needing me, experiencing it as “wrong.” I continued my attempt to validate her psychic reality by speaking to the more experience-near, preconscious

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surface of her passively experienced, “paralyzed” state of mind that originally occurred when she felt overwhelmed and helpless, with no one around who was able to help her make sense of what was happening to her. In recovering her ability to represent and associate, she recalled feeling so alone and now, able to reflect on her originary, primary dissociative defense, remembered often imagining a beautiful angel who would come down from the cloud (that she “saw” on the ceiling) and take her to heaven.

In naming the fact that no one was there to address what she needed, we spoke about her feeling flooded by what was going on inside and around her. To which I then added, “So, then as now, you try to escape from yourself in order to handle so many confusing feelings—of love and fear, excitement and terror—feelings that seem so intolerable to you even now.” I went on: “‘Spacing out’ has always been the way to protect yourself and survive, it's your way of putting on a mask to make you feel invulnerable to physical pain and unbearable thoughts and feelings.”

As she began to tear up and make eye contact with me, Ms. A. said, “But there *is* no other way.” Recognizing the return of her symbolizing “agent”—the “I” who dissociates—she increasingly was able to verbalize her fears of my abusing her (i.e., a strengthened imaginary register), thereby setting us forward on our course for dealing directly with her abusive stance toward herself.

Brief Discussion of the Case

Ms. A.'s conscious experience of an actively motivated, though passively experienced defensive operation had become more accessible. As a result, interpreting her secondarily dissociative processes in the transference could more easily bring to light any accompanying conflict, internal object relations, and preconscious fantasies. In short, whenever her positive feelings toward me emerged, she would suddenly anticipate that my being “nice” would lead to my betraying her, particularly since her desire to feel loved and tenderly connected, conflicted with her accompanying imaginings of being helpless to avoid hurt. The reliving came alive with me when she felt all alone, with excruciating terror, guilt, and anger, as well as bodily excitement. She began to understand in an emotionally real way, perhaps for the first time, how she would make her experience with me disappear into a very familiar, “spaced-out” mask that preserved her deeper, true self secretly being saved by an angel taking her to heaven.

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Finding the words that she could “hear” in order to name what she experienced passively could occur only after numerous oscillations in the work, including lengthy periods during which I felt increasingly helpless, particularly when she seemed to abruptly (and eerily) “disappear,” as when looking at me ominously, before “dissolving and spacing out” in paralyzed, catatonic fashion. As our work continued over several sessions and throughout two more years, her reliance on dissociative defenses continued to lessen. Ms. A. could begin to grasp in an emotional way that her needy and

tender feelings toward me evoked an ineffable yet terrified sense of annihilation linked with fantasies of impending abandonment (associated with her parents) and conflicts originating in painful abuse and sexual excitement (linked to her grandfather). Additionally, she was more able to see that both her dissociative and repressive processes were often registered and experienced through self-mutilation and somatic conversions.

Through achieving greater integrative capacity, she could better understand and manage how she employed secondary dissociative operations in an effort to cope with the unbearable, as yet insufficiently symbolized effects of a traumatized state of mind that foreclosed her ability to experience her unconscious fantasies and repressed, conflictual desires. For instance, following successful interpretive work that enabled her to experience me as “accepting” her desires to be “loved” by her grandfather by sitting on his lap and receiving his undivided attention, the unconscious fantasies, impulses, and conflicts associated with what would emerge before, during, and after the sexual abuse produced both repression and a more enduring secondary dissociative defense involving self-mutilation and her pleading with me to “hurt” her and thereby remove the “her” (i.e., the self) that might be annihilated. This understanding made it possible to represent and interpret how and why she would abruptly begin to dissociate in sessions.

Concluding Remarks

In offering a more inclusive psychoanalytic perspective on trauma, one that recognizes the role of dissociation in primitive, traumatized mental states, guidelines for successful treatment emerge that address both dissociative and repressive processes occurring in analytic space. To build the necessary bridges between segregated units of experience, the analyst must endure and work

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through the projected dead space and other enactments of dissociated trauma and related unconscious fantasies.

Once the terrifyingly helpless, flooded, and dissociating states of mind that treatment retrieves can be formulated in words, a different and transformative experience of the missing protective illusion can provide the patient a new experience of the original trauma (that will come and go in oscillating fashion throughout the analysis). Words at the appropriate moment can show the patient that the analyst understands “the deepest anxiety … experienced or waiting to be experienced” (Modell **1976**, p. **240**; see also **O'Shaugnessy 1983**).

A sufficient, often lengthy period of time is vital for the analyst to safeguard the patient's psychic survival and help structure into language and affect the somatic, gestural, and enacted expressions in which traumatic experiences are registered and conveyed.

Interpretive-based labeling linked to the trauma (which remains frozen in time), when achieved in the context of the analyst's emotional engagement, allows sufficient distance in the patient's mind to enable the reestablishment of symbolizing abilities (that can be used in addressing previously segregated, dissociated units of experience). In essence then, only when the dead space that had been frozen in time is recoverable, and brought to life in the relational field of transference-countertransference, can the intersubjective space previously compromised (and largely foreclosed) be re-created. Consequently, unconscious conflicts and fantasies (including projective identification), which in Ms. A.'s case, pertain to desires for affection and sexual excitement, as well as tormenting fears of violation, pain, and abandonment, can then be interpreted in the “traumatic” transference.

The analyst functioning, through both inhabiting the dead, often eerie (“queer”) space of dissociated trauma and eventually recovering the missing symbolic function (often through self-analytic work), is able to bring understanding and language to bear on the unbearable (Diamond **1997**, **2017**). By articulating the dissociated experience in analytic space, a bridge can form so that the now-ness of unconscious, traumatized time is able to become psychically represented and the trauma can enter chronological time, thereby promoting analytic transformation. The technical challenge depends both on the analyst's ability to become emotionally engaged and, ultimately, on his or her skills in validating the actuality of the trauma, its *too muchness*, and its

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object-relational failures, while helping to access and interpret the intrapsychic fantasies, constructions, identifications, and mental structures that impacted the experience of trauma.

Orcid ID

Michael J. Diamond [iD] **orcid.org**

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615 Hanley Way

Los Angeles, CA 90049

Email: ***michael@drmichaeljdiamond.com***

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