

THE DISSOCIATIVE MIND

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DISSOCIATION A Model of the Psyche

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My experience during the World Trade Center disaster of September 11, 2001, illustrates the initially protective role of dissociation in the moments of trauma, as well as its later consequences. I was on my way to work about 9:00 a.m. on the subway in New York City. People were talking about planes that had hit the World Trade Center, but I was focused on avoiding being late for a session with a patient, and pictured these as small planes, causing at most small fires. I thought to myself, "Small fires happen everyday." As I was on the subway and talked to more people and got more information, I decided I would get out and have a look at this fire, before proceeding on the subway under it (the next stop on the subway was the World Trade Center). When I exited, I saw the twin towers three short blocks away, burning rapidly, like matchsticks. They had already burned about a quarter of the way down. People were standing around staring, and appeared transfixed. I was transfixed too for a moment, and then I decided it was time to leave. But there was no way back by subway because the service had been stopped. Nor were there any cabs. It was too far to walk to my office, and I decided to walk home to Brooklyn. I made my way to the Brooklyn Bridge and walked across with a throng of others, many of whom had been in the towers and had escaped the fire. I talked with a man who had walked down 66 flights of stairs and believed that everyone had exited safely. At that moment, I believed that, too. Everyone was calm. No one was running. In short, people were in a state of shock en masse. I had an eerie moment of noticing what a beautiful, clear, crisp, near-autumn day it was, as a backdrop for the image of the towers rapidly burning, now more than halfway down. It was clear to me that they would collapse, and I began to worry about the impact of collapse on the stability of the bridge. Not knowing of the validity of this speculation in physics and not wanting to frighten others,

I walked faster alone, but like everyone else, I was calm. Now there was a huge black cloud of smoke and fumes and debris, billowing larger and larger and rapidly gaining on us. As I was exiting the bridge, I heard someone say that one tower had collapsed. (When someone asked me later if I saw the towers collapse, my answer was no, because I had been so absorbed, so intent on getting off the bridge.) As soon as I arrived home, there were calls from the superintendent to everyone to close their windows against the now arrived black cloud of soot and burned remains. I remained calm. It was a heartrendingly emotional time, but I thought that psychologically, *I* was fine. It was only a few days later that it hit me: I realized that I narrowly missed being caught in the conflagration. If I had stayed on the subway, the train would have either stopped at the World Trade Center, which was an underground maze, mostly leading into the towers, or in the tunnel, from which evacuation would have been, at best, a time-consuming process, with an exit close to the fires. I worried about all the people in the subway car, some with whom I had spoken, who had not left. I wondered what had happened to them, whether they survived. When I realized how imminent the danger had been, I couldn't stop telling anyone who would listen. To people who had no idea what had happened, this might have seemed a bit crazy. But many of the elements of trauma and dissociation are here—the calm narrowing of the focus of attention to only the most salient matters or helpful things, and the later realization of fear, concomitant with frightening, intrusive thoughts and hyperarousal. For persons who don't know or can't understand what the frightening event was, the subsequent agitated behavior might seem bizarre. Fortunately for me, I received enough understanding that my mild posttraumatic stress symptoms abated. However, people who are in chronic posttraumatic stress may be experienced by others as disordered or as behaving bizarrely, especially if the stressor is unknown, as is often the case.

PTSD Is Evidence of Dissociation

In posttraumatic stress a person may experience the intrusions of dissociated experiences, such as flashbacks, somatosensory experiences, or even obsessions, into consciousness, but may also vigilantly attempt to avoid any reminders of the trauma. These are the intrusion and avoidance aspects of PTSD. This was what happened to me in the World Trade Center disaster on September 11, 2001: my previous experience

of terror was not accessible to me for a few days. Then, the memories began to intrude. Although I felt like Coleridge's Ancient Mariner (who had to wander from town to town, endlessly telling his story), I began to heal. This process assumes dissociation, because some experience had to be cordoned off from other experience (dissociated) to intrude (Van der Hart, Van Dijke, Van Son, and Steele, 2000). The intrusion aspects are the dissociated memories of the trauma, often intruding in response to "triggers" or reminders of the trauma. The hyperaroused behavior may appear senseless to an observer and even to the individual in question. The avoidance aspects of the PTSD refer to the efforts to avoid the dissociated material which could be triggered by a reminder of the trauma.

Trauma

Until fairly recently trauma was officially viewed as an "out of the ordinary" experience (*DSM-III* described trauma in these terms). But such a view is inconsistent with observable reality (Brown, 1991; Herman, 1992). In times of war, trauma is not rare. Neither has it been rare in times of relative national tranquility. Indeed, trauma has never been rare. Rates of child abuse, including physical and sexual abuse, are shockingly high. A recent national survey, conducted by telephone, of 2000 randomly selected youths, aged 10 to 16, found that almost one half of the boys and one third of the girls had been subjected to some form of violent victimization (Boney-McCoy and Finkelhor, 1996). In a large study in which 900 women were interviewed, Russell (1986) found that the rate of contact child sexual abuse of girls before age 18 was 38%, and the rate of incest was 16%. A recent study of 600 college men indicated that 18% reported contact sexual abuse before the age of 16 (Lisak, Hopper, and Song, 1996). Assuming that much of this trauma is not resolved and has dissociative sequelae, these rates might push expected normal personality structure into the realm of what one might call the "pathological normal"—that is, an area that is statistically normal but highly problematic, even pathological.

We now understand that trauma is ubiquitous. In the statistical sense, it is normal. And so is dissociation, which is often a sequela to trauma. It follows then that everyday functioning for most people is bound up in the effects of trauma and dissociation. Although significant trauma does affect the majority of us, there are also many less extreme traumas and dissociations of everyday life. And these affect us in

ways that may be at first unexpected. Pollack (1995, 1998) contends that in our culture little boys frequently undergo a "normative developmental trauma" involving dissociation of affectively longing parts of the self and resulting in fears of isolation and feelings of deprivation. Indeed, many gender-related phenomena can be understood as post-traumatic adaptations, involving dissociation (Howell, 2002b).

Not Only Posttraumatic

Despite the prevalence of trauma-related dissociation, problematic dissociation does not proceed from trauma alone (Gold, 2000). It encompasses not only the "shattered self" of posttraumatic severed connections, but also more general failures of integration (Putnam, 1992, 1997). Poor psychological integration proceeds from family environments that are chaotic, abusive, neglectful, or all three; from attachment dilemmas, including disorganized attachment; and from severe interpersonal anxiety caused by interactions with caregivers and with a dissociogenic culture. Developmentally, lack of integration characterizes our beginnings (Siegel, 1999), and facilitative maturational environments enable disconnected sets of experiences to be linked (Putnam, 1997). In his important book, *Not Trauma Alone*, Gold (2000) amends the trauma-abuse model and emphasizes that individuals most likely to be characterized by severe dissociation have generally grown up in interpersonal environments that failed to provide the infant and child with requisite interpersonal resources to obtain full human status. He observes how remarkably consistent individual incidents of abuse often are with the family atmosphere in which they have occurred, and that atmospheres of neglect, deprivation, and rejection fail to nourish fundamental skills in living.

Fairbairn and Ferenczi (chapter 3) have articulated forms of dissociative adaptations to attachment dilemmas. Bowlby noted the importance of segregated internal working models, which modern attachment theorists such as Liotti, Lyons-Ruth, and Stern have observed is both phenotypic of dissociation and predictive of dissociative disorders. Interestingly, and counterintuitively, Lyons-Ruth (2003) has found that disorganized attachment is a better predictor of dissociation at age 19 than is trauma. The current attachment-theory emphasis on dissociated relational procedural enactments (chapter 6) intersects with current relational psychoanalytic models of Bromberg, Davies, and Stern (chapter 4).

Sullivan (1953) described the interpersonal genesis of dissociation. As a result of unbearable anxiety arising from interactions with caregivers, including extreme parental disapproval, certain kinds of experiences may become dissociated and part of “not-me.” Selective inattention to anxiety-fraught areas of experience leads to experience remaining unformulated, and hence dissociated (Stern, 1997). Thus, dissociation refers to the unconscious avoidance of formulating certain aspects of experience into meaningful constructs (Stern, 1997). Finally, the culture itself may be dissociogenic and discontinuous, such that experiences of self are also marked by discontinuities (Gold, 2004a).

What Is Dissociation?

In a general sense, dissociation refers to the separation of mental and experiential contents that would normally be connected. The word *dissociation* is laden with multiple meanings and refers to many kinds of phenomena, processes, and conditions. Dissociation is both adaptive and maladaptive, both verb and noun, both cause and effect (Spiegel, 1990b; Tarnopolsky, 2003). Dissociation is often psychologically defensive, protecting against painful affects and memories, but it can also be an organismic and automatic response to immediate danger (Van der Hart, Nijenhuis, Steele, and Brown, 2004). Dissociation can be understood as taxonomic or, alternatively, as existing on a continuum—describing all of us, varying in degrees (Putnam, 1997). It is both occurrent (in evidence or in process) and dispositional (a capability that can be tapped) (Braude, 1995). It refers to such psychical events as spacing out, psychic numbing, and even experiencing oneself as floating above one’s body. Dissociation has been thought of in spatial metaphor, as acts of “keeping things apart” (Tarnopolsky, 2003) as well as “vertical splitting” (Kohut, 1971; Hilgard, 1977).

Thus, multiple views of the etiology and nature of dissociation exist. According to Putnam (1997), these views “converge around the idea that dissociation represents a failure of integration of ideas, information, affects, and experience” (p. 19). Yet, when dissociation is so many things, how do we understand it? All of these different meanings potentially create a conceptual confusion. A danger is that the word *dissociation* can be used so loosely that it begins to lose its meaning.

A significant divergence of opinion currently concerns whether dissociation is best understood in terms of a continuum model or a psychopathological taxon model. Both models are supported by the

evidence. The first posits a continuum from adaptive, normative dissociation to the extremes of pathological dissociation. The taxon model addresses dissociation as classified by symptoms, exemplified by dissociative disorders.

The Health-to-Psychopathology Continuum

At the healthy end of this continuum are dissociative experiences that are normative, that enhance enjoyment and effectiveness in living, or both. Dissociation is not necessarily evidence of a history of trauma, or even of psychopathology. For example, hypnosis can result in one or more sets of experiences becoming inaccessible to ordinary consciousness as well as defensive. A prime exemplar of such normative, life-enhancing dissociation is absorption, which appears to be normally distributed throughout the population (Putnam, 1997). Absorption, which is highly interrelated with hypnosis (Putnam, 1997; Maldonado and Spiegel, 1998), is the ability to be “carried away” in a narrowed, concentrated focus of attention, to become so immersed in a central experience that context loses its frame. It has been classified as dissociation because the intense focal concentration can result “in the exclusion (dissociation) of other contents from the phenomenal field and, often, the context in which it is experienced” (Butler, 2004, p. 4). Some examples of absorption are being engrossed in a book or movie, having a highly engaging fantasy while driving, contemplation, reverie, and “flow” (Csikszentmihalyi, 1990, cited in Butler, 2004, p. 7). Butler (2004) believes that normative, adaptive, and enhancing experiences of dissociation have been generally overlooked. She notes that flow

shares many features with dissociative experience including intense, focused concentration, a merging of action and awareness (i.e., attention is completely absorbed in the present action that results in the loss of reflective self-consciousness and distorted time sense). The features that distinguish flow from other dissociative experiences are the sense of self-efficacy experienced with respect to the task at hand and the intrinsically rewarding nature of the experience [p. 8].

Similar to flow are meditative experiences and many positive trance experiences, which also involve loss of reflective self-consciousness.

Indeed, part of the process of yogic meditation involves a kind of surrender such that reflective self-consciousness is relinquished as it arises (Waelde, 2004).

A phenomenon commonly known as “highway hypnosis,” in which the driver of an automobile travels a well-known route and arrives at the destination without remembering the drive, has often been cited as an example of dissociation. What happens here is that the driver, focally attending to other thoughts than the road, is able to perform the drive automatically. It is an example of automatic dual tasking. Highway hypnosis is one of the items in the Dissociative Experiences Scale (DES) and may also measure absorption (Putnam, 1997), but it is not one of the taxonic, or typological, items indicating dissociative pathology.¹ How likely we are to drive safely while under the influence of highway hypnosis may depend on our degree of absorption in our own thoughts.

Is dissociation phenomenologically the same in pleasant experiences of absorption as it is in trauma? And are the same processes involved? A key issue relevant to adaptive versus pathological dissociation is whether the dissociation is under voluntary control. Thus, in meditation and peak experiences, a person consciously decides to become absorbed or to allow absorption to occur, and the person can return to everyday modes of functioning without difficulty. Highway hypnosis would be extremely dangerous if the person could not return attention to the road when necessary. Furthermore, there is the question of whether dissociation promotes or impedes integration. For example, meditation, which is consciously controlled, tends to promote integration (Waelde, 2004), whereas involuntary dissociation impedes it.

The same ability, absorption, can be used to enhance experience or to avoid it; it can be used for pleasure (Butler, 2004) or for defense. Many highly dissociative patients report that they have found ways to voluntarily disappear from traumatic experiences: deliberately going into a state of trance or absorption, becoming lost in the wallpaper, or mentally going into a mousehole in the wall. Here we have an initially adaptive response to interpersonal violence or threat in which the ability to become absorbed or go into trance is a coping mechanism. The problem is that the outcome of continuously avoiding painful experience is that it cannot be integrated and will therefore intrude into experience or dominate it at times. In all forms of problematic dissociation, too much is involuntary. People with dissociative disorders and with PTSD often cannot control the intrusive experience. Often people with DID and BPD cannot control the switching between self-states. Unformulated experience is involuntarily enacted.

The Taxon

Taxon refers to type or classification. Hence, according to the taxonic perspective, dissociation is equated with severe dissociation. There are individuals whose dissociativity is so chronic and severe that they fit into a taxon or personality type. Despite the fact that dissociation has often been understood as highly interrelated with hypnosis, Putnam (1997) has found that the supposed dissociation–hypnotizability relationship does not hold for the general population (and that most DID patients are not “highly hypnotizable”), suggesting that the dissociation–hypnotizability relationship is nonlinear. However, high hypnotizability does seem to characterize a group of abuse victims who had an earlier onset of incest and many more perpetrators. He called this relatively small subgroup of subjects “double dissociators”; that is, they scored high on both dissociation and hypnotizability. This finding is consistent with a taxon rather than a continuum model of dissociation for this group of people.

Putnam’s finding is also consistent with the age-related aspect of dissociative abilities: the ability to dissociate is greatest in childhood and gradually decreases with age, except for a period of increase in adolescence (Bernstein and Putnam, 1986, cited in Chu, 1998). High dissociative ability continues into adulthood only in situations of ongoing traumatic abuse (Kluft, 1984). Thus, people who encounter even extreme trauma in adulthood do not develop extreme, florid symptoms of DID (Chu, 1998) if they were not highly traumatized in childhood.

Structural Dissociation

One highly significant construct of pathological dissociation is Van der Hart et al.’s (2004) theory of the “structural dissociation of the personality.” These authors believe that the word *dissociation* should denote structural dissociation, a division of experiential parts of the personality. Invoking Janet’s postulation that “dissociation denotes an organized division of the personality,” Van der Hart et al. (2004) note that this division involves inadequate integration among two or more systems of ideas and functions, each of which encompasses a “sense of self, no matter how rudimentary or vastly developed” (p. 907). They believe that “conceptual clarity regarding trauma-related dissociation is urgently needed. There is pervasive misunderstanding of the nature of

dissociation. It precludes consensus as to which phenomena, symptoms, and disorders belong to the domain of trauma-related dissociation" (p. 906).

Van der Hart et al. (2004) believe that absorption, altered states, and experiences of depersonalization and derealization are such areas of conceptual unclarity because they do not necessarily involve structural dissociation. Although many people experience them under conditions of mild stress, depersonalization and derealization are often considered to be dissociative symptoms in the literature. Depersonalization, which involves a sense of strangeness with respect to the self, the body, or both, can be evoked by stress, illness, sleep deprivation, substance abuse, and sensory deprivation. In these instances, this sense of strangeness may reflect alterations in consciousness but does not necessarily imply structural dissociation. In contrast is "pathological depersonalization" (Steinberg, 1994), which involves a separation between observing and experiencing ego, as often occurs in child abuse, rape, combat, and motor vehicle accidents, and thus does qualify as structural dissociation.

This distinction between altered states and structural dissociation is a useful one. The concept lends itself to conceptualizing along a single continuum. Thus, PTSD caused by a tornado might involve a structural dissociation on a small scale. Events reminding the person of tornadoes might be triggering because a state of intense fear had been sequestered and never integrated. This might not seriously impede daily living, but the terror of the moment, normally unavailable to consciousness, might intrude at times. A war veteran with PTSD might have more significant structural dissociation, involving the sequestration of more and larger portions of experience. A person who was exposed to chronic or severe sexual abuse might be characterized by more massive dissociation of traumatic experiences, resulting in switching of self-states without the person's knowledge or volition. In this way, it is clear how DID is chronic PTSD. (The above progression is similar to Van der Hart et al.'s concept of primary, secondary, and tertiary structural dissociation.)

Van der Hart et al. (2004) note the importance of the intrusion of dissociative experiences (e.g., intrusion of thoughts or of sensory experiences): Intrusions imply a lack of integration of part(s) of the personality that remain fixated in traumatic events, thus a lack of integration of the personality" (p. 908). Consistent with Van der Hart et al.'s understanding of dissociative intrusions and negative dissociation is Dell's (2001) view of the phenomenology of dissociative disorders. On the basis of the testing of hundreds of patients with

dissociative symptoms, Dell believes that the intrusions of dissociated self-states into ordinary consciousness are more characteristic of DID than is the more dramatic switching. Dell also distinguishes between full dissociation, characterized by amnesia, and partial dissociation, which includes such symptoms as flashbacks, hearing voices in the head, passive influence symptoms, and intrusions of dissociated experience.

Process and Effect

However, the divide between normal and pathological dissociation is unclear. Current research indicates that absorption is just as highly correlated with physical, sexual, and emotional abuse, as well as depersonalization, as are the taxonic criteria (the DES-T) themselves (Dalenberg, 2004). There may be several aspects of dissociative abilities, such as absorption and detachment, which are functionally interlinked and highly intercorrelated. These may be adaptive and enhancing, or they may become involuntarily used.

Another way of understanding these two different perspectives (of continuum and taxon) is as *process* (e.g., absorption), which may or may not have a structural effect, and *effect*, which is the structured outcome of a dissociative process. The concept of structural dissociation refers to an enduring organized division of the experiential contents of the self, and implies inadequate integration. Even though it may begin automatically, once structural dissociation occurs, its maintenance can be said to be "unconsciously" motivated. Examples are PTSD, DID, and unformulated experience, all of which avoid the psychic contents "held" by other parts of the self, including severe and overwhelming anxiety. Unformulated experience (Stern, 1997) qualifies as a form of structural dissociation because it is not under voluntary control and is subject to enactments.

Dissociation: A Salve to Trauma

Even though dissociation can arise from other sources as well, problematic or maladaptive dissociation is often a chronic, rigidified outcome of trauma. Initially, it is adaptive, protecting the traumatized person from unbearable pain and knowledge and preserving a sense of safety and control in dangerous and overwhelmingly stressful circumstances

(Putnam, 1997; Maldonado and Spiegel, 1998; Brenner, 2000) and thereby enhancing survival (Freyd, 1996). When the continuity of being is traumatically interrupted, when whatever has happened is too frightening to be assimilated, people may “trance out,” develop “psychic numbness” (Lifton and Marcuson, 1990), go into “neutral gear” (Terr, 1994), or all of these. This dissociative ability appears to be an aspect of biological endowment, an organismic response to being overwhelmed (Levine, 1997). Livingstone (Freyd, 1996), the Scottish explorer, describes this experience well in his account of being attacked by a lion:

Starting, and looking half round, I saw the lion in the act of springing upon me. I was upon a little height; he came at my shoulder as he sprang, and we both came to the ground below together. Growling horribly close to my ear, he shook me as a terrier dog does a rat. The shock produced a stupor similar to that which seems to be felt by a mouse after the first pounce of the cat. It caused a sense of dreaminess in which there was no sense of pain nor feeling or terror, though quite conscious of what was happening. It was like patients partially under the influence of chloroform describe, who see all the operation, but feel not the knife. This singular condition was not the result of any mental process. The shrike annihilated fear, and left no sense of horror in looking round at the beast. This peculiar state is probably produced in all animals killed by the carnivora; and if so, is a merciful provision by our benevolent Creator for lessening the pain of death [p. 66].

In contrast to Livingstone's belief that this analgesia is a “merciful provision . . . for lessening the pain of death,” it is more typically a state that is adaptive for survival in life-threatening situations (Freyd, 1996). For example, in many extreme situations, such as injuries in battle or in sports, in moments of emotional duress, even states of profound joy, people often unconsciously suppress the emotion. Even in less extreme situations, such as being in a hurry when we are intensely focused on something else, we may not notice the pain of a minor injury. As Livingstone describes so well, people may at the moment of trauma narrow the window of consciousness and calmly, perhaps even dreamily, adapt to the immediate situation confronting them. Dissociation allows one to separate oneself from the experience of the trauma (Van der Hart, 2000).

The value of the capacity for this kind of dissociation is inestimable. It can be lifesaving and preservative of sanity at the time of the trauma. However, if maintained for too long and not overcome, dissociation becomes maladaptive. For instance, separating oneself from the experience can lead to derealization and depersonalization. Dissociation often becomes increasingly maladaptive as unhealed trauma accumulates and the person's way of life becomes constrained to continuously avoid any reminders of it. However, this depends on context. For instance, a child who lives in a home in which she is continuously abused sexually, may best adapt to her situation by learning to chronically dissociate. This is despite the fact that once she steps into a more just and nurturing social environment, her formerly adaptive behavior becomes pathological.

Posttraumatic Dissociative Symptoms and Conditions

Often pathological dissociation is linked to trauma. For instance, 85% to 100% of those with DID have a history of childhood abuse (Putnam, 1989). After isolated, single traumas, such as a rape, people often have marked dissociative experiences and posttraumatic stress. For instance, one study (Koss and Burkhardt, 1989), found that over 60% felt that they had not recovered in the first few months while four to six years after a sexual assault about a quarter of the victims felt that they had not yet recovered. The primary psychological task in such cases is recovery from one overwhelming acute stressor. However, when the trauma is repeated and occurs at an early age, the dissociative response may become automatic and achieve a secondary, functional autonomy, contributing to personality disorders and what Brenner (2001) calls a “dissociative character.” Initially, each of the repeated traumatic incidents may result in a dissociative response. However, when a person is no longer in an abusive environment, the chronic dissociativity remains (Putnam, 1997). There is now a fear or a “phobia” (Janet, 1907; Van der Hart et al., 2000) of knowledge and affects contained by other parts of the self.

In psychological trauma, particularly at the hands of a person on whom one is dependent, dissociation allows a sequestering of the traumatic experience, allowing the traumatized individual to continue functioning in a double-bind relationship (Spiegel, 1986), without having to notice the inherent contradictions. For instance, a child who is subject to sexual abuse in the home may “forget” the night's events

during the day and use all her resources to “be like” a “normal” person during the day. She hasn’t repressed the abuse, for when it occurs again the next night, she can “remember” it again well, and she has a good idea of how she can or must deal with it.

Putnam (1997) has classified posttraumatic dissociative symptoms into sets of primary, secondary, and tertiary. Primary dissociative symptoms refer to the direct effects of dissociation on thought and behavior. Putnam follows Lowenstein in dividing the primary symptoms into two groups: (1) amnesias and memory symptoms and (2) process symptoms, such as depersonalization, derealization, trance states (dissociative), auditory hallucinations, switching, and altered personality states. Putnam also includes associated posttraumatic symptoms such as physiological avoidance, physiological reactivity, detachment, hyperarousal, and so on because of their common link through trauma and because they frequently occur together with dissociative symptoms. Then there are secondary responses to the primary dissociative and posttraumatic symptoms, which include affective and somatic symptoms as well as disturbances of self, such as the low self-esteem that often characterize trauma survivors. Finally, there are tertiary responses, such as self-destructive behaviors and substance abuse, which are understood as maladaptive ways of coping with the primary and secondary dissociative symptoms. This schematization is illustrative of the scope of dissociation in psychopathology as well as the extent to which it is intertwined in daily life.

Trauma and “States”

As Putnam (1992, 1997) observes, the word *state* comes from the Latin word *status*, meaning “state of being” or “condition.” “States” characterize changes in the patterning of an individual’s personality, behavior, and consciousness over time. They are contrasted to “traits,” which are assumed to characterize constancy in individuals. Individual differences are measured in terms of “traits,” a topic that has been a staple of psychological research. Mental states, or states of consciousness, are the building blocks of human behavior and consciousness.

Following Putnam (1997), although the effect of trauma on consciousness is complex, there are two particular ways in which it disrupts a person’s sense of continuity: (1) by interrupting and retarding the linking of states in the course of development and (2) by creating

new, highly discrete states. As for the first, trauma interferes with the associative pathways, according to which states would normally be linked. It limits the connections among states. For example, fear-conditioned states may be dissociated from other states. Or intense negative affect that cannot be integrated in a childhood dyad with attachment figures tends to increase the dissociation of self-states organized by these emotions (Lyons-Ruth, 1999). Trauma interrupts metacognitive, self-observing, self-reflective functions, which are to some degree independent of states, and which can facilitate the integration of states. This may also happen in an interpersonal, social way: Abusive families may evince and require different behavior in different circumstances, in public and in private, in day and in night. Posttrauma, narrative memory may not be connected with affective and state memory. However, as for the second way, trauma also contributes to the creation of specific altered states. Frightened, traumatized children may develop and rely on restitutive states of reality-altering fantasy (Putnam, 1997).

In sum, an important consequence of trauma may be a general increase in the number of discrete behavioral states (DBS), limiting the person’s control over experience (Putnam, 1989, 1992, 1997). Putnam (1997) emphasizes that the DBS model implies that the identity fragmentation seen in DID and “other disorders associated with childhood trauma is less a ‘shattering’ of a previously intact identity, than a developmental failure of consolidation and integration of discrete states of consciousness” (p. 176). Although all young children have state-dependent aspects of self, childhood trauma can lead to a profound developmental failure to coherently bind these state-dependent aspects of self together.

Recent research emphasizes the role of state-dependent memory in the creation of segregated states of consciousness, especially in circumstances associated with strong emotions (Siegel, 1999). Some of the more dramatic illustrations of how mental states may be highly sequestered comes from patients with DID. For instance, a child state may emerge in which the patient does not know what a modern telephone looks like or what a computer is. Indeed, this phenomenon of the sequestration of certain self-states over long periods of time may find expression in certain fiction stories about time. For example, Washington Irving’s Rip van Winkle fell asleep for 20 years during a walk in the Catskill Mountains. When he awoke the world about him was dramatically changed. He had set out as a subject of King George III, and

emerged as a citizen of the United States. The story is actually explainable in terms of dissociative phenomena: A part of Rip van Winkle was asleep for 20 years while other parts of the self lived in chronological time, day by day. The part that had been asleep came out to find the world vastly different.

Somatoform Dissociation

According to *DSM-IV* (American Psychiatric Association, 1994), the “essential feature of Dissociative Disorders is a disruption of the normal integrative functions of *consciousness, memory, identity, and perception of the environment*” (p. 477, italics added). However, this is not a simple matter. If the traumatic experience has been too intensely overwhelming to be assimilated by ordinary consciousness, aspects of the experience may be encoded in somatosensory modalities, rather than becoming part of narrative experience.

Today our diagnostic system repeats the ages old Cartesian dualism, in the form of a mind–body controversy with respect to the “location” of dissociation. With the advent of *DSM-III* (APA, 1980) and the pursuit of a theoretical neutrality, the mind–body aspects of somatoform dissociation became, themselves, split apart, disassociated (Cardena and Nijenhuis, 2000).² Indeed, in *DSM-IV*, the cognitive and affective aspects of dissociation have been categorized as dissociative disorders, whereas those dissociative processes that are experienced as somatic, such as motor control and sensation, are classified as somatoform (Nijenhuis, 2000). As Nijenhuis has observed, according to the current *DSM*, the only dissociative disorder that even refers to bodily symptoms is depersonalization disorder, in which the person feels detached from or outside the body.

It is common to think of symptoms as compromise formations in which drive-related concerns are repressed but expressed motorically. However, to do so may obscure the real events that have become encoded in the “body memory.” It may divert attention away from a more immediate historical source of the somatoform symptoms, which may be more directly expressive of real events, real violations, involving harm done to the body. Furthermore, the idea that these repressed wishes are located in *one unconscious* makes it difficult to see the fragmentation of experience and memory and to appreciate the many different loci of unconscious memory that are stored in the body memory.

Animal Defensive and Posttraumatic Biological States

Nijenhuis et al. (1998a) and Nijenhuis, Van der Hart, Kruger, and Steele (2004) have examined trauma from the perspective of animal responses to terror which may have counterparts in human response. They report the similarity between various animal states, including “total submission” and freezing/analgesic states, and human behavior following exposure to terror. The human animal may have a repertoire of discrete behavioral states that are adaptive to conditions of predation. For instance, bodily symptoms such as body stiffness, analgesia, and high muscle tension may all represent a human freezing response. Total submission involves anesthesia and low muscle tension. These animal defense states may underlie different dissociative parts of the personality.

Perry (1999) outlines how exposure to trauma alters neurodevelopmental processes via two primary responses of hypoarousal and hyperarousal. These responses become more pronounced with more severe, chronic, and early trauma. They are interactive, and most individuals suffering from this altered neurobiology use combinations of the two patterns. Hypoarousal, a pattern that Perry labels *dissociative*, involves dissociative symptoms such as fugue, numbing, fantasy, analgesia, derealization, depersonalization, catatonia, and fainting. Observed behaviors are robotic compliance, glazed expressions, and passivity. Heart rates go down. This defeat response, similar to “learned helplessness” (Seligman, 1975), is more characteristic of infants, young children, and females. It is adaptive to immobilization or inescapable pain. The other response pattern of hyperarousal involves “fight or flight” reactions. This begins as a neurophysiological alarm reaction and continues with elevated heart rate, vigilance, behavioral irritability, increased locomotion, and increased startle response. There is a tendency to overread cues as threatening, which can increase the probability of aggression.

Neurobiological Organizations Underlying Dissociated States

A complicated neurobiological organization and response system underlies these dissociated states. This process occurs through various pathways, including the altering of brain structures and the creation of neurobiological patterning in the brain. Repeated trauma leads to maladaptive gene expression, altering synaptic connections and resulting in neurological deficits and increasing vulnerability to

trauma-based disorders (Stien and Kendall, 2004). Trauma overwhelms the autonomic nervous system with stress hormones, overactivating the amygdala, which is involved in immediate, automatic response. As a result, the hippocampus, which is more related to information processing, may be damaged and decrease in size (Van der Kolk, 1996b; Nijenhuis, Vanderlinden, and Spinhoven, 1998; B. D. Perry, 1999). A number of studies have found decreased hippocampal volume in adults with PTSD who have reported physical and sexual abuse (Nijenhuis, 2003). Ehling, Nijenhuis, and Kirkke (2003) found that patients with florid DID had 25-percent less hippocampal volume than controls, whereas patients with dissociative disorder not otherwise specified (DDNOS) had 13-percent less hippocampal volume, suggesting that hippocampal volume correlates with severity of dissociation. After successful integrative treatment, the DID patients recovered considerable hippocampal volume.

The neurological effects of trauma thus also contribute to decreased integration of states and decreased reflectiveness. Because linkage of states contributes to an awareness of context both within the self and within the world, and to the capacity for increased reflectiveness, people who have suffered more interruption of state linkage have more difficulty understanding their emotions, and tend to feel buffeted by circumstances. As a result, they tend to overrely on dissociation. Dissociation of self-states will be more numerous and severe.

B. D. Perry (1999) has described how induced behavioral states become traits. As a result of repeated activation of particular states, they become "use-dependent" and hardwired in the brain. For instance, terror involves activation of a certain patterning of brain stem, limbic system, midbrain, and cortex neurophysiology. "Because the neuronal systems alter themselves in a use-dependent way in response to patterns, repetitive neuronal activation, a state of terror will result in patterned, repetitive neuronal activation in this distributed and diverse set of brain systems—resulting in a set of memories" (p. 15). In PTSD the physiological hyperreactivity is a cue-evoked state memory, involving memories of a particular time and an alarm response. However, these memories are not necessarily conscious. As Van der Kolk (1996c) says, "the body keeps the score" (p. 214).

The brain is organized to promote survival and procreation. Thus, cues that herald danger to survival, such as the growl of the saber-toothed tiger, are most salient and need to be learned only once. This kind of information reaches the amygdala, which sends the message for action before the message reaches the cortex (Van der Kolk, 1996b; B. D. Perry, 1999). One outcome is that the state arousal may not result

in the activation of the associated cognitive memories that would provide knowledge of why one is anxious or upset. B. D. Perry (1999) writes of a little boy he met in a residential treatment center who persistently refused to eat his hot dog unless it was cut up. There were frequent escalating confrontations with the staff around the issue of his problems with eating. Perry's inquiry revealed that the child had been forced to perform fellatio on his father and other men until he was removed from the abusive environment at age six. The oropharyngeal patterns of stimulation of eating—especially things like hot dogs—evoked state memories of the abuse, involving terror and confusion. Neither the child nor anyone else had any idea why this particular child was being so "difficult" until the matter was understood as "state and affect memories evoked by motor memories" (p. 26).

Dissociation in Neurosis, Psychosis, and Personality Disorders

Over the past two decades a number of theorists have argued that dissociation is an integral part of most psychopathology of nonorganic genesis. Those problems in living that used to be called neuroses may be largely dissociation based (Howell, 1997). Bromberg (2003c) views dissociation as underlying all personality disorders. As opposed to dissociative disorders themselves, in which the dissociation is focally identified as the problem, ego-syntonic dissociation underlies all personality disorders:

Each "type" is a dynamically "on-alert" configuration of dissociated states of consciousness that regulates psychological survival in terms of its own concretized blend of characteristics. In each type, certain self-states hold the traumatic experiences and the multiplicity of raw affective responses to them, and others hold whichever ego resources (pathological and non-pathological) have proved effective in dealing with the original trauma and making sure the pain would never again be repeated (e.g., vigilance, acquiescence, paranoid suspiciousness, manipulateness, 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).

Psychosis

As opposed to being distinct from the realms of experience we term *psychotic*, dissociation is often inseparably related to these. Primary process, which need not be considered a lesser form of thought (Lewis, 1981), often interlaces with dissociative conditions. Indeed, "dissociative thought disorder" (Lowenstein, 1991) can describe psychotic-like dissociative phenomena that are not indicative of schizophrenia. They can involve bizarre perceptions, such as flashbacks and other auditory and visual hallucinations that the experiencer does not believe to occur "outside the head." A trauma/dissociation model helps us to understand flashbacks as evoked capsules of dissociated and often implicit memory. Terr (1990) terms certain visual hallucinations *posttraumatic misperception* (p. 131). Although most of us do not experience hallucinations and flashbacks, we are likely to have dissociative psychotic moments when a cue or "trigger" evokes a state of mind contexted in state-dependent memory such that we misperceive or misinterpret in accordance with anticipatory fears.

Kluft (1987), Ross (1989), and Putnam (1997) have outlined how dissociative disturbances have often been misunderstood in terms of schizophrenia concepts. In a landmark study, Kluft (1987) found that patients with multiple personality disorder (now called dissociative identity disorder) endorsed 8 of the 11 Schneiderian (Schneider, 1959, cited in Kluft, 1987, p. 2) first-rank symptoms considered to be pathognomonic of schizophrenia. These symptoms were voices arguing, voices commenting on one's action, influences playing on the body, thought withdrawal, thought insertion, "made" impulses, "made" feelings, and "made" volitional acts. The hallucinated voices and the "made" actions are understood as the activities of an alter, rather than as indications of schizophrenia. Dell (accepted for publication) has incorporated these Schneiderian passive influence symptoms in his Multiaxial Inventory of Dissociation (MID) diagnostic questionnaire.

Dissociation Cross-Culturally

The human capacity for dissociation can manifest itself differently in accordance with the relational patterns, opportunities, and constraints of different cultures (Cardena, 2001). In many cultures, altered mental

states, switching of mental states, "possession," and trance phenomena are considered desirable rather than pathological (Kirmayer, 1994). For example, shamanism involves a self-hypnotic trance state. Dissociative altered states can provide socially acceptable ways of expressing extremely intense feeling such as in *ataques de nervos* in Puerto Rico (Lewis-Fernandez, 1994) and of accessing highly unusual abilities, such as clairvoyance. In many cultures the dissociative abilities of mediums are highly valued, and certainly not considered pathological (Krippner, 1990). Throughout the world and throughout history, dissociative trances have been a part of many community religious ceremonies and have contributed to many personal, mystical religious experiences of rapture, ecstasy, agony, and transformation (James, 1902).

Various kinds of dissociative experiences have been well-known throughout history. For instance, records of the Society for Psychical Research, which in the late 19th century included members such as James, Janet, and even Freud as a corresponding member, indicate the spontaneous occurrences of trances, state-specific memory, and trance speaking without the use of hypnosis, during and before the 19th century (Alvarado, 2002). One particular kind of dissociative trance, possession trance, has also been well known throughout history. This includes both benign spirit possession and demon possession (Hilgard, 1977; Levine, 1997; Cardena, 2001). In many cultures, possession trance provides socially accepted ways for the powerless to exert some power and influence, and to get their needs met, often in otherwise almost intolerable socially oppressive circumstances (Ross, 1989). For example, it can be a highly efficacious, culturally accepted means of handling familial problems, such as difficult in-laws. Lewis-Fernandez (1994) describes such a case in India in which a powerless new bride was possessed by the spirit of a deceased relative. The spirit instructed the in-laws to treat the daughter-in-law with more respect and provide her with better care. Because the in-laws respected and feared the spirit, the possession syndrome also allowed the daughter-in-law greater control over her life.

Syndromes of Distress

Although none of the above are necessarily understood in terms of psychiatric illness, some culturally defined dissociation-based syndromes

do cause impairment and distress and are recognized as pathological. For example, some indigenous disorders indicate cultural variations of learned dissociation. One such culture-bound syndrome is “amok,” which often involves a sudden rampage ending in homicide and amnesia (Rhodes, 2003). Notable among these are certain dissociative reactions to startle stimuli, characterized by compulsive imitation of words and acts of others, called *latah* in Indonesian languages, *bah-tschi* in Thailand, *yawn* in Myanmar, *mali-mali* in the Philippines, *miryachit* in Siberia, *imu* among the Ainu, and *Lapp panic* among the Sami (Somer, 2003, pp. 3, 12). However, even among those syndromes recognized as pathological, it is not always understood that these syndromes have their basis in dissociation.

Possession is listed in the World Health Organization’s 1992 International Classification of Diseases (Krippner, 1990). Spirit possession—especially demon possession—may express important conflicts and cause sufficient distress to self and others to be considered pathological. For instance, one of Janet’s famous cases, that of Achilles, involved demon possession linked to guilt about an extramarital affair. Janet induced the demon state to speak to him (Janet), and then to demonstrate his power by placing the patient (the host) under hypnosis, which Janet had been unable to do. With the host under hypnosis by the demon, Janet was able to discover the tormented man’s guilty secret (Ellenberger, 1970). Ellenberger speculates that “instances of multiple personality may have existed long ago, but remained unnoticed” (p. 127).³ In Western civilization, possession trances were common until they began to come under the medical domain and were considered symptoms of mental disease (Ross, 1989).

Somer (2004) documents the occurrence of trance possession in 16th-century Near Eastern Judaism, in which the phenomenology of these possession experiences is very similar to that of DID as currently understood. These possessions involved the *dybbuk*, a spirit of a departed one that clung to the possessed person. In his study of the records of exorcisms, he noted that the spirits, who were in these cases male, often entered and exited their victims’ bodies through the vagina and the rectum, suggesting sexual intercourse. He concludes, “By allowing individuals to communicate about their forbidden secrets and inner conflicts through a ‘non-me’ agent, the *dybbuk* may have enabled ventilation and some processing of otherwise inexpressible traumatic and/or guilt-promoting experiences” (pp. 142–143).

Our Own Dissociogenic Culture

Referring to our own culture, Greaves (1980) wrote that fewer than 200 cases of multiple personality disorder had been reported in over 200 years of psychiatric literature. Perhaps many were misdiagnosed as schizophrenia, and then later as borderline (Howell, 2002). Of course since 1980, the numbers of people diagnosed with DID have vastly increased. Today, Hollywood is fascinated by DID (Butler and Paresh, 2004). In a fascinating review, Steve Gold (2004a) addresses *Fight Club*’s depiction of our own dissociogenic culture. The opening scene of this movie is a montage of scenes from airports and airplanes: “This is your life, ending one moment at a time. . . . If you wake up at different time, in a different place, could you wake up as a different person?” (Gold, 2004a, p. 21). Thus, the primary message of the movie is not that Tyler Durden, the main character, discovers that he has DID, but that the violence of contemporary culture has created a normative pathological dissociation.

Differentiating Multiplicity and Dissociation in Culture

In contrast to normal pathological dissociation, flexible multiplicity would be a desirable normative condition for the human mind. Differentiating multiplicity and dissociation, Colin Ross (1999) counterposes the more familiar bipolar continuum model, according to which the unified self represents the healthy pole, and a multiple, dissociated self represents the pathological end of the pole, with an alternate model that puts adaptive, flexible multiplicity at the healthy end of the pole, pathological pseudounity in the midrange of psychopathology, and DID, with its greater dissociation, but not greater multiplicity, at the extreme end of psychopathology. Similarly, Rivera (1996) suggests a continuum on which the robust multiplicity is at the healthy end of the continuum and the fragile self, which can be characterized by either pathological dissociation or pathological association is at the other end: “Defensive association pretends to simple unity to hide fragmentation, suppression, and complex humanity in all its contradictory manifestations. Defensive dissociation acknowledges the depth and complexity of the human condition through the interplay of a multitude of self-states, but denies it utterly at the same time through radical

disconnection" (p. 34). Gold (2004b) interprets Rivera to mean that "normal" people maintain a sense of integration and continuity . . . by systematically and routinely invoking processes that enable them to ignore the glaring gaps, inconsistencies, and lack of continuity in their experiences and behavior." Gold's own continuum puts this "normality" between an ideal mindfulness at the healthy end of the pole and fragmentation at the pathological end.

Two Myths: Cain and Osiris

Two great myths of civilization depict different prototypical psychological responses to the terror of brother murdering brother. These are the story of Cain and Abel, and the myth of Osiris. Cain and Abel were the children of Adam and Eve. Cain slew Abel, and hence, as his descendants, we inherit this identification. According to Genesis, Cain was cast out from the presence of God, and made to wander the earth. Ross (1989) observed that one solution to this dilemma is to push this sense of ourselves as murderous *down*—either into the id and the unconscious as Freud believed, or into Hell. In these nether regions, we are all renegades of civilization. This solution also appears to characterize a patriarchy that values a solitary independent self.

In contrast to the Cain and Abel story in the myth of Osiris, there is a very active, helpful sister. Whereas Abel simply died, Osiris is a survivor. In Egyptian mythology, Osiris, the god who symbolized the imperishability of life, was killed and cut up into many pieces by his brother, Set. His wife/sister, Isis, gathered together the scattered fragments of her husband, embalmed him, made him whole and resurrected him as king/god of the underworld. Later, his son, Horus, defeated Set, and Horus became king on earth. Here we find the themes of fragmentation, healing, and resurrection or transcendence into a new form.

In contrast to the legacy of Cain, the Osiris myth comes ready-made with a language of parts and an expected outcome of healing, connection, and continuity. Ross (1989) suggests that the Osiris complex as a metaphor of psychological dissociation may achieve prominence alongside the Oedipus complex as a model of repression. It gives us a language for understanding impediments to loving, authentic, satisfying life, and it helps us to understand these as outcomes of our early relationships with significant other people.

It is the Isis-like healing aspect of ourselves that allows us to recognize how we may often mistake the self-state, or particular organization

of self-states that has provided the most security, for the "self." The Isis-like healing allows us to take a metaperspective on the self as an aggregation of self-states, and to understand that privileging the self-states that pursue security is not always necessary.

Rather than a unitary place, the unconscious might better be understood as containing rageful and murderous parts of ourselves, as well as parts that have all kinds of longings. Most of what we have understood as the unconscious is better described as the dissociative unconscious or, as Janet did, as multiple centers of consciousness. Bromberg (1998) argues that we are moving away from Freud's unitary conscious and unconscious, which are archeologically layered with respect to access to awareness, toward a "conception of mind as a non-linear, dialectical process of meaning construction . . . a view of the mind as a configuration of discontinuous, shifting states, with varying degrees of access to perception and cognition" (p. 225). As Davies (1996) observes, "we deal not with one unconscious, but with multiple levels of consciousness and unconsciousness—a multiply organized, associationally linked network of meaning attribution and understanding" (p. 562). The dissociative unconscious is not necessarily linked to forgetting over time (Bowers, 1994), but to contemporaneous, subjective realities that alternate as foreground and background.

ENDNOTES

Chapter 1

1. The DES is a screening instrument. Even though highway hypnosis is one item on the DES, it is so normative that, in and of itself, it should never be construed as an indication of the presence of a dissociative disorder.

2. *DSM-II* linked conversion hysteria and dissociative hysteria together, under the same broad category of hysteria. While the reorganization resulting in *DSM-III* was intended to free it from automatic subscription to Freudian theory, it added to the confusion surrounding somatoform dissociation, without addressing or solving the problems posed by the Freudian view of conversion hysteria (Cardena and Nijenhuis, 2000).

3. Hilgard (1977) observed that the fact that the demons spoke to Jesus—in the case of Gadarene asking to be sent into a herd of swine, who then rushed over a bank and drowned in the sea—is indicative of dissociative identity disorder (DID). Likewise, it seems that many descriptions of demon possession, and especially those in the *New Testament* of Jesus' casting out demons, may have been expressions of dissociative disorders.

Chapter 3

1. This may be an oversimplification. Janet's interests were broad, and he wrote on many psychological topics, including, but not limited to, hysteria, psychasthenia (a diagnostic grouping that included, among other disorders, obsessive-compulsive disorders and phobias), psychoses, psychology of conduct, and religion. Moreover, the time periods in which different interests were prominent, differed. From 1880 to 1900, hysteria was in the forefront for Janet; then he concentrated more on psychasthenia, in which the female-to-male ratio was more balanced.

Endnotes

From 1920 to 1930, he wrote more about psychoses (Van der Hart, personal communication).

2. The splitting of the ego (or actually the self) (Greenberg and Mitchell, 1987; Padel, 2000; Sutherland, 2000).

3. Fairbairn observes that his concepts of ego structures are in some ways comparable to Freud's concepts of ego, id, and superego. The libidinal ego is comparable to the id, the central ego to Freud ego, and the antilibidinal ego to the superego. Fairbairn emphasizes, among other differences, that the id is not a structure, but only energy, and that the superego is not a dynamic structure because it is an internalized object. Only the ego is a dynamic structure. Furthermore, in contrast to the superego, the antilibidinal ego is not moral. (Fairbairn postulates the development of a superego by a separate process.)

Chapter 4

1. Also known as species identity theorem, which stated, "Everyone and anyone is much more simply human than otherwise, more like everyone else than different" (letter, dated about 1944, photocopied on frontispiece of Sullivan, 1962, *Schizophrenia as a Human Process*).

2. Sullivan viewed the unconscious as a hypothetical construct without which psychological events are or appear to be erratic and unpredictable. It fills all the discontinuities that are present in mental life and in theory, at the least it restores orderly continuity. The hypothetical unconscious includes (1) much that has been conscious but has not been verbalized (i.e., preverbal or subverbal), (2) selectively inattended phenomena, and (3) dissociated processes, much of which has been never represented in consciousness (Mullahy, 1970, p. 296). Referring to how dissociated integrating tendencies can be "choked off," Sullivan said, "It is because there are such things that Freud was led into what I feel is the flat mistake of assuming that the unconscious is largely the habitation of the primitive, the infantile, the undeveloped, etc." (1956, p. 66).

Chapter 5

1. Vygotsky was a follower of both Janet and Piaget, who was Janet's student. In constructing his principle that individual consciousness is built from the outside through relations with others, Vygotsky