



## When the Body Keeps the Score: Some Implications of Trauma Theory and Practice for Psychoanalytic Work

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### ABSTRACT

Trauma has wide-ranging effects on somatic functioning, nervous system regulation, relational engagement, and personality integration. This article provides an overview of how posttraumatic dysregulation and dissociation limit patients' ability to engage in an analytic process, potentially leading to prolonged, stalled, or ruptured treatments. In this context, it offers suggestions for integrating insights and techniques from trauma therapies into psychoanalytic work, focusing on interventions that help people modulate posttraumatic reactions and so build their capacities to work through trauma's impact.

A generation ago, psychoanalysis emerged from the shadow of Freud's rejection of his seduction hypothesis, freeing theorists to explore the many connections between traumatic suffering and our thorniest clinical dilemmas. This process has spurred analytic interest in the findings of trauma researchers. Clinically, too, trauma therapies have begun to offer useful perspectives from which to consider analytic technique. Comparing analytic thought and contemporary trauma studies reveals many points of convergence that complement analytic approaches and deepen the insights of analytic theories. At the same time, however, some ideas from trauma experts challenge longstanding analytic assumptions, both theoretical and technical, while others represent new and surprising discoveries that can open up new ways of thinking and working. In the following pages, I will outline ways that trauma affects somatic functioning, nervous system regulation, relational engagement, and personality integration. In that context, I will offer some suggestions for applying techniques of trauma therapy in analytic work, focusing on interventions that help people build their capacities to work through trauma's impact.

Above all, research on trauma calls attention to its pervasive impact on the systems that help us maintain physical and mental equilibrium (Chefet, 2015; Van der Kolk, 2014). Trauma disrupts basic bodily processes, including nervous system regulation, hormonal activity, and immune functioning. Disturbances of physiological homeostasis in turn destabilize psychological functions, including memory, impulse control, and emotional balance. Neuroimaging confirms that when trauma is activated, brain regions that allow us to sustain logical thought and synthesize information shut down; in a traumatic state, we literally cannot think.

Trying to treat trauma without recognizing and addressing these effects can result in drawn-out analyses that expose patients to years of potentially avoidable suffering. An emphasis on verbal understanding can also lead to apparent gains that fall apart when traumatic states get triggered and cognitive functioning breaks down, discouraging patients and analysts alike.

Happily, though, relatively simple concepts drawn from trauma research offer a broad, accessible framework to guide work with traumatized people and provide scaffolding for the nuanced insights of psychoanalysis. Based on research and clinical experience, experts are forming a consensus about how best to work through the effects of acute and chronic traumatization. Techniques of all major trauma modalities, including but not limited to Somatic Experiencing (Levine, 2010), Sensorimotor

Psychotherapy (Ogden et al., 2006), EMDR (F. Shapiro, 2018), and Internal Family Systems (Schwartz & Sweezy, 2019), share key features:

- Focusing on present-moment experience;
- Prioritizing mindful noticing over “thinking about”;
- Sustaining felt contact with present safety;
- Safely developing somatic awareness;
- Actively cultivating self-regulatory capacities;
- Attending closely to dissociative processes;

and, perhaps most surprisingly to psychoanalysts, shifting emphasis away from the relationship to the therapist and toward patients’ relationships with their own inner worlds.

## What is trauma?

Before going further, it seems important to define what, exactly, constitutes trauma. Current use of the word ranges widely, sometimes extending to normal suffering and sometimes excluding all but the most extreme events. I base my working definition closely on that of Pat Ogden (2012), the founder of sensorimotor psychotherapy. By focusing on trauma’s psycho-physiological impact rather than on the nature of any given event, this definition distinguishes trauma from pain and strain, even severe pain and strain, that do not have traumatic effects.

Traumatic injury occurs when an event, a series of events, or a set of enduring conditions overwhelms a person’s capacity to integrate emotional experience and/or is perceived as threatening safety or survival, triggering subcortical defensive responses and autonomic hyper- or hypoarousal.

Before discussing this definition in more detail, it’s important to note that something else must happen for traumatic injury to result in longer-term symptoms: after the threat has passed, the person fails to receive adequate comfort and containment. This failure, which ensures that the traumatized person cannot integrate what has happened, may occur within a person, between and among individuals, or within a society. For example, New Orleanians traumatized by Katrina fared dramatically worse, as a group, than New Yorkers traumatized by 9–11. Where Katrina survivors endured false accusations of violence and looting along with ongoing devastation in their neighborhoods, 9–11 victims lived in a largely intact city, supported by a nation’s praise for their courage and concern for their plight (McClelland, 2015).

Ogden’s definition makes it clear that trauma may result from external events or internal experiences, such as flashbacks or panic attacks. It confirms that experiences of humiliation, neglect, or emotional cruelty can be every bit as traumatic as physical assault. The same goes for life events like the loss of a job or relationship, or cultural strain, like growing up closeted or living with systemic racism. This fact, which we recognize as clinicians, has been confirmed by recent research (Mol et al., 2005; Spinazzola et al., 2014), even if not by DSM definitions.

This point is worth emphasizing: When an event triggers fragmentation of experience and/or enduring subcortical defensive responses and symptoms of hyper- or hypoarousal, it constitutes a trauma, no matter how serious it may or may not appear. Clinically, therefore, when an otherwise healthy patient suffers from pathological dissociation<sup>1</sup> or dysregulated autonomic arousal, we are seeing the aftereffects of trauma, even when the person does not report a traumatic history. The trauma may be infantile, unrecognized, denied, or forgotten, but the body, as Van der Kolk (2014) put it in the title of his already-classic book, keeps the score.

So often people come to analysis feeling fundamentally flawed, that “nothing happened” and yet they’ve never felt safe or steady. They feel like a head on a stick, or a brain in a mound of flesh, or

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<sup>1</sup>Defining pathological dissociation goes beyond the scope of this article. In non-pathological multiplicity, however, individuals sustain access to situationally relevant thoughts, feelings, sensations, and actions. Parts of the personality appear in contexts that suit their capacities, without disrupting autonomic regulation, and they can adjust their goals to those of other parts. As it grows more severe, dissociation increasingly undermines such processes.

a live wire constantly sparking or shorting out. Ogden's definition tells us that some kind of trauma, whether shock or developmental (Heller & LaPiere, 2012), has thrown their nervous systems out of balance. We don't know what happened, but we know that something did. We can say to these people, "What we know is that you're living in a traumatized body. As we work to create a greater feeling of safety, we may or may not discover exactly why, but the more the body feels safe in the present, the more the mind can relax and allow access to experience. We will learn as we go." Such an attitude can help more generally with the often-insistent question, "What happened?" Attending to the body makes it easier for patient and analyst alike to trust that body and mind are always communicating what we need to know. We don't need to figure out what happened in the past in order to help. Instead, we can focus on helping patients feel safe when they are in fact safe, and to live fully in the present.

### The Window of Tolerance and the ability to connect

Thinking of trauma using Pat Ogden's definition focuses our attention on the meeting ground of psyche and soma. A key concept here is known as the Window of Tolerance (Figure 1):

Stephen Porges (2011) has laid out an elegant psychobiological theory that deepens our understanding of this simple diagram. His ideas explain how subcortical signals regulate hard-wired defenses that we have inherited through evolution. Importantly, this system does not rely on conscious perception but on what Porges calls *neuroception* – information processed deep in the brain, in the brainstem and limbic system, and so registered somatically, emotionally, and associatively rather than logically or verbally. What we neurocept determines our felt sense of safety, and how we neurocept a given moment depends on both present realities and past experience. Early relational experience, which lays the foundation for the body's self-regulatory capacities (Lyons-Ruth et al., 2006; Schore, 2003), plays an especially important role here.

Porges makes two central points. First, we neurocept safety and danger; subcortical processes, not conscious thought, govern our feelings of security or vulnerability. Second, and vitally for analysts, *what we neurocept determines our ability to engage with ourselves and others*. How safe we feel, in other words, determines our access to inner and outer relatedness. Porges's research implies that

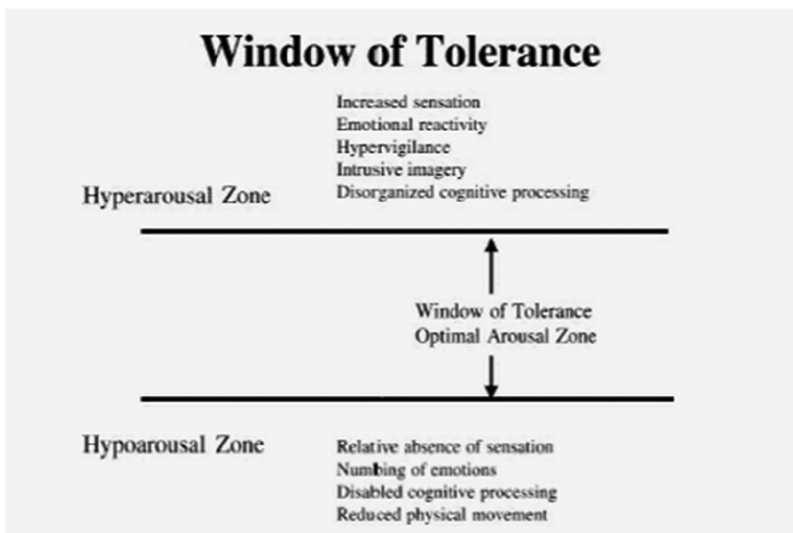


Figure 1. The Window of Tolerance.  
(Ogden et al., 2006)

Klein (1946) would have been more on target if she, rather like Erikson (1954/1963), had formulated the paranoid-schizoid position in terms of trust vs. fear instead of love vs. aggression.

Let's take a closer look at how Porges's theory works. When the neuroception of threat is not too high – does not push us out of the window of tolerance – what Porges calls the *ventral vagal system* is on line. The ventral vagus is a nerve that, among other functions, helps control muscles in our faces, in our necks and throats, near our mouths, around our eyes, and in our inner ears. From infancy on, it allows us to send, receive, and respond to relational signals, even very subtle ones (see Beebe et al., 2012). When the ventral vagus is dominant, we relate to others through what Porges calls the *social engagement system*.

Our social engagement system allows us to manage potential dangers not just through reflective thought and action, but also in connection with others. We adjust our gaze to head off an argument, signal a boundary, or evoke a caring response. The baby facing the visual cliff looks at his mother's expression and sees that he's safe. Dad calls out from the living room—"Don't touch that cookie sheet!" – and the child avoids a burn.

When the social engagement system is active, we are in our windows of tolerance. We have access to Bion's (1962) "thinking" and Winnicott's (1971) "play," and transference has the transitional quality that allows for analytic exploration. In other words, when both we and our patients have access to our social engagement systems, we can help them think about their internal worlds.

But what happens when our minds neurocept that threat has grown, and we move out of the window of tolerance? Most people move first into hyperarousal, in which the ventral vagal system is superseded by the sympathetic nervous system. Hyperarousal evokes active evolved defenses meant to protect life in the face of threat: attachment for survival, fight, and flight.

The notion of attachment as a primary defensive strategy may be unfamiliar. There are of course lots of reasons why we engage with one another – sensuality, play, and exploration, for instance. Attachment behaviors, though, are a response to threat, just as Bowlby (1969/1982) theorized. Hyperaroused attachment behaviors represent attachment for survival (Ogden, 2012), and they belong with the more familiar fight and flight among the ways we instinctively move to protect ourselves. We see this clearly in the patients we call borderline.

When we're hyperaroused, we can't contain activation and either become overwhelmed or remain focused on the struggle not to. We may feel defensive, vigilant, icy, desperate, rageful, or panicked, and our thinking becomes disorganized or fervently single-minded as we try to maintain control. Simultaneously, as the ventral vagal system goes off line, our ability to use social cues to assess safety and danger plummets. Our system is orienting itself to signs of threat, and that's what it notices. When sympathetic activation is high, a furrowed brow or a worried tone gets interpreted subcortically as judgment, fear, or anger (Van der Kolk, 2014); we don't take in the tentative smile or the soft voice that might more accurately convey concern to someone – including the same person at a different time – who's in their window of tolerance.

In psychoanalytic theory, we're on the paranoid side of Klein's (1946) paranoid-schizoid position, and in the territory of Bion's (1962) beta elements, where people become flooded with unintegrated traumatic fragments. Transference moves toward what gets called psychotic: the analyst is experienced concretely, as the last, best hope or as a real and present danger.

Though it brings significant costs, sympathetic hyperarousal enables active self-protection – fighting, escaping, finding a protector. If, however, the system neurocepts – again, through subcortical responses, not conscious appraisal – that active measures will not bring safety, then a person moves into hypoarousal, sometimes quite abruptly. The *dorsal vagal system*, which slows or shuts down biological functions, becomes activated. A blend of sympathetic and dorsal vagal activation creates a deer-in-the-headlights, high-energy freeze. As hypoarousal deepens, the person becomes passive, hopeless, numb, detached, or stereotypically dissociated. Shame – an emotion that facilitates submission – often gets activated. An inhibited patient shows a flash of interest, moves to speak, deflates. "Never mind. It doesn't matter."

In psychophysiological terms, we're looking at evolved defenses of "low freeze," submission and collapse, even fainting – all forms of parasympathetic activation that passively discourage predators and reduce the felt experience of pain. This is the mouse that goes limp in the cat's mouth. As it intensifies, hypoarousal increasingly functions to numb pain that's felt to be inevitable. In this way, hypoarousal allows us to endure (Fisher, 2017). People who have experienced sustained, inescapable physical or emotional danger often survive in chronically hypoaroused states that drain their lives of meaning and enjoyment (Levine, 2010; Van der Kolk, 2014).

Clinically, hypoarousal dulls transference feelings and interest. By now, the social engagement system is largely off line, making work in the relationship a real challenge. Hypoaroused people may yearn for connection, but attaining it feels hopeless, futile, humiliating to desire, threatening to approach.

If we accept Porges's findings, traditional analytic theory has often misinterpreted hypoaroused states. For instance, Freud's theory of the death instinct emerged from his clinical observation of the state of "feigned death" (Porges, 2011) that exists in almost "pure culture" in severe depression (Freud, 1923). Famously, though, Freud attributed this state to a universal death instinct, not to the body's attempt to cope with inescapable suffering in the present or too much helpless suffering in the past. Similarly, although Klein's (1946) portrayal of a schizoid patient clearly depicts someone in a hypoaroused state, her formulation of his withdrawal defenses emphasized their aggressive component.

Defensive dorsal vagal activation, however, is an evolved brainstem system for discouraging predators and minimizing pain that's felt to be unavoidable. This pain may originate in overwhelming, futile, or hopelessly dangerous anger – but as we have seen, hypoarousal follows naturally from irresolvable hyperarousal, regardless of its emotional tone. Anger in itself has little to do with it. Instead, it's the deep sense that active impulses cannot help, and may in fact bring more pain, that matters. We recognize this process when we understand patients' self-abasement as a defense against nascent positive emotions like excitement, pride, or desire. Sufficient experience of rejection or abuse can turn any or all of these feelings into subcortical signals of danger.

Technically, Porges's work leads to the conclusion that asking someone in a state of significant hyper- or hypoarousal to reflect on the meaning of a situation presents an impossible task – until the nervous system stabilizes within the window of tolerance, the person can't access much cortical functioning. This point is vital for people whose overwhelming panic or anxiety, chronic passivity, or recurrent rages leave them hopeless and humiliated. As Ogden has written, "The capacity to self-regulate is the foundation upon which a functional sense of self develops" (Ogden et al., 2006, p. 42). When the body's protective systems are functioning in posttraumatic overdrive, shame all too regularly compounds the original suffering.

Happily, it's far easier to notice one's state than to understand its meaning. Taking the emphasis off "thinking about" to help a dysregulated patient expand the window of tolerance can support a range of analytic goals, including deepening relatedness, increasing the capacity to think, reducing impulsivity, and supporting self-esteem. A number of important questions arise here. How narrow or wide is the person's window – in other words, how much difficulty can be tolerated before dysregulation takes over? Of what kinds? In what circumstances? What triggers dysregulation? How easily does the person move into hyper- or hypoarousal? How strongly does each state appear? Does the person usually have accessible ways of regaining equilibrium?

With people who readily slip outside the window of tolerance, or live predominantly in distressing states of hyper- or hypoarousal, I'll discuss with them how normal and necessary those responses are for survival. I'll describe hyperarousal and hypoarousal, emphasizing their protective functions and working to identify specific ways that these states helped keep the person safe earlier in life. We'll notice together how the states appear in the present and discuss their consequences, including whatever benefits they bring. People often rely heavily on their hypervigilance or numbness. Before attempting to let go of familiar patterns, they need to have some faith that change can happen safely.

When they feel ready, we will begin tracking changes in their physical state as they speak and think. When do they relax, lean forward, widen their eyes, slump? “When you mentioned your father, your voice got so quiet.” We’ll explore different ways of calming or enlivening their nervous system, often using somatic techniques such as breathing, grounding, centering, shifting the gaze, or straightening the spine. Many of these approaches, used differently, can address either hyper- or hypoarousal. For example, asking someone to feel the support of a chair back can calm agitation, but it can also help a faraway, dissociated patient ease back into contact with current reality. (See Ogden & Fisher, 2015).

Considering each person’s inner world remains as vital with somatic interventions as it is in psychodynamic work. The subtlest movement toward eye contact may further dysregulate a person who needs distance to feel safe, while strong mutual gaze can soothe someone who’s literally looking for reassurance. Straightening the spine can counter hypoarousal. But it can also be too much – in more shut-down states, careful micro-movements may be all that’s manageable without provoking a shift into a sudden, dangerous hyperarousal. Grounding often helps people return to their window of tolerance, but some hyperaroused patients become even more agitated when they try to ground through the feet. Exploration may reveal that they don’t feel safe unless they can move in an instant; staying on the tips of their toes feels better.

Because of this variation, and because people with dysregulated nervous systems so often feel incompetent in relation to their bodies, I offer each technique as an experiment: if it creates greater ease, it can become a resource for self-stabilization, but if it doesn’t, we will learn something valuable about the person’s experience. The experimental stance means that the patient’s job is simply to notice and report what happens. They can’t get anything wrong because the goal is to discover what they need, not to impose any particular solution. Ongoing attention of this kind helps people begin to track signs that they’re leaving their window of tolerance and to shift that process. And in doing this work, we, too, can come to know our somatic signals of threat – tight jaw, shallow breath, flaccid muscles, heavy eyelids. We can take in the information they offer and, over time, learn to bring our own bodies back to a state of social engagement, within our window of tolerance.

Finally, even for people who do usually maintain arousal in their windows of tolerance, I ask myself what they have to do to stay there. What price do they pay for their control? Some people are lucky enough to have had experiences that give them relatively well-regulated nervous systems. But many have to dramatically restrict the range of their feelings, perceptions, and thoughts in order to hold autonomic dysregulation at bay. Thinking in terms of the window of tolerance therefore throws new light on character disorders and pathological organizations – all of which can be understood in part as ways of trying to stay in the window of tolerance, or, in the case of borderline organizations, as a result of repeated failures to do so.<sup>2</sup>

In characterological presentations, what a clinician might identify as signs of chronic hyper- or hypoarousal can feel normal and natural to the patient: “I’m always on the go”; “I’m just not that interesting.” These people do not experience conscious dysregulation, so symptoms will need to be differentiated from self before attention to the window of tolerance can be useful. Consider, for instance, a man who began therapy feeling alone and unhappy. He also reported, initially defiantly, that he often exploded, terrifying his children. Over time, it became clear that he got enraged when he felt ignored, and exploring those moments revealed a profound and despised sense of powerlessness born out of painful childhood experiences of feeling invisible and unheard. Only as we worked with those feelings of vulnerability did the idea of traumatic dysregulation become

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<sup>2</sup>Adequately developing this theme requires a paper in itself. Looking through the window of tolerance, however, we see that virtually any feeling can be profoundly dysregulating. For all the reasons I’ve outlined, if experiencing grief, guilt, uncertainty, shame, anger, fear, or any other emotion means being thrown out of the window of tolerance, people will do everything they can, consciously and unconsciously, to avoid these states and to go on functioning. Character styles built around such efforts are necessarily dissociative, sometimes extremely so (though not always in the DSM sense). They create an apparent window of tolerance based on control of primitive dangers rather than on a genuine experience of feeling safely relaxed. This difference has broad therapeutic implications.

meaningful to him. He recognized that he wanted to use the rage to make him feel strong and in control – but it often took him over. He then became more interested in exploring the difference between effective self-assertion and destructive acting out. Over time, he made significant progress in calming his nervous system so that he could modulate his anger without denying his needs or having to suppress his considerable energy.

### **One foot in the past, one foot in the present**

In trauma, the neural markers that normally give us the feeling that an image, sensation, thought, or emotion belongs to the past fail to be encoded. As a result, traumatic memories do not carry the feeling of something recalled; instead, they feel here and now (Levine, 2015; Siegel, 2010). This quality creates confusion and terror even when images intrude that cannot belong to current reality, as in a nighttime flashback. It becomes even more difficult when emotions or sensations arise in full force in the present – you *are* terrified, panicked, alone, threatened, in physical pain. Everything in your awareness screams danger, now, and it's almost impossible to sustain a sense of safety. Even if you can summon the idea that the danger belongs to the past – a thought that demands a fair amount of knowledge and presence – nothing in your body believes it.

Evoking trauma without a felt sense of safety reinscribes traumatic memory. Too much distance, however, makes the effort purely cerebral, without touching what needs healing. As a result, all good trauma work now emphasizes *dual awareness*, which helps to minimize reexperiencing and defensive distancing, as well as post-session flooding. Dual awareness entails emotional and cognitive contact with present safety alongside sensory and/or emotional contact with past pain. With dual awareness, a person is by definition in the window of tolerance, even when dealing with extremely difficult material. Dual awareness creates the opportunity to experience traumatic memory *as* memory, separate in time and space from current reality.

It often helps to explain dual awareness early in therapy: “To process trauma, you need to have a clear sense that you’re here, now, safe with me, and at the same time make contact with the painful memory. If you get in touch with too much pain too fast, you could get flooded, or your mind could react to the threat by taking you away or numbing you out and making it impossible to do any work.” This explanation can help people accept that you will need to slow them down if they start going too deeply into painful, trauma-based material without enough connection to the safety of the present. Many patients have an outdated concept of trauma treatment, a belief that they need to get it all out in order to get over it. They need to understand that this approach not only fails to cure trauma, it actually makes it worse. Others may feel understandably desperate to tell their stories and be heard. They need sincere and usually repeated assurances that you want to hear them, but you want to do it safely, in a way that helps them build strength rather than hurting them more. Laying the groundwork may take time.

Most contemporary trauma modalities organize the work into three stages: stabilization, trauma processing, and integration of newfound skills and knowledge into daily life. Many consider this three-stage model the standard of care. Stabilization involves building enough personal and relational resources to make trauma work approachable; working with the window of tolerance, for instance, is stabilizing. Still, what makes traumatic memory traumatic, as opposed to just painful, is that it intrudes on the present and takes over, and severe enough trauma will overpower many stabilizing techniques.

Trauma therapists have developed a wide range of techniques to help patients sustain dual attention while processing traumatic memory and affect (see, for example, Fisher, 2017; R. Shapiro, 2016). One approach asks patients to touch into the traumatic material and then to return quickly to the present, before getting lost in the pain. The technique brings mindful attention to the second part of this process, the return to present safety. Over time, as people sustain greater contact with what previously overwhelmed them, confidence in their ability to work with intense experiences grows.

A woman entered treatment pessimistically, saying she'd tried therapy several times without improvement. "I only cried and felt worse, so I quit." And indeed, when we began, any reminder of tender feelings pulled her instantly into helpless tears, confusion, and bitter self-blame. She lived alone, unable to work, isolated from everything she had once enjoyed.

Seeing that strong feelings put her in a freeze state where she could not think, I suggested that we work to help her experience greater competence and agency when she "got emotional," as she put it. She agreed readily. So, when she teared up, rather than asking her about what was happening, I began to play catch with her. Tossing a pillow back and forth entertained her and brought her back to the present, and she discovered for herself that it's not possible to dissociate into traumatic emotions and play catch simultaneously. From a mental space more grounded in present reality, she began to identify more of her feelings without losing herself in them.

After several weeks of this work, strong emotion came up in a session, and I asked if she had words for it. "I do, but if I say them, I'll cry." Knowing how much she wanted to access emotions without feeling overwhelmed, I posed a series of tasks meant to shift her attention to immediate, non-threatening perceptual experience: "Can you point out three stains on the carpet? Name three blue objects in the room. Tell me when you hear a car passing." Then I asked her to bring to mind just one of the emotional words she had been thinking about before, and to notice whether it was as hard to think about now. "No," she said, smiling. "Notice that; you can have that intense feeling, move away from it, and then come back from a stronger place." Pleased with the space she had created, she chose not to say the word aloud that day but to savor the calm she now felt. I appreciated (and chose not to discuss) the boundary-setting implicit in her decision, which seemed to arise from a sense of accomplishment rather than fear. The next week, for the first time, she spent the session talking about disappointments in past and present relationships, without feeling flooded.

### **When the center does not hold**

The burgeoning interest in trauma has inspired ongoing sophisticated efforts to identify and define dissociative processes (Chefet, 2015; Dell & O'Neill, 2009; Van der Hart et al., 2006). For everyday clinical purposes, though, I follow Bromberg (2006) and consider dissociation when normal, thoughtful analytic work fails to generalize. We often assume that when talking with all but the most troubled patients, we are speaking to a "you" who hears, understands, and responds as a unified being. If a high-functioning patient repeatedly tells a story as if for the first time, or proudly arrives at a conclusion that we have interpreted again and again, we may think of narcissism without considering the possibility of dissociative gaps.

Trauma experts, however, argue that dissociation is far more common than we generally realize, and that people can experience significant dissociation without zoning out, losing time, or displaying obvious shifts in identity. These writers contend that unrecognized dissociation lies at the heart of many failed or disappointing treatments (Bromberg, 2006; Chefetz, 2015; Fisher, 2017).

Anyone who has worked long enough with trauma has accompanied someone through a profoundly connected, meaningful session, only to have the person return a short time later with no memory of the experience, a trivializing attitude toward it, or a completely different, unintegrated emotional response to it. We've felt the shock and disconnection, the questioning of our clinical skills and emotional reality. These reactions, which often enough include our own dissociations, are hallmark countertransference responses to dissociative processes.

More generally, we may intuit dissociation when empathy fails us in unexpected ways. By definition, successfully dissociated states are emotionally absent from the transference-countertransference field, and so we won't feel our normal empathic resonance with them. We may, however, experience the "hole" that their absence creates, perhaps as confusion or disorientation, perhaps as more defensive responses: frustration, control, apathy, withdrawal. Just considering the possibility of dissociation can help relieve these countertransference states. Developing a conceptual map of the parts that make up a person's inner world further reduces their impact,

on you and on the analytic process. As Chefetz (2015) says, we “imagine a mind that is not wholly present while dealing with a person who is” (p. 14). We aim to speak empathically with all parts, not just the ones whose presence are felt, much as family therapists tune their comments to all the members’ concerns even when addressing just one person directly.

Although each person’s inner world is uniquely his or her own, Van der Hart et al. (2006) have offered an overarching theory of dissociative structure that can help in constructing this map. They suggest that dissociative parts form along fault lines dictated by our inherited biology. Some parts focus on daily life, avoiding contact with any behavior, sensation, thought, or emotion that could interfere with functioning in external reality. Others hold the pain of the trauma or unintegrated defenses against it: attach, fight, flight, freeze, and submit (Fisher, 2017). All of these parts hold different procedural memories – different “unthought knowns” (Bollas, 1989). They have different action patterns. They may hold separate memories, or may interpret the same events in highly discrepant ways. These differences, along with the parts’ distinct and unintegrated means of ensuring survival, often bring them into fierce conflict.

Not uncommonly, for instance, a fight part may have certainty, boldness, a focus on grievance, and an indifference to judgment, while the same person’s submit part is empathic, subdued, and conflict avoidant. The submit part dreads the fight part’s willingness to court trouble; the fight part rejects the submit part’s docility. The attach part longs for love and care; the flight part recklessly seeks distraction; and the freeze part panics at reminders of past trauma, including those created by the other parts’ actions. The patient feels caught in a shifting array of compelling and apparently irreconcilable thoughts, feelings, and impulses. “Who am I, anyway?”

Meanwhile, daily life parts, which formed by splitting off overwhelming aspects of traumatic experience, are inevitably phobic of the split-off parts and so resist their integration (Van der Hart et al., 2006). Daily life parts minimize trauma, fail to appreciate its impact, or deny it altogether; by definition, they cannot understand the actuality of what a person has suffered.

For instance, one young woman entered therapy with severe symptoms of dissociation and autonomic dysregulation, as well as multiple near-fatal suicide attempts. Having initially denied a history of significant early trauma, she ended up slowly and painfully working through extensive childhood sexual abuse. As her memories and identity became more coherent, I asked about the previous memory loss. She said it wasn’t quite that she had forgotten: “I always had the thought of it [the abuse], but I thought I was making it up.” Another, sophisticated patient who had an objectively dreadful childhood was telling me he never thought it was really that bad. “You know that’s a symptom of trauma, don’t you?” I asked. He looked at me, surprised. “Of course. But I never thought about it applying to me.” This is the daily life part in action, routinely and unconsciously deflecting awareness of pain that could threaten the ability to cope.

We want to avoid mistaking daily life capacities for the whole person, seeing someone as “really” high functioning rather than recognizing that they have a high-functioning part that can’t integrate their traumatic experience – or making the opposite mistake and taking the defensive emotional parts for who the person “really” is, treating the daily life part as just a veneer. Using van der Hart’s model, we can also see how attach parts will tend to cling to analysis and the analyst, freeze and submit parts to comply, and fight and flight parts to oppose the relationship. The daily life part will often bring someone to treatment but remain ambivalent about it, particularly as the work begins to unearth buried thoughts, feelings, and memories that could disrupt current functioning. Each part has its own role in a complex intrapsychic system.

Analytic theory has often honored “good, dependent” parts and opposed “bad,” “sneaky,” “aggressive” ones. Yet fight and flight parts virtually always see themselves as protecting other, vulnerable parts, including those that get repeatedly devastated by attach parts’ sometimes indiscriminate bids for connection. In other words, the “destructive gang” that Rosenfeld (1971) described so vividly in his classic paper on narcissistic organizations normally believes in the necessity of its protective function; it’s not just running a racket. Understanding and speaking respectfully to that protection, and the concerns that lie behind it, can do a lot of good.

Here's a clinical example: Having begun to reveal an intimate thought, a woman stopped abruptly. "I don't want to talk about this." She was silent for a minute, then burst out: "So – what are we going to do now? You're the therapist; you should know." I replied, "What I hear is that a vulnerable part of you is needing me to get things right, because it could get badly hurt if I go too far or misunderstand. And the part that's speaking wants to make sure I move carefully and pay attention." If you're lucky, you can add, as I could that day, "It's tricky, because it's sometimes hard to see what that vulnerable part needs when a more aggressive part has the voice."

More elaborated work with parts can encourage self-acceptance even in relation to vexing symptoms. When a woman came in distressed that her eating disorder had reemerged, I used Internal Family Systems (Schwartz & Sweezy, 2019; see also Frank, 2020, this issue) to help her explore her inner world. I asked her to focus on the place in her body where she felt the urge to buy cookies. "Let that part of you know that you're curious, and ask it what it needs you to know." She got an instant response, "You deserve a treat." We continued to ask the part what mattered to it and why it had appeared now. The patient, eyes closed, saw a fairy godmother who wanted to bestow goodies on a suffering child – the patient's seven-year-old self, left alone and terrified every day for hours, eating and watching tv to distract herself. Seeing how the part was still using food to soothe pain associated with that trauma alleviated some of the patient's disgust about overeating, which she had previously understood just as a lack of self-control.

With warmth and appreciation, she began showing the fairy godmother that she was now an adult who could manage many strong emotions and no longer needed those treats to survive. The fairy godmother remained dubious – Why would anyone ever want to feel bad feelings? – but engaged in the dialogue. Over time, as this patient came to know all her "eaters and feeders," as she called them, she developed compassion for the various ways that previously unintegrated early trauma had led parts of herself to want to relieve pain with food. Reduced inner conflict led in turn to greater overall contentment and a progressive easing of her compulsive symptoms.

Thinking about dissociation has changed the way I intervene in other ways, too. For one, I often see and speak to dissociation where I might once have seen simple conflict. For instance, a patient showed up 20 minutes late for an initial session, highly agitated, having gotten lost on the way to the office for reasons that bewildered him. In the past I might have said, "Maybe there are some ways you don't want to be here." Now I said, "I can hear how much you want my help and how frightened you are to feel that something inside seems to have another agenda." I find that in dissociation people feel far more understood if I recognize that some parts feel scarily foreign to them – if what I say conveys that I get how terrible it is to feel invaded by thoughts, feelings, actions, and impulses that are unrecognizable as one's own (Dell, 2006).

Thinking about dissociation also brings us back to a basic analytic principle, the life-shaping impact of infantile experience. Research has confirmed that disorganized attachment is the strongest independent predictor of dissociative and borderline conditions in adolescence and later, more than even severe later trauma (Lyons-Ruth et al., 2006). Tragically, such attachments do not necessarily imply abuse or neglect: even in loving families, when parents' unresolved loss and trauma block them from taking in vital emotional communications, their babies' sense of themselves and their worlds suffer badly (Beebe et al., 2012). Disorganized infants face "fright without solution" (Hesse & Main, 2000): approaching the attachment figure increases fear, but so does staying away. The feeling of inescapable danger leads these babies to develop physiological symptoms similar to those of traumatized adults (Lyons-Ruth et al., 2006). Disorganized attachment, in other words, is traumatic. In non-abusive samples, about one in five infants is classified as disorganized.<sup>3</sup>

All this means that many people – about a fifth of the general population, more in at-risk groups, and, quite possibly, more yet again among those who seek analysis – will have a deep unconscious memory of attachment as literally maddening, soul-destroying, even life-threatening. This implicit

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<sup>3</sup>In non-maltreatment, middle-class samples, disorganized attachment averages about 15%. The incidence rises to about 25% in low-income samples (Beebe et al., 2012; Fonagy, 2001; Hesse & Main, 2000).

network will be awakened in any therapy that offers the promise and threat of an intimate relationship. Let's consider what happens then.

To use Van der Hart's model (Van der Hart et al., 2006), as a traumatically dissociated attach part depends more deeply on the analyst, fight and flight parts, which protectively oppose dependency, become increasingly agitated. Their attacks both internally (on the attach part's needs) and externally (on the analyst, perceived as actually or potentially hurtful) make the attach part even more desperate for the analyst's comfort. But dissociation creates a minefield. Overtly caring responses from the analyst evoke increased distrust from the patient's protectors; signs of the analyst's anger or anxiety devastate the attach part and confirm the protectors' assumptions; interpretations that fail to resonate with all parts feel distant or rejecting. The building pressure can awaken the analyst's own difficult attachments, further undermining the relationship. Both analyst and patient can feel stymied, trapped in a situation that replicates the disorganized infant's "fright without solution." Psychotic transferences – which are fundamentally flashbacks to impossible relational binds, experiences that once threatened life, sanity, integrity, or all of these – may develop.

This predicament threatens many people who have been traumatized in an intimate relationship, especially if their wounding came young. As a result, the trauma community holds that relying on a dependent relationship to hold and contain highly traumatized patients is a high-risk proposition. Analysts like Bromberg (2012) have begun to recognize that good analytic work has to take place both "within and between" patient and analyst. But we as a community are just developing our capacity to help a person work within him- or herself. Our theory and training may encourage us instead to deepen the relationship, for instance, by offering additional sessions.

Other analytic practices can also inadvertently expose traumatized individuals to the dilemma of the disorganized infant. Silences meant to allow space to think may leave patients alone with wordless terror or emptiness, heightening the need for and fear of a seemingly distant analyst. Use of the couch limits mobility and restricts basic self-protective gestures like scanning the environment, reducing the felt sense of autonomy. Facing away from the analyst also inhibits mutual use of the social engagement system to help sustain internal regulation and differentiate past from present, even as it makes it harder for the analyst to register subtle dissociative shifts. Frequent sessions (more than one or two a week) can encourage patients to look to the analyst, not their own growing capacities, to ensure their safety and stability.

To reduce this threat, trauma therapies emphasize helping patients hold and contain *themselves* with ever-increasing effectiveness, through developing mindful concern for their inner and outer worlds (Fisher, 2017; Mosquera, 2019; Schwartz & Sweezy, 2019). The analyst's role also shifts, though of course not absolutely: toward being an active, caring, reliable partner in hard work, and away from becoming the transference object of early needs and desires. In this more side-by-side relationship, we help our patients develop their capacity to care for their own suffering, without leaving them alone in it.

A recurrently suicidal man grew up with a rigid concept of masculinity. His daily life self dismissed the passions that led him to try to kill himself, calling them stupid; he just needed to grow up. His therapist, a consultee, began using "parts" language to approach the dissociated pain, helping the daily life part look at "the part that tried to die" almost like a character in a novel, without needing prematurely to accept those feelings as his own. In this process, she remained as curious and caring about what the daily life part valued – work, creativity, respect, independence – as about the patient's confused and neglected attachment needs. After a few months, loyalty to his family still left this man prone to insisting his suffering had no cause beyond his "weak character." Yet, when he imagined the despairing part inside without thinking about its origins, he felt some concern, and at times wondered how he might care for it better.

Following an unusually intimate session, his therapist was concerned about containing his emerging feelings; she knew that feeling dependent had often led him to act out dangerously. He returned to the following session safe but distanced. His therapist noted aloud that the part of him that was speaking that day was different from the one that had been present the previous week.

Invited to be curious rather than challenged to be different, he conceded that he probably had cut himself off from his feelings. He saw that his suffering would likely continue as long as those feelings remained split off, but he didn't want – or know how – to make contact again.

They explored his fears. Near the end of the session, he spontaneously offered a vision of himself as a general proudly marching at the head of a beleaguered army. The general gazed resolutely forward, shouting orders back to his troops to move faster, wholly unaware of their serious wounds, the sporadic guerrilla attacks that they faced, or even that some were deserting. Identifying himself critically with the general and his disastrous leadership, the patient felt discouraged, afraid he'd never change. Then his therapist said, "And notice – you're seeing the whole thing—the general in his determination and obliviousness, the hardworking overwhelmed soldiers, the angry deserters, and all the dangers the troops are contending with. You can see the whole picture, you can understand all the players, and as a result, we can help you help everyone in that army, and so help yourself." The patient was not just the general, not just the troops. He was the one who, with help, could come to know and care for himself, in all his complexity.

In this way of working, the analyst avoids becoming the caretaker of or spokesperson for a patient's excluded wounded parts – getting to know that general will also be vital to this man's treatment. The therapist instead supports the patient in recognizing, appreciating, and eventually negotiating the hopes, fears, and intentions of all parts – those that support daily life, those that offer fierce protection against intolerable pain, and those that carry the pain itself.

Actively helping people relate to their inner worlds with compassion and care, rather than just asking them to internalize our compassion and care, reduces the frequency and intensity of highly regressed transferences. When it comes time to enter the most fearful realms of trauma, patients don't have to go there desperately dependent, terrified as much by the dependency as by the trauma itself. They still need us and the relationship, very much so, but there's a stronger feeling that if we stumble, they can hold themselves up. And this feeling helps immensely.

Generations of analysts have struggled with how to conceptualize and treat posttraumatic suffering. Our literature has long recognized that until it finds meaning and containment, the pain of trauma spreads, passing from person to person, group to group, and generation to generation. Trauma research and the therapies based on it have opened up new and exciting pathways for interrupting these tragic cycles. If we can approach these ideas with anything near the creativity and sophistication we have brought to transference and relational work, we will emerge with far more to offer our traumatized patients, and so to our communities and our world.

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No potential conflict of interest was reported by the author.

## Notes on contributor

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