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When Understanding and Connecting aren't Enough: Working with Traumatic States[11]

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Over the past quarter century, researchers and clinicians have learned an enormous amount about how trauma affects people's ability to benefit from psychoanalytic work. Above all, these discoveries help us understand those painful times when our efforts to help our patients connect, think, and feel not only fail to contain their distress, but sometimes even heighten it. Appreciating how trauma disrupts nervous system regulation, cognitive functioning, and interpersonal connectedness can enhance our engagement with people in pain and help us find new ways to help them. This knowledge becomes even more essential as we navigate so much current turmoil, with all the individual and collective trauma it generates.[2]

What is Trauma?

Current use of the word *trauma* 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 going into more detail, it's important to note that something else must happen for traumatic injury to result in long-term symptoms: after the threat has passed, the person fails to receive adequate comfort and containment, which ensures that the traumatized person cannot integrate what has happened, may occur within a person, through an

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[2] *Sections of what follows also appeared in Psychoanalytic Inquiry (Dent, 2020).*

inability to self-soothe or make sense of experience. It can happen between and among individuals, through lack of care or understanding.

And it happens within societies. 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). A recent NPR interview (Elliott, 2020) described how the impact lives on in New Orleans, 15 years later.

Pat Ogden's definition makes it clear that trauma may result from external events or internal experiences, including nightmares, flashbacks, or panic attacks. It confirms that experiences of humiliation, neglect, or emotional cruelty can be 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.

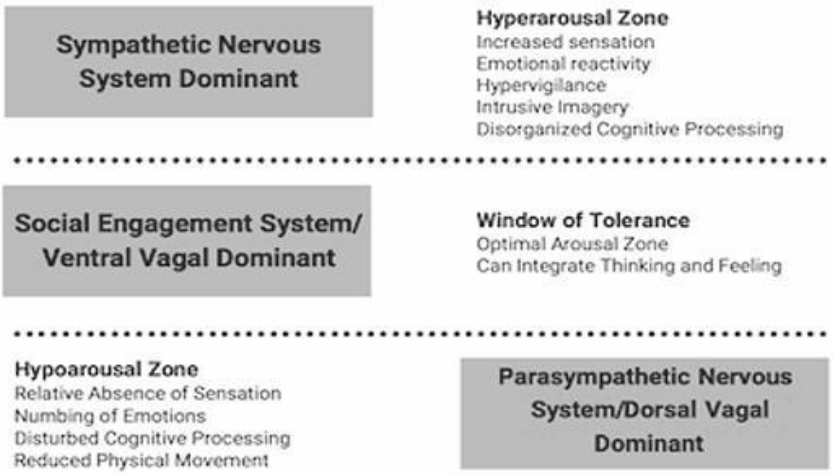
It's vital that clinicians recognize that when an event fragments internal experience or sets off enduring symptoms of hyper- or hypoarousal, it constitutes a trauma, regardless of whether it meets DSM criteria. Clinically, therefore, when an otherwise healthy patient suffers from pathological dissociation or chronically 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 his already classic book, keeps the score. And the body cannot lie.

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 a live wire constantly sparking or shorting out. Pat Ogden's definition tells us that some kind of trauma, whether shock, strain, or developmental, has thrown their nervous systems out of balance. We can tell 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." We don't need to figure out what happened in the past in order to help. Instead, we can focus on helping patients to feel safe when they are in fact safe and to live fully in the present.

Stephen Porges and the Window of Tolerance

Pat Ogden's definition locates trauma at the meeting ground of psyche and soma. A key concept here is known as the Window of Tolerance (Ogden, Minton, & Pain, 2006):



Within the window of tolerance, you may be drowsy, playful, solemn, or angry, but you have a mind that remains open to new information and connection with others. You can reflect on a troubling situation and respond flexibly, taking a stand or acknowledging a mistake. As you move into hyperarousal, though, cognition becomes rigid or disorganized, physical and emotional reactivity intensify, and you become prone to both hypervigilance and intrusive thoughts and images. In hypoarousal, by contrast, sensation, emotion, and cognition become dulled, and movement slows or ceases.

The *polyvagal theory* (see Figure 1), developed by researcher Stephen Porges (2011), enriches our understanding of the window of tolerance. Importantly, the system Porges describes does not rely on conscious perception. Instead, it involves a process he calls *neuroception*: information processed deep in the brainstem and limbic system, and so registered unconsciously — somatically, emotionally, and associatively — rather than logically or verbally.

We neurocept safety and danger: our felt sense of security or vulnerability arises not from conscious assessment, but from subcortical responses to present cues, based on implicit memories of past experience. Early relational experience, which lays the foundation for self-regulatory capacities, is especially important here. Importantly for analysts, *what we*

neurocept determines our ability to engage with ourselves and others. How safe we feel, in other words, governs our access to inner and outer relatedness.

Let's take a closer look at this theory. When the neuroception of threat is not too high, what Porges calls the *ventral vagal system* is active. The ventral vagus is a nerve that, from infancy on, allows us to send, receive, and respond to relational signals, even very subtle ones (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 (1961) “thinking” and Winnicott's (1971) “play,” and transference has the transitional quality that allows for exploration of difficult feelings and memories. In other words, when 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 toward the top of the chart into hyperarousal. Hyperarousal evokes active, inborn defenses meant to protect life in the face of threat: attachment for survival (Fisher, 2017), fight, and flight. In case it's not a familiar term, “attachment for survival” seeks safety through an intense focus on connection, spurring behaviors like desperate clinging or pursuing, or a compulsive need to talk.

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, desperate, rageful, or panicked, and our thinking becomes

disorganized or fervently single-minded as we struggle to maintain control. Simultaneously, as the ventral vagal system goes offline, our ability to use social cues to assess safety and danger plummets. Our mind is orienting itself to signs of threat, and that's what it notices. When sympathetic activation is high, a furrowed brow or 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. As hyperarousal increases, transference moves toward what gets called psychotic: the analyst is experienced concretely, as the last, best hope or as a real and present danger.

Despite its costs, hyperarousal helps us actively defend ourselves — we fight, escape, find a protector. If, however, the mind neurocepts — again, through subcortical responses, not conscious appraisal — that active measures will not bring safety, then a person moves into hypoarousal, often abruptly. The *dorsal vagal* system activates. A blend of sympathetic and dorsal vagal activation creates states like “hot shame” or a deer-in-the-head-lights, high-energy freeze. As hypoarousal deepens, a person becomes flat, hopeless, dully ashamed, or stereotypically dissociated. An inhibited patient shows a flash of interest, moves to speak, deflates. “Never mind. It doesn't matter.”

Hypoarousal offers passive protection against what the brain neurocepts as inescapable danger. This is the mouse that goes limp in the cat's mouth. Hypoarousal evolved to conserve energy, to dull pain, and to discourage predators, who often ignore limp or dead prey. In this way, hypoarousal allows us to endure (Fisher, 2017). People who have experienced sustained 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 transferential feelings and interest. By now, the social engagement system is largely unavailable, 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.

Porges's findings imply that analysts have often misinterpreted hypoaroused states, seeing them as unconsciously aggressive. Defensive dorsal vagal activation, however, is an ancient brainstem system — it exists in lizards — that functions to minimize unavoidable pain. That 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 a deep sense that active impulses cannot help, and may make

things worse, that matters. We recognize this process when we understand a patient's self-abasement as a defense against nascent positive emotions like excitement, pride, or desire. Sufficient experience of rejection or abuse can turn any feeling into a subcortical signal of danger.

Technically, Porges's work leads to the conclusion that asking someone in a state of significant hyper- or hypoarousal to think about their experience presents an impossible task — there's just not enough access to cortical functioning. Symptoms like extreme anxiety, chronic passivity, or recurrent rages often leave people hopeless and ashamed. They can feel like failures at therapy, and at life as a whole.

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, improving self-esteem, and developing affect tolerance. 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? Can the person usually find ways to regain equilibrium?

With people who readily slip outside the window of tolerance, or who 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 will 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 (P. Ogden & Fisher, 2015).

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.

Considering each person's inner world remains as vital with somatic interventions as 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 helps people return to their window of tolerance, but some hyperaroused patients become 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 the patient's job is simply to notice and report what happens. They can't get anything wrong because we want to learn what helps, not to impose a solution. Ongoing attention of this kind helps people recognize when they're leaving their window of tolerance and shift that process. And we, too, can come to know our somatic signals of threat — tight jaw, shallow breath, slumped shoulders, heavy eyelids. We can take in the information they offer and learn to bring our own bodies back to a state of social engagement, within our own windows of tolerance.

Trauma, Memory, and Dual Awareness

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 logically

cannot belong to current reality, as in a nighttime flashback. It becomes even more challenging when emotions or sensations arise in the present — you *are* terrified, panicked, in physical pain. 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, 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, trauma work now emphasizes *dual awareness*, which helps 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 feelings are intense. Dual awareness creates the potential to experience traumatic memory as *memory*, separate in time and space from current reality.

A patient's otherwise helpful long-term therapy had not resolved what she suspected were symptoms of sexual abuse.[3] We quickly recognized that she tended to push forward when thoughts, feelings, or memories potentially related to the abuse came up, overriding her distress with the thought that she had to be strong in order to heal. Too often her feelings then exploded into anger, shaming her and increasing her fear of the split-off material.

We began working with the window of tolerance, helping her notice the tension and tightness of breath that signaled apprehension and then strengthening her connection to present safety. When a disturbing memory fragment emerged, I might pose a series of simple tasks meant to shift attention to immediate, non-threatening perceptual details: “Can you name three blue things in the room with you?” “What's the texture of that fabric?” “Tell me when you hear a car pass.” After several such questions, when she felt less tense, I could ask her to notice specific evidence of how her life now differed from her childhood — concrete indications of her autonomy, successes, or supportive relationships. She discovered that consciously touching her wedding ring reliably made her feel safer and stronger. Then we returned to the memory image, and she felt calm enough to approach it — and delighted to be finding a path forward that did not mean pushing past her limits.

[3]*All clinical vignettes come from recent online sessions.*

Especially online, if I'm unsure whether someone still has dual awareness, or if we're approaching the end of a session that has taken a significantly traumatized person into deep or unfamiliar territory, I may use Jim Knipe's (2019) Back of the Head Scale. Demonstrating with my hands, I'll ask the patient to imagine a line extending from the back of their head to about a foot in front of their brow. Then I'll tap the back of my head and say, “If you're back here, you're looking at me but your mind is miles away.” With the other hand I'll gesture at the point in front: “And if you're out here, you're completely present with me; nothing else on your mind. Where are you now? Show me on the line.”

If the person indicates that they are less than four or five inches outside their head, but not in a comfortably thoughtful state, I will work to bring them more fully into the present. On Zoom, I may ask them to describe something in the room with them “so that I can see it in my mind.” As they do, I'll ask a lot of questions: “How tall is the plant? What shade of green are the leaves? Are they shiny or matte? Delicate or sturdy?” Or I might ask them to tell me about an interesting show they've seen or a recipe they like. Some people like to stand and walk around, to push hard against a wall, even to sing.

It all depends what works — it's still a series of experiments. But for any patient who is susceptible to potentially destabilizing traumatic reactions, I'll try to develop two or three familiar exercises that we can call on when needed to end sessions safely.

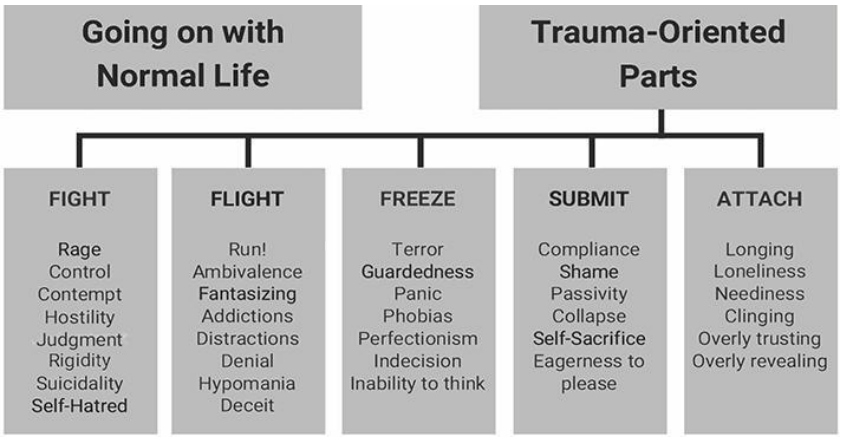
When the Center Does Not Hold

Recent theorizing offers many sophisticated efforts to identify and define dissociative processes (Chefetz, 2015; Dell & O'Neill, 2009; van der Hart, Nijenhuis, & Steele, 2006). For clinical purposes, though, I follow Bromberg (2006) and consider dissociation whenever 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. But such gaps are often there.

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

Here's a common example. You feel great after accompanying a patient through a connected, meaningful session — finally, they're letting themselves feel! Then the person returns to therapy with no memory of the experience, a trivializing attitude toward it, or an utterly 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 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 resonance with them. We may, however, experience the “hole” that their absence creates, perhaps as confusion or disorientation, or as more defensive responses: frustration, control, apathy. 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) describes, 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 those whose presence are felt, much as family therapists tune their comments to all members' concerns even when addressing just one person directly.



Although each person's inner world is unique, Onno van der Hart and his colleagues (2006) offer 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 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.

Parts based on these defenses carry 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 other parts' actions.

Meanwhile, daily life parts, which formed by splitting off overwhelming aspects of traumatic experience, remain 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 truth of what a person has suffered.

For example, one young woman entered therapy with severe symptoms of dissociation and autonomic dysregulation, including multiple near-fatal suicide attempts. Having initially denied a history of significant early trauma, she ended up working through extensive childhood sexual abuse. As her memories 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 yet 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. Understanding and speaking respectfully to that protection, and the concerns that lie behind it, can do a lot of good.

Here's an 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.”

Conceptualizing dissociation along these lines has reshaped my approach to many signs of internal 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 scary it is to feel that something inside seems to have another agenda.” Similarly, in situations where I once might have commented on a person acting against their best interests, I might say now that some part of them doesn't seem to be on board with their conscious intentions — could we get to know that part, too?

As dissociative processes deepen, I find that people feel far more understood if I recognize that some parts feel genuinely foreign — if what I say appreciates how terrible it is to feel invaded by thoughts, feelings, actions, and impulses that feel unrecognizable as one's own.

On my return from a two-week vacation last summer, a long-term patient said that for several days she'd been having stretches of time when she blanked out — she couldn't think, and she couldn't work. The episodes frightened her, as she had a lifelong fear of becoming like her father, immobilized and unable to care for herself. We decided to investigate using an Internal Family Systems (Schwartz & Sweezy, 2019) approach.

I asked her to focus on the blank feeling. “Let that part of you know you're curious. Ask what it needs you to know.” Eyes closed, she saw a funny-looking man in a suit. “He” felt too anxious to talk, but he could signal yes or no, so we continued asking him simple questions, reflecting the answers back, until he began to relax. He said he had an important job, and then the patient's face crinkled in confusion. “He's in my childhood dining room, and he's trying to make himself invisible by turning into a statue.” She laughed, “Not that a statue in the dining room wouldn't be noticeable, but I don't think he knows that.”

She asked why he was trying to become invisible and he replied anxiously, “I'm not supposed to be seen.” She asked what he was worried could happen when he's visible — and then looked up, alarmed: “I'm really

scared.” A new part had emerged.

Checking for dual attention, I asked, “Are you still here with me?” When she nodded, I asked if we could get to know the fear. She nodded again, focused on the clutching sensation in her chest, and immediately saw herself at age seven, alone in the house after school. She was sitting under the dining room table with a kitchen knife, preparing to defend herself from the intruders she feared might already have broken in — something she did for hours every day. We worked to calm that terrified part, letting her know she was safe now. But the part remained suspicious. We were adults, and adults, in her experience, were not to be trusted. Her attitude made sense to my patient, who assured the part that she did not have to trust us; it was our job to earn *her* trust. Then we asked if anything in the recent past had scared her, and my patient started upright: “It was the Republican Convention. All the adults seemed crazy and dangerous.” With this clearer understanding of what had been triggered, we made plans for how the patient could care for herself better and scare the part less during this politically volatile time.

Thinking about dissociation also returns us to a basic analytic principle, the life-shaping impact of infantile experience. Research confirms 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 suffers badly (see 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. Disorganized attachment, in other words, is traumatic. In non-abusive samples, about one in five infants is classified as disorganized (see Beebe et al., 2012; Fonagy, 2001; Hesse & Main, 2000).

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 an unconscious memory of attachment as literally maddening, soul-destroying, even life-threatening. This implicit 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 (2006) model, 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 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 easily 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 recognized 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. Interpretations of dependency can undermine fragile self-sufficiency without creating adequate structure to replace it (Mitrani, 1998). 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 worlds (Fisher, 2017; Schwartz & Sweezy, 2019). The analyst's role also shifts — though, of course, not absolutely — towards being an active, caring, reliable partner in hard work, and away from becoming the transferential 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 man entered therapy suffering from lifelong anxiety. Situations of conflict sent him into a vicious cycle of compliance and resentment, alternating between fury at self-negating decisions and shame over angry outbursts. Since he seemed to be experiencing an ongoing internal argument, I asked him to imagine a comfortable meeting place where parts of himself could gather and talk (Mosquera, 2019). He then invited in all parts that played a role in his current distress or wanted a voice in its resolution. A regular group emerged: a vigilant, distrustful part; a people pleaser; an ambitious part; a part that feared attack; another that feared abandonment; and a very lonely little boy. Work with these parts (Schwartz & Sweezy, 2019) led to greater internal trust, and a young, angry part, rejected by the others and furious about it, showed up after several weeks. As the patient cared for these parts and listened to them one by one, rather than all at once, his internal battles eased. At work and at home, he began to stand his ground effectively without being overcome by terror of the cruelty he experienced throughout his childhood.

In this way of working, the analyst avoids becoming the caretaker of or spokesperson for a patient's rejected wounded parts — every part at the meeting place needed to be heard before this man could begin to experience anger safely. The analyst 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.

When a person is overwhelmed, asking them to understand why can easily add pressure instead of relieving it. A psychic container that was already straining is asked to hold more — thoughts, connections, sensations, emotions — and it bursts or overflows. As the well-known trauma therapist Sandra Paulsen often notes, when there's too much to contain, you have to grow the container or shrink the contained. Growing the container and limiting the contained are what many techniques of trauma therapy are all about.

Trauma therapists help steady patients in their windows of tolerance. They lead patients, safely, to deepen their awareness of somatic signals and the meanings they convey. Trauma therapists emphasize mindful awareness of the here and now, with special attention to indications of present safety. They teach the value of dual awareness, as well as means of sustaining and regaining it. They encourage patients to recognize the capacities they have developed, to have compassion for the suffering they've endured, and to develop faith in their ability to grow. And they work to help people see, appreciate, and integrate aspects of themselves that have long been working at cross-purposes.

As these abilities develop, so does people's openness to examining their experiences, feeling their emotions, and sustaining meaningful relationships. In other words, as traumatic states become workable ones, patients become more able to think, feel, and connect, and so to involve themselves more deeply in all that psychoanalysis has to offer.

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