WHAT IS DISSOCIATED?

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ABSTRACT

Our current view of the severe dissociative disorders as trauma-based implies that the dissociated material consists of the traumatic abuse memories, related traumatic affects, etc., and does not adequately address what else is dissociated. It is argued here that chronic, severe trauma also results in the splitting off of the child's healthy, developmental, relational needs and longings. By segregating those needs and longings which are offensive to the child's pathologically-vulnerable caretakers, dissociative defenses serve to maintain and regulate relatedness to others. This expanded view of dissociation suggests that the treatment of severe dissociative disorders must include the remobilization of those early relational need states within the transference relationship and their integration into the patient's central self experience.

Our growing understanding that the severe dissociative disorders are the offspring of trauma (Spiegel, 1984; Putnam, 1989; Ross, 1989; Schultz, Braun, & Kluft,1989) has brought about a revolution in their treatment over the past two decades. At the same time, the prevailing focus in the multiple personality disorder (MPD) field on trauma—that is, the overwhelming trauma of active, intrusive abuse—has also brought with it a narrowing of vision that I wish to address in this brief article.

At issue is our theoretical grasp of *what*, exactly, is dissociated. The current etiological emphasis on trauma carries with it the implication that the dissociated material consists primarily of abuse memories and related traumatic affects, sensations etc., an implication which continues to have profound consequences for our understanding of the psychodynamics of the disorder and for our philosophy of treatment as well. The notion that MPD involves the dissociation of "trauma" leads inevitably to the persistent preoccupation in the field with "memory work," the belief that the recovery, abreaction and integration of abuse memories is the overarching goal of therapy, and—despite some significant recent attempts to the contrary (Barach, 1991; Davies & Frawley, 1991; Sands, 1991b; Liotti, 1992; Kinsler, 1992; Schwartz, 1994)—to the continuing failure of the field as a whole to understand dissociative disorders as disorders of relationship.

More specifically, what the prevailing theories fail to examine sufficiently are the ways in which chronic, severe abuse results not only in the traumatic memories and affects' being dissociated, but also in the child's healthy, relational needs (for empathy, affect attunement, soothing, admiration, security, self-differentiation, etc.) and the longings and relational fantasies linked up with these needs' being split off as well. In other words, when a relationship is traumatizing, a child cannot use that relationship to meet his or her deepest yearnings, and these yearnings must go underground. Indeed, if only the "trauma" were split off, the consequences for personality development would not be so severe.

This expanded, relational psychoanalytic view of dissociation further suggests that the treatment of severe dissociative disorders must include the remobilization of those hidden needs and longings within the transference relationship and their integration into the patient's central self experience. Indeed, it is the recrudescence of the dissociated , relational needs and fantasies which accounts for much of the harrowing and tumultuous nature of MPD treatment. In the language of affects (Stolorow, Brankchaft, & Atwood, 1987), "need" is best translated as "longing" or "yearning." "Longing" is also a more appropriate term in the language of subjective experience (Kohut, 1977; Stolorow et al., 1987) than the more reified, experience-distant "need." However, because "need" is still a more recognizable and commonly understood psychological construct, "need," will be used interchangeably with "longing" and "yearning."

BRIEF REVIEW OF THE LITERATURE

Psychoanalytic views

Only recently has relationship been included in our formulations of dissociation or, for that matter, in our understanding of any of the defenses. Until the last few years, psychoanalytic contributions on multiple personality and dissociation (e.g., Breuer & Freud, 1953a; Freud, 1953b; Glover, 1943; Lasky, 1978; Marmer, 1980; Berman, 1981) have focused on the defense mechanism of splitting. (For a discussion of psychoanalytic formulations of MPD and splitting, see Berman, 1981.) Splitting, like all defense mechanisms in classical psychoanalytic thinking, has been conceptualized as an intrapsychic defense against unconscious, forbidden aggressive or libidinal impulses. Similarly, in much of the

object relations literature, dissociation and splitting have been seen similarly in purely intrapsychic terms as defenses against unconscious ambivalence (e.g., Fairbairn, 1952; Kernberg, 1975) rather than as arising in an intersubjective context.

With the concepts of "false self" and "vertical split," Winnicott (1965) and Kohut (1971) respectively took significant steps towards including the actual relationship with the caretakers in their formulations of splitting and dissociation. Winnicott (1960) viewed the splitting off of the true self as a means of protecting it from "impingement" by the environment—that is, from the failure of the "mother" to serve as the medium for formlessness or the instrument of omnipotence. Kohut (1971) argued that a vertical split develops due to the failed empathic responsiveness of the environment and the subsequent need to distort the self to comply with the narcissistic demands of the caretaker. In the views of Kohut and Winnicott and their followers, the child's genuine needs are split off or dissociated until such time as conditions are safe enough (e.g., a trusting therapeutic relationship) for development to begin again where it was earlier derailed.

Neither Kohut nor Winnicott applied their ideas on splitting to MPD, but Gruenewald (1977) has done so for Kohut, as has Smith (1989) for Winnicott. Gruenewald (1977) likens the kind of splitting in multiple personality disorder to that in narcissistic personality disorders—that is, "vertical" in nature. Smith (1989) views MPD as a layered false self organization stemming from an initial psyche-soma split designed to protect the true self from an impinging environment. In addition, Ulman and Brothers (1988), following Kohut, explore how trauma results in the shattering of narcissistic fantasies. Marmer (1980), following Winnicott (1953), suggests that alter personalities be viewed as transitional objects of childhood, located somewhere between inner and outer reality.

Two recent contributions bring contemporary relational psychoanalytic models to bear on dissociation and MPD. Using an object-relations perspective, Davies and Frawley (1991) discuss the splitting off of the self- and object-representations attached to memories and fantasied elaborations of incest trauma and explore the transference-countertransference picture comprising fantasized victim, abuser and idealized omnipotent savior. Schwartz (1994) proposes a comprehensive relational psychoanalytic model, conceptualizing MPD as a variation of narcissistic personality organization involving an over-reliance on omnipotent defenses, the collapse of intersubjective experiencing and disruptions of aggression, fantasy and the use of transitional phenomena. Neither of these excellent relational accounts, however, gives adequate attention to the dissociation of healthy, developmental need states and the later importance of remobilizing these need states in treatment.

Dissociation/Trauma Literature

The dissociative disorders and trauma literatures have for the most part conceptualized dissociation as a defense against overwhelming traumatic memory and affect (e.g., Braun, 1986,1988; Kluft, 1984; Ross, 1989; Putnam, 1985; Spiegel, 1984; van der Kolk, 1987). Multiple personality disorder is now universally viewed as a post-traumatic stress disorder (e.g., Spiegel, 1984; Ross, 1989). According to Putnam (1989), the process of dissociation "binds pain and horror by dividing it into little parts and storing it in such a way that it is difficult to reassemble and to remember" (p.125), a description which is certainly eloquent and true but which fails to acknowledge the dissociation of healthy relational needs. While many contributions, following Braun's (1986) BASK model, enlarge the concept of dissociation to include behavior, affect, sensation and knowledge, their focus is still the contents of trauma.

It is not that these accounts fail to acknowledge the MPD patient's intense dependency upon the therapist. Much has been written on how to understand and manage these patients' overwhelming needs through interpretation, hypnosis, limit-setting, confrontation, maintaining firm boundaries, contracting, etc. (e.g., Kluft, 1992; Chu, 1992). Too often, however, the need states remobilized in the therapy are viewed as something to be resolved and managed along the way to the *real* work of therapy (*i.e.*, the abreactive/integrative work) rather than recognized as being at the very heart of the therapy.

Those contributions to the dissociative disorders field which explore the transference relationship should also be noted, beginning with Wilbur (1988). Kluft (e.g., 1992) has consistently revealed a deep psychoanalytic understanding of working with the transference needs of patients and has characterized the process of integration in MPD treatment as within the tradition of psychoanalytic perspectives on structural change (Kluft, 1993). Loewenstein (1993) has discussed the post-traumatic and dissociative aspects of transference and countertransference in the treatment of MPD. Kinsler (1992) has argued forcefully for the central importance of profound therapeutic engagement with MPD patients. But these accounts still fail to link the *dissociative process per se* with the segregation throughout development of healthy need states which are then re-awakened in the therapy.

What I am suggesting here may appear to bring us back full circle to the much earlier and currently repudiated "reparenting" tradition of MPD treatment, in that these therapists did encourage the emergence and gratification of the early developmental needs within the therapeutic relationship. However, reparenting efforts were almost invariably associated with severe boundary violations and are not considered appropriate approaches (Kluft, personal communication, April, 1994). While both the early reparenting tradition and the relational psychoanalytic approach advocated here allow for the remobilization of early need states, I believe that the needs will be integrated not by gratification but only through psychoanalytic understanding and interpretation.

Two recent contributions bring Bowlby's attachment theory to the dissociative disorders field and come closest to addressing the kinds of relational, developmental issues under discussion here. Barach (1991) and Liotti (1992) argue that MPD should best be viewed as a disorder of attachment. Barach relates MPD to the process of "detachment" (Bowlby, 1982), describing how the parents' emotional neglect leads the child

to detach from internal and external signals that would normally lead him to search for a parent. Upon the detached state are superimposed the sequelae of active abuse. Barach also explores the ways in which attachment needs and behaviors become mobilized in both patient and therapist during the treatment process. Liotti (1992) argues that the dissociative disorders are better conceptualized as relating to the "disorganized/disoriented" form of attachment (Main & Solomon, 1986), which manifests in the infant's display of odd, disorganized, seemingly inexplicable and conflicting behavior patterns in the parent's presence. This "disorganized/disoriented" form of attachment is related to frightened and/or frightening parental behavior which may stem from the parents' own unresolved trauma. The infant's disorganized/disoriented attachment behavior corresponds to an internal working model of self and attachment figure that is multiple and incoherent. Multiple internal working models, Liotti hypothesizes, may be responsible for the child's later predisposition to dissociation in the face of further traumatic experiences.

Like Barach and Liotti, I view relationship disorder as being at the heart of multiple personality disorder and attachment behavior as crucial to development. However, I think there are other crucial developmental needs in addition to attachment, needs which may be less related to protection and security and which will be discussed further below.

THE DISCUSSION OF EARLY RELATIONAL NEED STATES

Relational Need States

In using the term,"relational needs," I am referring to early developmental needs which are necessary for the development of the self. These relational needs are experienced by the individual as longings, that is, as *affects*, which signal the organism that certain environmental responses are missing which are necessary for self development. I have chosen the term "*relational* need" to emphasize that these nuclear needs can only be met through relationship and, in fact, can be experienced only in the context of relationship, whether conscious or unconscious. Indeed, I believe that a relational need state must necessarily always imply at least a fantasy of an "other," be it conscious or unconscious. Indeed, the needs become dissociated precisely because they are relational; that is, the child tries to protect him or herself as well as the caretaker from the impact of her needs, knowing only too well that the relationship cannot tolerate them.

As discussed above, Barach (1992) and Liotti (1992) focus solely on the needs for attachment, while I believe that there are many other developmental, relational needs which are also dissociated when caretaking is severely abusive. Attachment needs, in Bowlby's technical sense, refer particularly to the security of the biological organism. According to Bowlby (1982), the attachment system is an innate behavioral control system that motivates primates to search for the protective proximity of conspecifics whenever the individual is distressed, threatened or frightened by environmental danger. What of all the other emotional needs that children hope to have met by their caretakers even when they are not distressed, threatened or frightened? Kohut (1971,1984) named three such "self-object needs" necessary for the development of the self: the need to have the developing self mirrored (i.e., admired and confirmed), to idealize a calm and powerful other, and to experience an essential alikeness with or twinship with an other. Wolf (1988) proposed the need for a benign "adversary." Stern (1985) and Stolorow et al. (1987) have discussed the overarching need for "affect attunement"; Benjamin (1990) the all-important need for "recognition." The list could go on and on. I have deliberately chosen to use the term "relational need" here, because it is inclusive, even vague, and therefore can encompass the myriad of developmental needs experienced by the (healthy) child, many of which have not yet found labels.

The Dissociation of the Relational Need States

How, then, are these relational need states dissociated? Put in the simplest theoretical terms, those parts of the self which are responded to empathically during early development become integrated into the self. Those which are traumatically rejected, neglected or distorted because they threaten the caretakers narcissistic equilibrium become disavowed or dissociated from the total self structure (Kohut, 1971, 1977). In other words, when the central caretaking relationship is traumatizing, a child cannot use that relationship to meet his or her deepest yearnings, and these yearnings must go into hiding.

I view MPD as a severe self disorder—that is, a disorder which develops due to pervasive disturbance in the empathic interplay between the growing child and the care-giving environment and which eventuates in serious structural deficits in the self, particularly in self-regulation and self-cohesion. This view is confirmed by studies of the developmental pathology caused by severe abuse (Cole & Putnam, 1992; Fink, 1988; Peoples, 1991) which conclude that the effects are most pronounced in the domain of self-development. The extreme forms of active and sadistic abuse which we see in parents of MPD patients are always but one part of a much more pervasive and insidious failure to respond empathically to the developmental needs of the child, including the more "passive" forms like neglect and abandonment. Parents of MPD, who often themselves have MPD or other severe psychopathology and who are struggling with their own overwhelming unmet needs, invariably invert the normal parent/child relationship and come to expect the child to meet their own narcissistic needs. The child is seen as a self-object rather than a self.

Incestuous abuse is particularly damaging to the child's needs system, for the child's own needs for love, comfort, soothing and touching are themselves exploited and used for the parent's own gratification. The child then experiences the needs themselves as contaminated and bad or, even more devastating, as evidence that he or she is an accomplice in the incest.

When the parent perpetrator is also sadistic, which is usually reported to be the case with MPD patients, there results

a terrible distortion, even reversal, of the normal need/response cycle. The child's need for help, the *need itself*, triggers the caretaker's need to hurt; the child's pain, the pain itself, gratifies the caretaker and intensifies the desire to hurt more. The child learns that need states lead inevitably to pain and that showing pain leads to more pain. Thus, the needs themselves must not be acknowledged lest they be expressed and awaken a sadistic response in the caretaker. The child's various needs and affects are split up and hidden away among various parts of the self.

In addition to the need states' being split off, the child's ability to express need symbolically as wish is also severely hampered by ongoing, traumatic breaches of empathy. Auerhahn and Laub (1987) describe this process in their study of Holocaust survivors, whom they describe as having lost their capacity for wish-organized symbolic functioning. The child's internal playground, which Winnicott (1953) calls potential or transitional space, cannot develop or, if embryonically developed, cannot be maintained in an abusively impinging environment. It is within that potential space between inside and outside, between primary and secondary process, between fantasy and reality that the child can play with desire. When that internal space is traumatically collapsed, the capacity to play, to wish and to dream is lost also.

Multiple personality disorder results when the caretakers' ongoing active, sadistic abuse coupled with their ongoing rejection, distortion and exploitation of the child's central need states necessitates the sequestering of the different need states along with the traumatic material into separate parts of the self. Then, in the presence of high dissociative ability, these part-selves can become amalgamated with childhood fantasies of restitution (Young, 1988), concretized (Stolorow et al., 1987) and personified into alter personalities. With structuralization into multiplicity, there also comes a collapse into polarities, as no one alter can hold hold the paradox of contradictory need and affect states. Thus, an outcome of MPD suggests the most pervasive and profound failure of environmental response, a failure so profound that the child is compelled to escape his own subjectivity and dissociate his very *self* (Spiegel, 1986).

Structuralization into multiplicity is also the child's attempt to create a restitutive system by which internal selves, rather than other people, are relied upon to meet crucial nuclear needs, because turning to people had led to intolerable disappointment, abuse and shame. The internal alter personalities protect the system from becoming overwhelmed, contain intolerable affect, soothe, create hope, etc., functions which the environment has not been able to provide (Marmer, 1980). A radical form of precocious self-sufficiency develops, wherein needs are not even felt, much less expressed. By investing in internal rather than external object relations, the child circumvents the need for the caretakers' responsiveness and protects him or herself from further abuse and shame. The multiplicity also relieves the caretaking relationship of the impossible burden of having to meet his or her needs. However, once multiplicity is employed as a solution, the individual's development is also derailed. The early needs remain split off and cannot be integrated into the central personality. The "host" goes about the task of living bereft of the full range of his or her human responsiveness.

The Dissociation of Rage

Also dissociated is the narcissistic rage that goes hand in hand with the terrible narcissistic injury of ongoing abuse—particularly the rage born of the relentless failure of the caregivers to meet the nuclear needs of the child's fragile, developing self.

In the chronically threatening early environment of the individual with MPD, there is no place for the rage to go. The perpetrators are "unattackable" in the sense that an angry outburst which threatens their omnipotence can literally result in injury or death. The rage instead becomes structuralized within the MPD system in the form of "hostile alters," who tend to remain in hiding until treatment is well underway. In yet another paradoxical twist of MPD, all the so-called hostile alters also operate in some way to *protect* the needs of the child's fragile, developing self, some by preventing the dangerous revelation of the abuse memories, some by gagging the needy child alters, etc. Some are identified with the perpetrator. Identifying with the aggressor not only shores up a fragile sense of self; it also, in intersubjective terms, maintains a life-sustaining, unconscious connection with the other through identification. Identifying with the aggressor can also be motivated by the wish to make the bad parent good (e.g., Shengold,1989) by internalizing the bad parent, making the self "bad" and thus purifying the actual parent.

It is as Winnicott (1971) said—an object who cannot survive destruction in fantasy remains an internal object under one's fantasied omnipotent control. Elaborating on Winnicott, Benjamin (1990) states: "when the other does not survive and aggression is not dissipated, it becomes almost exclusively intrapsychic....What cannot be worked through and dissolved with the outside other is transposed into a drama of internal objects" (p. 41). In MPD, this internal drama of aggression takes place among the alter personalities, certainly a less dangerous state of affairs than actually fighting with one's perpetrators. The intrapsychic drama finally becomes played out on the external stage within the transference, where the therapist and patient take turns playing the roles of abuser and abused. Painful, compulsive re-enactments often dominate the therapy, repeating the sadomasochistic dynamics of the original traumatic interactions.

Addictive Processes as a Means of Accessing Needs

Once the needs and longings have been segregated, the individual may attempt to use addictive/dissociative processes as a means of maintaining the dissociation and also, paradoxically, as a way of accessing and temporarily gratifying the needs.

I have suggested earlier that dissociation is a neglected link in the chained sequence leading to and through addictive activity (Sands, 1991a). Environmental failure triggers traumatic memory which evokes traumatic affect which leads to the need for some kind of addictive activity (e.g., drugs or alcohol, an eating disorder, compulsive exercise, com-

pulsive work, self-harm, etc.) the aim of which is an altered or dissociative state which keeps dissociated that which one dares not experience. At the same time, addictive/dissociative processes serve another, seemingly contradictory, function by allowing the individual to access the needs embedded in the split-off parts of the self. As I wrote earlier in regards to bulimia:

> . . . when the individual . . . begins to experiment with bulimia, the biochemical effects of the binge-purge cycle create an altered state that serves to reinforce the already existing split in the psyche and further organize the dissociated needs into a "bulimic self." The split-off state becomes associated with the bulimia, and the bulimic behavior becomes a way of voluntarily accessing this hidden self. (Sands, 1991a, p. 40).

The addictive behavior also offers some actual gratification of the needs by providing soothing, comfort, etc. The disadvantages of such addictive-dissociative processes, of course, is that they do not "work," because the self-regulatory functions they provide, while often seductively powerful in the moment, are only temporary. As Kohut (1978) said of the addictions, "it is as if a person with a wide-open gastric fistula were trying to still his hunger through eating..." (p. 847). The individual is not satiated; tolerance sets in, and more and more of the addictive activity is required. Most regrettably, the needs which can be truly engaged only through relationship remain split off, unmet, and unintegrated.

THE RELATIONAL FUNCTION OF DISSOCIATIVE DISORDERS

By sequestering early narcissistic needs and affects which are offensive to the MPD child's pathologically-vulnerable caretakers, dissociative defenses serve to *regulate* relatedness to others (Sue Saperstein, personal communication, August, 1991). Paradoxically, multiples take parts of themselves "out of relationship for the sake of relationship" (Gilligan, 1990).

Since a relationship by definition has two parts to it, the dissociation of relational needs works in two ways to regulate and maintain relationship. One way is by changing one's perception of oneself, the second by altering perception of the other. It has been repeatedly noted that dissociation involves a profound alteration of self experience (e.g., Spiegel, 1986; Fink, 1988; Sands, 1991b). The "I " which remains intact when other defenses are employed is not maintained in dissociation, and dissociated content becomes *not me* (Fink,1988). Thus, the traumatic events become *not me,* (as well as *not you*) and, as I have argued above, the early developmental needs for soothing, comfort, protection, admiration etc. become *not me* as well. By removing the offending needs and longings from the experience of self, the dissociative defenses protect the self from the untoward reactions of the other (Stolorow et al., 1987), reactions which, in the case of many of our MPD patients, have the potential to be lethal.

Moreover, when the offending need states are split off from ones central self experience, the *other* is made to look better. The caretaker is "excused" from being asked to meet the child's needs and failing miserably, and the child is protected from his or her disappointment and rage at the caretaker's failure to respond. The child is saying in essence, "Since I don't have needs, you are not failing to meet them." By protecting the other from the needs and affects which are intolerable to the other, the child shores up the functioning of the emotionally fragile caretaker.

All these dissociative maneuvers serve to support, maintain and regulate relationship. The dissociative cleansing of oneself and the other of offending affects and attributes regulates the tenuous connection to the other and allows the child and later the adult to maintain that modicum of relatedness necessary for survival. These positive, relational functions of dissociative defenses have been underemphasized in both the dissociative disorders/trauma and the psychoanalytic literature (Sands, 1991a). Indeed, the metaphors of dissociative process themselves suggest a "getting away from"—dissociating, splitting off, walling off, sequestering—when the ultimate purpose of dissociative defenses is rather a "staying with." The dissociative patient is attempting to stay enough in relationship with the human environment to survive the present while, at the same time, keeping the needs for more intimate relatedness sequestered but alive in the hope that they can be awakened at a safer, future time.

TREATMENT

From this perspective of dissociated relational needs, it becomes clear that the healing process can take place only when the patient is able to remobilize his or her sequestered need states and longings. The relational needs, which have existed only in rudimentary, "potential" form, can now become articulated, developed and experienced fully in relationship to the therapist who has become the wished-for object. As the need states and longings are carefully understood and interpreted within the transference, they will be felt more generally and can slowly and painfully become an integral part of the patient's self experience. This process cannot begin, of course, until some semblance of safety and trust has been established, and the patient can dare to hope that his or her most vulnerable and early need states can finally be brought into relationship. The longings will both be experienced and alternately violently resisted vis à vis the therapist, and it is this wrenching conflict around approaching the early relational needs which accounts for much of the harrowing and tumultuous nature of the treatment of MPD.

This certainly does not mean that the remobilization and integration of the early relational needs comprises the entirety of the treatment process. In addition, traumatic memories and affects must be recovered, experienced in the transference, and integrated, the various aspects of the patient's character pathology (notably, omnipotence and sadomasochism) analyzed and worked through, new life narra-

tives and meanings negotiated, etc. But it is well to remember, when one seems to be doing primarily "memory work," that the memories are often in the service of the transference rather than vice versa; that is, the recovery of memories may allow the patient to get closer to or more distant from the therapist, may "test" the therapist's ability to understand and respond to various need states (Sands, 1991b) or may pose any number of other "questions" regarding the relationship.

In my experience, the need states become mobilized alter by alter and only after the individual alters have had a chance to abreact some of their abuse memories. Only then do they become "freed up" to experience their own particular unmet longings for the empathy, soothing, admiration, etc. that they were not allowed to experience as children and which, despite their outstanding imaginative potentials, they have been unable to successfully create within themselves. In other words, each alter must develop a separate and different "transference of need" to the therapist. Revealing these yearnings is frightening and disorganizing in the extreme, for the needs have been so consistently distorted, exploited and rejected by the caretakers that the patient now automatically experiences them as threatening and alienating to others. Herein lies the greatest anguish for these individuals. That which is most fervently yearned for—whether it be empathy, admiration, soothing, or whatever—is also that which is most desperately feared. Understandably, the patient's revelation of the hidden needs and fantasies is slow and excruciating and marked by the greatest heroism.

Analytic treatment is a radically intersubjective process, and, in the case of MPD, it is dramatically so. Patient and therapist are locked in a system of reciprocal, mutual influence (Stolorow et al., 1987), in which each constantly affects and is affected by the other. The patient not only fears that the therapist will become the perpetrator; the patient will inevitably evoke controlling or sadistic responses (hopefully, mostly manageable, useable ones) from the therapist. Similarly–and this is particularly relevant for the current article–the patient will not only yearn for soothing or enhancing responses from the therapist but will inevitably trigger in the therapist such selfobject responses, or the opposite responses of feeling depleted, engulfed or wanting to get away. In short, in a successful treatment, the therapist will alternately be experienced both as the "old" pathogenic object, a source of fear and resistance, and the "new," needed object, the target of one's most profound relational longings (Stolorow et al., 1987).

Moreover, once the needs and longings begin to be felt in all their rawness, the patient then will have to deal with the pain and frustration of reconciling these new felt parts of the self with the realities of the shocking deprivations of the past as well as the never-completely-gratifying realities of the present and future. The patient must also learn to tolerate contradictory affects and needs and thus to hold for the first time the paradoxical tension of opposites in one consciousness (Winnicott, 1971; Schwartz, 1994).

The integration of the split-off rage requires particular sensitivity and restraint on the part of the therapist, for this process can plunge the patient into the depths of suicidality and homicidality and the therapist into a cyclone of countertransference reactivity. The patient who has been brutalized holds within her the extremes of aggression created not only in reaction to abuse but also via identifications with sadistic aggressors, aggressive states which have only been manageable when relegated to certain "hostile" alters. But when these baser, aggressive instincts begin to be interpreted as the patient's own, the patient can feel so shameful, so evil, so sick, so despicable that the only solution appears to be to blot out this intolerable new sense of self through suicide. Moreover, when the therapist confronts the patient's sadism, the patient can experience the therapist as "disarming" him or her and leaving her defenseless, prompting him or her to new levels of sadistic and coercive aggression in a desperate attempt to correct what is experienced as a power imbalance in the relationship. The patient's homicidality may also be transformed into suicidality in an attempt to protect the therapist. The therapist's task often seems to be an impossible one: to acknowledge the patient's rage, hate, revenge, etc., within the therapeutic relationship while not shaming or "disarming" the patient to such an extent that he or she falls into suicidality or homicidality.

In summary, the therapist must be careful to acknowledge, welcome into the treatment and empathize with all the different need/affect states, so as not to replicate the patient's internal politics of exclusion and repudiation (Rivera, 1989). At the same time, the therapist must recognize and hold the essential wholeness (or potential wholeness) of the system. As the patient experiences the therapist's empathy for all the different parts of the self with their attendant need states, she or he will experience increased empathy among the alters, a sharing of their often contradictory need and affect states, and a diminishing of their separateness.

CONCLUSION

Chronic, severe abuse leads not only to the dissociation of traumatic memories and the other sequelae of trauma but to the dissociation of the child's healthy, developmental relational needs and wishes as well. This expanded view of dissociation suggests that treatment must include the remobilization of those early needs and longings of the self within the transference relationship and, ultimately, to their integration into the patient's central self experience. It also helps elucidate how the dissociative defense "takes oneself out of relationship for the sake of relationship" (Gilligan, 1990). By sequestering early relational need states, the dissociative individual takes out of the relationship that which is most offensive to the pathologically-vulnerable caretakers and thus, paradoxically, helps to maintain some modicum of relatedness. ■

REFERENCES

Auerhahn, N., & Laub, D. (1987). Play and playfulness in holocaust survivors. *Psychoanalytic Study of the Child*, 42, 45-58.

Barach, P. (1991). Multiple personality disorder as an attachment disorder. *DISSOCIATION*, 4(3), 117-123.

Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology* 7, (Suppl.), 33-46.

Berman, E. (1981). Multiple personality: Psychoanalytic perspectives. *International Journal of Psycho-Analysis*, 62, 283-300.

Bowlby, J. (1982). *Attachment and loss, Vol. 1: Attachment.* (2nd Edition). London: Hogarth Press.

Braun, B. (1986). *Treatment of multiple personality.* Washington, DC: American Psychiatric Press.

Braun, B. (1988). The BASK model of dissociation. *DISSOCIATION*, 1(1), 4-9.

Breuer, J., & Freud, S. (1953a). Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud*, vol. 2. London: Hogarth. (Original works published in 1893-1895).

Chu, J. (1992). Empathic confrontation in the treatment of childhood abuse survivors, including a tribute to the legacy of Dr. David Caul. *DISSOCIATION*, 5(2), 98-103.

Cole, P. & Putnam, F. (1992). Effects of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, 60(2), 174-184

Davies, J. & Frawley, M. (1991). Dissociation processes and transference countertransference paradigms in the psychoanalytically-oriented treatment of adult survivors of sexual abuse. *Psychoanalytic Dialogues*, 2(1), 5-36.

Fairbairn, W. (1952). *Psychoanalytic studies of the personality.* London: Tavistock.

Fink, D. (1988). The core self: A developmental perspective on dissociative disorders. *DISSOCIATION*, 1(2), 43-47.

Freud, S. (1953b). Fetishism. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud*, vol. 21 (pp. 147-157). London: Hogarth. (Original works published 1927)

Gilligan, C. (1990). Joining the resistance: Psychology, politics, girls and women. *Michigan Quarterly Review*, 29(4), 501-356.

Glover, E. (1943). The concept of dissociation. *International Journal of Psychoanalysis*, 24, 7-13.

Gruenewald, D. (1977). Multiple personality and splitting phenomena: A reconceptualization. *Journal of Nervous and Mental Disease*, 164, 385-393.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Aronson.

Kinsler, P. The centrality of relationship: What's *not* being said. *DISSOCIATION*, 5(3), 166-170.

Kluft, R. P. (1984). The treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America*, 7, 9-29.

Kluft, R. P. (1992). Discussion: A specialist's perspective on multiple personality disorder. *Psychoanalytic Inquiry*, 12(1) 139-171.

Kluft, R. P. (1993). Clinical approaches to the integration of personalities. In R.P. Kluft and C.G. Fine, *Clinical perspectives on multiple personality disorder* (pp. 101-133). Washington, DC: American Psychiatric Press.

Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Kohut, H. (1978). Preface to Der falsche weg zum selbst, studien zur drogenkariere by Jurgen vonScheidt. In P. Ornstein (Ed.), *The search for the self*, Vol. 2 (pp. 845-849). New York: International Universities Press.

Lasky, R. (1978). Psychoanalytic treatment of a case of multiple personality. *Psychoanalytic Review*, 65, 355-380.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *DISSOCIATION*, 5(4), 196-204.

Loewenstein, R. (1993). Post-traumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine, *Clinical perspectives on multiple personality disorder* (pp. 51-85). Washington, DC: American Psychiatric Press.

Main, M., & Solomon, J. (1986) Discovery of a new, insecure disorganized/disoriented attachment pattern. In T. B. Brazellton & M. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Norwood: Ablex.

Marmer, S. (1980). Psychoanalysis of multiple personality. *International Journal of Psychoanalysis*, 61, 439-459.

Peoples, K. (1991). The trauma of incest: threats to the consolidation of the self. In A. Goldberg (Ed.), *Progress in self psychology*, 7, pp. 107-135. Hillsdale, NJ: Analytic Press.

Putnam, F. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality disorder* (pp. 65-97). Washington, DC: American Psychiatric Press.

Putnam, F. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford.

Rivera, M. (1989). Linking the psychological and the social: Feminism, poststructuralism and multiple personality. *DISSOCIATION*, 2 (1), 24-31.

Ross. C. (1989). *Multiple personality disorder: Diagnosis, clinical features and treatment.* New York: John Wiley.

Sands. S. (1991). Bulimia, dissociation, and empathy. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 34-50). New York: Guilford.

Sands, S. (1991, October). *The dissociative disorders: Nature of the self and the transference.* Presented at the 12th Annual Conference on the Psychology of the Self, Chicago.

Schultz, R., Braun, B., & Kluft, R. P. (1989). Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. *DISSOCIATION,* 2(1), 45-51.

Schwartz, H. (1994). From dissociation to negotiation: A relational psychoanalytic perspective on multiple personality disorder. *Psychoanalytic Psychology,* 11(2), 189-231.

Shengold, L. (1989) *Soul murder.* New Haven, CT: Yale University Press.

Smith, B. (1989). Of many minds: A contribution on the dynamics of multiple personality. In M.G. Fromm, & B. Smith (Eds.), *The facilitating environment* , pp. 424-458. Madison, CT: International Universities Press.

Spiegel, D. (1984) Multiple personality as a post-traumatic stress disorder. *Psychiatric Clinics of North America,* 7, 101-110.

Spiegel, D. (1986). Dissociating damage. *American Journal of Clinical Hypnosis,* 29, 123-131.

Stolorow, R., Brandchaft, B., & Atwood, G .(1987). *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, N J: Analytic Press.

Stolorow, R., & Atwood, G. (1992) *Contexts of being.* Hillsdale, N.J.: Analytic Press.

Ulman, R., & Brothers, D. (1988). *The shattered self: A psychoanalytic study of trauma.* Hillsdale, NY. The Analytic Press.

van der Kolk, B. (1987). The psychological consequences of overwhelming life experiences. In B.Van der Kolk (Ed.), *Psychological trauma* (pp. 1-30), Washington, DC: American Psychiatric Press.

Wilbur, C. (1988). Multiple personality disorder and transference. *DISSOCIATION,* 1 (1), 27-31.

Winnicott, D. (1953). Transitional objects and transitional phenomena. *International Journal of Psycho-analysis* 34, 89-97.

Winnicott, D. (1965). Ego distortion in terms of true and false self. *The maturational processes and the facilitating environment* (pp. 140-152). New York: International Universities Press. (Original work published 1960)

Winnicott, D.(1971). Use of an object and relating through identification. *International Journal of Psycho-analysis* , 53, 711-716.

Young, W. (1988). Observations on fantasy in the formation of multiple personality disorder. *DISSOCIATION,* 1(3), 13-19.