

DO YOU KNOW WHAT I KNOW?
EXAMINING THE THERAPIST'S INTERNAL EXPERIENCE WHEN A PATIENT
DISSOCIATES IN SESSION

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There is a story I've been told many times in my life. My mom awakens from a sound sleep with a startle. She sits up in bed and says, "One of the girls is sick." My dad asks, "How do you know?" "*I just know.*" This is the essence of what attunement is. I have known it and lived it long before I knew the word. For this, I am eternally and enormously grateful. It has shaped my life in innumerable ways and made me the social worker, the clinician, and the mother I am today. Thank you to my loving, wonderful, generous parents for teaching me how to be in relationship with clear perception and an open heart.

This dissertation topic is born of pain and love. I have been touched and inspired by the stories of many survivors of grave and early life trauma. I am honored to be with them in both pain and in love. To them, I am deeply grateful for allowing me to enter into the deepest recesses of their minds and hearts and to travel with them to the pain of their traumas and back.

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Many people admonish mothers of a new baby to “sleep when the baby sleeps!” Well, my motto was “write when the baby sleeps!” This would not have been possible without the enormous help from my devoted husband, who did countless loads of laundry, middle of the night diaper changes and trips to the grocery store. You stepped up big time when I needed you and I will be eternally grateful. You have been generous with your love and stingy with your criticism. You are my heart and my home. Without you, none of this would be possible, but with you, anything is.

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ABSTRACT

DO YOU KNOW WHAT I KNOW?

EXAMINING THE THERAPIST'S INTERNAL EXPERIENCE WHEN A PATIENT
DISSOCIATES IN SESSION

Jacqueline Russo Strait, MSW, LCSW

Jeffrey Applegate, PhD

There is rich theoretical literature that cites the importance of the therapist's use of self as a way of knowing, especially in cases where a patient has been severely traumatized in early life. There is limited empirical research that explores the in-session experience of therapists working with traumatized patients in order to support these claims. This study employed a qualitative design to explore a therapist's internal experience when a patient dissociates in session. The aim of this study was to further develop the theoretical construct of *dissociative attunement* to explain the way that therapist and patient engage in a nonverbal process of synchronicity that has the potential to communicate dissociated images, affect or somatosensory experiences by way of the therapist's internal experience. Findings revealed that therapists have strong emotional and behavioral responses to a patient's dissociation in session, which include anxiety, feelings of aloneness, retreat into one's own subjectivity and alternating patterns of hyperarousal and mutual dissociation. Findings also revealed that the process of dissociative attunement is at play when a patient dissociates in session. The process of dissociative attunement was comprised of seven component parts: Disjunction and Connection, Perception of Nonverbal Cues, Induced Feeling, Therapist as Placeholder, Asymmetry of Roles and Responsibility in the Dyad, Containment, and Therapist Imaginings. Findings imply that a patient's dissociation in session should be

considered an interpersonal phenomenon that holds the potential to communicate important aspects of the patient's affective experience and needs through examination of the therapist's internal experiences.

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PREFACE

Clara: A Mindscape

I entered the cavernous, dark space and was met with four walls, each covered entirely in small scraps of black fabric. The room was empty except for a wooden stool standing in the center of the room, inviting me to stay a while and feel my way through this space. There was loud music playing in another language. The music was overlapping, playing only one verse of one song from several different locations in the room, with the music from each location started at a different time. It was as if a record was skipping, except there were nine records all skipping at different places – each stuck in its own moment of time. The felt experience was that of confusion and panic. Was something coming through the door? Who’s watching me? What’s going to come of me? This is bad. Bad. Bad. I could not catch my breath. There was also sadness, deep sadness, caught in my throat, caught in my eyes. I have to get out of here.

The last thing I noticed in the room was the title and explanation of this art exhibit, hung on the wall. It said: “*A Mindscape. There are gaps in my mind. There are many things I cannot remember and I do not know. When I try to retrieve them, the closest I come is an image of raw red meat and raspberry jam, all mashed together.*”

Such is the internal space of a dissociative mind. Clara, a patient with a history of early and chronic deprivation, neglect and abuse, invited me into this space that she had created as an art exhibit. She called it a mindscape – a landscape into her mind – and shared her wish that I begin to know what it feels like to walk around the world from within her own subjective self. Even now, as I detail my experience living momentarily in her subjectivity, I am aware that my words have failed. There are no words to describe the guttural panic, the dread, and the despair

that lived in that space. Clara was right. The only way I could know what it feels like to live in a dissociative mind was to enter it.

The essence of what trauma is and what it imposes on the body, the mind, and the soul of each of its victims is *unspeakable*. Words always fail to convey the lived experience of terror in the midst of a traumatic event and the despair that it leaves in its wake. And yet, we embark on a journey of words to convey the essence of what happens to a developing child's way of knowing, thinking and relating as a result of exposure to grave and chronic trauma, suffered so early in life. Words, again, will fail us. Thus, I have allowed Clara to tell her story. It is a story rife with images, affect and memories – a story that fills in the spaces of what cannot be uttered aloud. Clara's story represents a composite case example, taken from real stories and clinical scenarios experienced by my supervisees, my mentors and myself. Great care has been taken to protect the identity and privacy of these survivors. An infinite debt of gratitude is owed to them for sharing their stories, both verbally and nonverbally, such that we can know and speak what has heretofore been unspeakable.

CHAPTER I

INTRODUCTION

Problem Statement

Chronic and pervasive trauma experienced early in life leaves an indelible mark on each of its victims. Many of these marks are unmistakable: a stark physical wound, the panic induced by a flashback, the constant expectation of danger, or the extremes of deep depression and rage. Other marks are noted only by an absence, a vague indication that some part of the self or experience is not wholly present. For instance, we cannot know about the gruesome memories stored in the dissociative spaces of the mind, just out of reach of conscious awareness. We cannot speak about the hypervigilant states held in the body, barely kept at bay. We cannot see the life filled with a sense of safety and security that might have been.

Chronic traumatic events that occur early in life, before the development of the left brain structure and the hippocampus, cannot be integrated into narrative memory or encoded as verbally retrievable events or experiences of self (van der Kolk & Fisler, 1995). However, they do not disappear. These traumatic memories and self-states are stored intact as isolated fragments in the earlier-developing right brain, disconnected from the ability to organize or know about one's own experience (Schoore, 2001). These fragments cannot be expressed in words, and often cannot be known in a conscious, verbally know-able way. They live on, though, as static images untethered to memory, behavioral reenactments, unexplained gaps in the mind, or intense affects that both confuse and overwhelm (Davies & Frawley, 1991). The survivor lives on too, but is consumed by this pervasive sense of fragmentation, feeling always at the edge of annihilation of the self. As Clara has shown us, these marks of absence are not wholly absent; they linger like a skipped record – screaming to be heard, but static and senseless, always just out of reach.

The theoretical construct of dissociation captures the essence of what has been lost as a result of trauma. Dissociation in its most basic form describes the compartmentalization of experience and mental contents that would otherwise be connected (Howell, 2005; Kihlstrom, 2005). Dissociation can be understood first as an adaptation to the chronic exposure to extreme trauma, where the mind learns to turn off or disconnect in order to promote survival. This is seen in psychic instances such as trance, experiences of numbness or blankness, depersonalization and derealization, and at an extreme, gross disconnection from self or reality. Dissociation when used as a defense provides a protective cocoon from the horrors of trauma, however it also preserves the intense affects, sensory perceptions, and memories of the trauma that it tries to deflect, intact but separated in the mind (Bromberg, 1998; van der Kolk & Fisler, 1995). When dissociation as a defense is relied upon relentlessly, the result is a dissociative structure of mind (Howell, 2005), alternately called a dissociative personality (McWilliams, 1994). The dissociative mind is rife with vertical splits that hold disparate contents of the mind parallel to one another and yet disconnected, just out of reach of the conscious experience of self in each moment (Herbold, 2000). Dissociation thus offers both the potential to forget and to remember, to not-know and to know, all at the same time.

The process of psychotherapy, which has historically relied upon words, verbal and conscious knowledge, and talking and interpretation, fails to capture what has not been spoken and cannot be known by the patient. In fact, research has suggested that speaking about traumatic memories has the potential to activate implicit memory systems of the patient, leaving him/her feeling scared and unsafe, with no attuned other to regulate this hyperarousal (van der Kolk, 2009). The process of psychotherapy with a survivor of chronic trauma with a dissociative personality structure presents an obvious challenge to patient and therapist alike. The task of

therapy is the integration of mental contents and experiences of self, and yet this task is conceptually at odds with the first aim of dissociation: to escape and to not-know. The process of psychotherapy must access these dissociated and yet preserved memories and experiences of self and welcome them into the intersubjective space of the therapy dyad.

Current thinking in the field of relational psychoanalysis, particularly relational analytic trauma theory, suggests that the only way to access dissociated content is by way of the intersubjective therapeutic relationship, and more specifically, the therapist's internal and subjective experience of the patient. It is widely recognized by psychodynamic theorists today that the therapist's reactions to the patient, including his/her own internal and affective responses commonly called countertransference reactions, represent an important pathway to understanding an emic perspective of the patient's life or internal experience (Dalenberg, 2000; Maroda, 1999). Relational analytic trauma theorists apply this belief to trauma work, and are even more specific in their claim. They suggest that it is *only* through the intense scrutiny of the therapist's internal experience, reactions, affects and behaviors in session with a patient with an early trauma history that dissociated experience can become known by either partner in the therapy dyad (Bromberg, 1998; Davies & Frawley, 1991; Stern, 2010). These theorists suggest that as the therapist engages interpersonally with the patient, dissociated aspects of the patient's self will become enacted in the therapy relationship, and then be available for formulation in the mind of the therapist. It is clear that the internal experience of the therapist represents a crucial means to access, know and contain otherwise inaccessible and unknowable parts of the patient's self. What is less clear, however, is the process of *how* this implicit, nonconscious attunement to the dissociated aspects of the patient's self unfolds in each therapy session.

One recent theorist has confronted these difficult questions. Karen Hopenwasser (2008) developed the construct “**dissociative attunement**” to describe the therapist’s nonconscious and psychobiological attunement to the dissociated parts of the patient’s self that become manifest in the therapist’s subjectivity. Hopenwasser begins to parcel out the component parts of dissociative attunement, labeling *empathic attunement*, *dissociative transference* and *affective resonance* as three crucial components of this process. These three components, though, emphasize only the input and the output of dissociative attunement. Dissociative transference and affective resonance are the minimal component parts necessary to initiate a dissociative attunement; the attunement is the outcome. But what happens in the middle? What is the *process* of how dissociative attunement unfolds moment to moment in a therapy session? Answering these questions is critical to applying direct clinical utility to the construct of dissociative attunement, enabling clinicians to actively engage in and recognize the process of dissociative attunement in session as it occurs. A more nuanced understanding of the process of attunement to the patient’s dissociated self-states as it manifests in the internal experience of the therapist is needed to refine the theoretical construct of dissociative attunement and then assess its utility in the therapeutic relationship.

Despite the rich theoretical literature expounding the nature of intersubjective communication in the therapy dyad and the importance of the therapist’s use of self as a way of knowing, very little *empirical* research has been conducted on the inner experience of the therapist in session in order to support these claims. Further, there is no empirical research that explores the in-session experience of therapists working with patients with a dissociative mind, despite the widely held belief that such patients are thought to communicate largely by way of transference and countertransference in nonverbal and nonconscious ways. Empirical studies are

needed to examine the in-session experience of therapists confronted with patients with a dissociative mental structure in order to understand the way that dissociated content is communicated intersubjectively in the therapy dyad. An iterative process of comparing this empirical data to existing case studies and theoretical claims will make an important contribution to refining and advancing the construct of dissociative attunement.

Purpose of Study

Dissociative attunement as a theoretical construct has the unique ability to emphasize and bear witness to the silenced memories of trauma that the social work profession has long fought to uncover and confront. An exploration of how dissociated content and parts of self are communicated nontraditionally and nonconsciously inherently acknowledges those “marks” of trauma that are less visible, enabling both partners in the therapy dyad to give voice to the suffering parts of the self that have heretofore been unbearable and unthinkable. As a result, this inquiry furthers social work’s macro commitment to justice for survivors of grave trauma, while enhancing social work’s clinical commitment to the worker’s use of self in the therapy dyad. Finally, this inquiry will translate esoteric concepts from psychoanalytic literature into a practice concept relevant to clinical social workers.

The primary aim of this inquiry is the further elaboration of the theoretical construct of dissociative attunement to capture the nature of the therapist’s in-session internal, symbolic and subsymbolic process of attunement to the patient’s dissociated aspects of self. This inquiry will explore how dissociated content is communicated intersubjectively in the therapy dyad by way of exploration of the therapist’s inner experiences in a therapy session with a patient with a dissociative structure of mind.

CHAPTER II

LITERATURE REVIEW

Trauma and Dissociation

We sat for what seemed like a very long time. Clara asked if she could draw. I handed her a sketchpad and she took out several colored pens. She proceeded to sketch a scene that I later learned was an image from her own memory. She drew a little girl's bedroom. There was a small bed and an even smaller girl on the bed. The girl was wearing a yellow nightdress. Clara then drew a very big man hovering over the small girl. The outline of this big man was dark, drawn in black ink, and colored in deeply and darkly, likely emphasizing the aggression in that little girl's room. Then, Clara drew another little girl wearing the same yellow nightdress as the little girl on the bed. This second little girl, however, was on the ceiling, floating above the bed and watching the gruesome scene below. When I asked Clara to help me understand her drawing, she explained, "There were two of me. That's how I survived. There was the me that was getting raped by my father, and then there was the me that was safe, floating on the ceiling. I used to feel like I was watching IT happen to someone else. I felt bad for that little girl, but she wasn't me. This is the me (pointing to the little girl floating on the ceiling) that survived."

Trauma

Trauma is understood as a terrifying or horrifying experience in which the experience itself or the intense affect engendered threatens psychological survival (Howell, 2005). By definition, trauma overwhelms the human ability to adapt and thus resists integration into conscious experience. This is evidenced first in the acute and biological experience of a trauma, in which energy and attention are directed away from the processing of experience or the ongoing maintenance functions of the brain and body. The amygdala, the emotion-processing

center of the brain, becomes overstimulated and the intensity of the affect registered in the limbic system triggers the autonomic nervous system in the direction of fight, flight or freeze (Bloom & Farragher, 2011; Erskine, 2008). The sole endeavor becomes survival. When the exposure to trauma is acute and short-lived, the intense affect generated in response to the trauma promotes this survival; it motivates the victim to resist danger, or when all else fails, get out of harm's way. When the exposure to trauma is repeated, however, the victim learns that despite how hard she fights, she will never win, and no matter how fast he runs, he cannot flee. The trauma is relentless and leaves the victim with nowhere to escape to and no place to hide. The intense affect generated in response to the trauma cannot be expelled by fighting or fleeing; it, like the victim, remains frozen. There is no resolution of the affect, no final escape and no end in sight.

This kind of repeated and relentless exposure to trauma is referred to as chronic or “big T” trauma. When this trauma occurs in the context of interpersonal relationships, particularly relationships with important others that are relied upon for safety and comfort, it is known as relational trauma. Judith Herman, considered one of the foremost experts in trauma treatment, refers to single incident exposures to trauma from the natural world as *disasters*, but reserves the term *atrocities* for relational traumas, those acts of violence imposed by a fellow human being (Herman, 1992, p. 33). Using the language of atrocities candidly conveys both the brutality and the destruction that survivors of chronic relational trauma – children exposed to the overwhelming force or aggression of a caregiver – contend with so early in life. Such children are presented with a daunting conundrum. The person who is meant to provide comfort and security is the very person imposing the trauma, or minimally, failing to protect the child. The abuse calls into question the primary attachment relationship, leaving the child with no sense of security and no secure base (Davies & Frawley, 1994). The child is left alone with states of high

emotional intensity and few functions, internally in the self-structure or externally in relationships, to regulate them.

Elizabeth Howell (2010), a traumatologist, describes how the child adapts to his/her experience of this overwhelming, chronically aroused affect:

A traumatically abused and terrified child may deal with overwhelming affect and pain by distancing herself from the experience to such a degree that she dis-identifies with the experiences and becomes an observer (rather than an experiencer) of the event. In this depersonalized state, she then pseudodelusionally views this as happening to another child. This ‘other child’ then ‘holds’ the affects and memories that would be unbearable to the host, thereby protecting the host from being continually overwhelmed and safeguarding the ability to function. (p. 84)

This adaptation promotes survival, and yet it comes at a cost. As Clara’s drawing has suggested, one part of the self, in her case the little girl on the ceiling, lives on, but is always haunted by the “other child”, the little girl on the bed, who carries the visceral memories of the trauma, gruesome images in her mind, and the overwhelming horror. Bromberg (1998) terms the experience held by the “other child” *traumatically unbearable mental states*. He explains:

For these individuals, inadequacy of early object relationships has so seriously impaired the normal development of tension-reducing mental structure that certain constellations of presymbolized experience too intense to be cognitively processed by the forming self were forced to be retained as *traumatically unbearable mental states* [emphasis added] that were then dissociated to whatever degree possible to preserve other areas of adaptive functioning and sometimes sanity itself. (p. 132)

When the child cannot fight and cannot flee, she freezes. Yet this is not precise enough: a *part* of her freezes, the part that holds the *traumatically unbearable mental states*, while another part lives on.

The Neurobiology of Trauma

Recent advances in infant research and neurobiology help clarify how this affective intensity is registered in the brain and how this is connected to the process of dissociation and freezing. Research by Perry, Pollard, Blakely, Baker and Vigilante (1995) suggests that an infant's psychobiological response to trauma consists of two alternating patterns of response: hyperarousal and dissociation. When a threat is registered, the autonomic nervous system is triggered, causing the maintenance functions of the brain and body (the parasympathetic nervous system) to pause, and the fight or flight responses of the brain and body (the sympathetic nervous system) to be activated. This results in increases in heart rate, blood pressure and respiration, increased blood flow to the muscles, and a state of hypervigilance (Schoore, 2001). When this state of hyperarousal persists without any successful attempts to soothe the distressed child, the second response pattern to trauma, dissociation, becomes activated. Schoore (2001) describes this as a "primary hypometabolic regulatory process" in which the child withdraws into him/herself, loses postural control, and attempts to conserve energy by freezing and feigning death. Schoore (2001) explains, "It is this parasympathetic mechanism that mediates the 'profound detachment' of dissociation" (p. 211). In this neurobiological state, endogenous opioids are increased, which numb pain, inhibit mobility and deactivate cries for help (Schoore, 2001). This dissociative state, which includes freezing, affective numbing and avoidance, promotes survival, however it blocks the developing motivational systems intended to cope with stress, elicit help, and deactivate hyperarousal (Gill, 2010). The child cannot rely on normal regulatory functions to down-regulate

affect or self-soothe, and thus despite the presence of a dissociative state, the hyperarousal persists. The states alternate nearly simultaneously and remain activated concomitantly. Schore (2001) explains, “In the traumatic state, and it may be long-lasting, both the sympathetic energy-expending and parasympathetic energy-conserving components of the infant’s developing ANS (autonomic nervous system) are hyperactivated” (p. 212). The child might appear numb or frozen, but remain affectively aroused, or might appear with states of intense affect that are seemingly untethered to understanding or memory.

The dual processes of hyperarousal and dissociation also appear to play a primary role in the encoding, storage and retrieval of traumatic memories (van der Kolk, Hopper & Osterman, 2001). During a traumatic experience, intense affect is registered in the amygdala, but such unusually high levels of activation of the amygdala hamper hippocampal functioning (Applegate & Shapiro, 2005). Van der Kolk, Hopper & Osterman (2001) describe the impact of this hippocampal failure:

Sensory imprints of experience are stored in memory, but because the hippocampus is impaired in its integrative function, these various imprints are incompletely unified into a whole. The experience may be laid down, and later retrieved, largely or primarily as isolated images, bodily sensations, smells and sounds that feel alien, and separate from other life experiences. (p. 28)

As a result, memories of a traumatic event are famously affective and sensory based, experienced in raw sense perceptions as opposed to organized, verbal narratives (van der Kolk & Fisler, 1995). For some traumatized people, there may be no explicit recall of the traumatic memory whatsoever; instead the memory may be stored only an implicit level. The affective and sensory

memory of the trauma persists, but remains unintegrated and unattached to autobiographical narrative or communicable language.

Dissociation Defined

“It’s cold in here,” Clara said as she clutched her shivering body. “It smells damp, and my bones feel cold.” “My back is aching. What is happening to me?” Clara asked, terrified of the visceral, somatic states in her body. This came after she described a particularly horrifying experience of being gang raped in the dark, damp, and cold basement of an apartment complex where she used to live. She told the story in a disconnected, emotionally numb state. She denied any experience of horror or terror in this instance, but her body held the truth. The somatic state, when it appeared, was wholly confusing and unrecognizable to her. It was not connected to a memory or a self-experience. It came seemingly out of the blue to replicate the original experience of powerlessness and fear that first evoked this response. What Clara’s body felt and remembered, her conscious mind could not bear.

Judith Herman suggests in the opening paragraph of her widely praised trauma book, “The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable” (Herman, 1992, p. 1). The banishing act that Herman alludes to is understood in clinical contexts as dissociation. Dissociation as a construct is somewhat elusive; it refers to both an active process of defense, as well as a state of mind (Howell, 2005). In the most basic terms, dissociation refers to a rigid separation of parts of self or experience, including separation or splits between thoughts, consciousness, affect, memory, identity, behavior or perception (Cozolino, 2002; Howell, 2005). In dissociation, the typical associative and integrative functions

of the mind fail. This leaves certain constellations of experience “banished” from consciousness. While this construct sounds similar to the process of repression, repression implies a horizontal split where there is a single barrier between conscious and unconscious. Dissociation, on the other hand, implies a vertical split; contents of the mind exist in separate but parallel form, and function independently without knowledge of the existence of the other part(s) (Davies & Frawley, 1994; Herbold, 2000). Certain parts of the mind are banished from the day-to-day conscious experience of self, but they do not vanish. Chefetz (2010) explains that dissociation does not put parts of experience “in orbit, completely isolated from reach,” rather, “dissociation is an odd binding-disruption where the ‘tag ends’ of what ought to match are held in close proximity, but outside awareness, procedurally” (p. 233). Dissociated states operate in alternating fashion, emerging under different internal or external circumstances to behave, feel and remember in unique ways (Davies & Frawley, 1994). Often, these dissociated states can be felt or sensed, but not seen or known.

This contradictory mental function often grows from a contradictory beginning. Dissociation is highly correlated with experiences of pervasive trauma, particularly chronic relational trauma early in life (McWilliams, 2011). In this case, the child has to learn to maintain an ongoing relationship with a caregiver who is both violent and frightening, but also much needed and likely loved. Dissociation enables this contradiction (Howell, 2005). Research by van der Kolk et al. (1996) has found that those who have suffered interpersonal trauma have more dissociative symptoms than do victims of natural disasters, and those who have suffered interpersonal trauma as children have more dissociative symptoms than those who have suffered interpersonal trauma as adults. This link between trauma and dissociation is so convincing that Howell (2005) has described trauma as *the event that causes dissociation*.

During an acute experience of trauma, dissociation first is relied upon as an active mental process or defense mechanism to tolerate the overwhelming fear, pain or anger in response to traumatic force. Dissociation as a mental process most closely resembles the neurobiological process of dissociation as a “primary hypometabolic regulatory process” (Schore, 2001) described above. When the trauma that is occurring is too much to bear, the individual enters a detached, trance-like state. People commonly refer to this in everyday language as “zoning out,” going into “neutral gear” or “spacing out.” Clinically, we refer to such processes as psychic numbing, dissociative amnesia, depersonalization, and derealization and identity fragmentation. In each of these manifestations of dissociation, there is a turning away from external reality and an intense, gripping focus on the internal world. Howell (2005) explains, “People may at the moment of trauma narrow the window of consciousness and calmly, perhaps even dreamily, adapt to the immediate situation confronting them” (Howell, 2005, p. 24). For a chronically traumatized child, this is highly adaptive. Dissociation can protect the abused child by allowing him/her to separate the lived experience of the self from the experience of the self that is being traumatized. This separation persists, too. The self that was traumatized is relegated to a dissociated state of “not-me.” However, the dissociated part will not allow itself to be completely forgotten. Bromberg (2011) explains that dissociation produces “relative amnesia for perceptual memory of past trauma but [leaves] bodily and affective memory intact, often horrifyingly intact” (p. 5). While the intention of dissociation as a mental process is to preserve continuity of the self and prevent fragmentation in the midst of overwhelming trauma, the outcome of dissociation is a hidden, but pervasive, fragmentation. There may be an apparently healthy ego, free of traumatic affect, that moves about the world, but the traumatized person will be haunted

in ways beyond her conscious comprehension by the perceptual memories and affect that remain, untethered to one another or the self.

When dissociation has been relied upon relentlessly as a defense against chronic trauma, the dissociative mental process becomes a *dissociative mental structure*. Chronic use of dissociation implies a multitude of splits in the personality. Arizmendi (2008) explains:

Dissociation leads to a disconnection between the actual event and its symbolic (verbal) representation. Thus, dissociated experiences are not symbolized and not communicable by ordinary language. When depicted as a ‘healthy adaptive function’, dissociation allows, paradoxically, for the intactness and coherence of one’s self. Under extreme conditions such as those associated with trauma, however, it can evolve from a normal process into a defense in which the person becomes ‘not me’. (p. 444)

Here, Arizmendi describes how a chronically traumatized person is unable to experience alternating states of being simultaneously or to articulate certain aspects of experience verbally (Arizmendi, 2008; Stern, 2010). Alternate states of consciousness, memory, affect and identity are left unintegrated, and the person is left with no sense of continuity, or as Winnicott describes it, the experience of “going on being” (as cited in Abram, 1996, p. 261). This separation is not maintained simply due to habit or convenience; each dissociated self-state becomes defensively and rigidly isolated from the other(s) in the interest of survival. Bromberg (2011) explains, “When the normal function of dissociation is enlisted as a defense against trauma, the brain uses dissociation to inhibit potentially discrepant views of reality held by different self-states, which, if ‘on stage’ at the same time, would be more than the mind could contain without destabilizing” (p. 4). The survivor develops a phobia of what is known and felt by the other parts of the self (Howell, 2005). This leaves the individual in a constant state of fear and hypervigilance.

Bromberg (2011) explains, “The process of dissociation has now become enslaved to a dissociative structure that takes as its highest priority the preservation of self-continuity through turning the act of living into an ongoing reminder that trauma is always waiting around the next corner and that it will be more than the mind can handle” (p. 5). This dissociative mental structure is overwhelmingly consumed by the task of keeping parts of self and experience rigidly intact and yet out of awareness; there is no room for one’s imagination to run free and consequently, a restricted ability to play (Stern, 2010). There is an internal sensation of dead spots, or alternately a sensation of being simultaneously pulled in many different directions (Gill, 2010). There is a dampened capacity for authentic human relating and for self-reflective functions. There is often a chronic feeling of emptiness and fragmentation, and an exasperating feeling of living on the edge of disintegration (Howell, 2005). The dissociative mental structure both protects and preserves the survivor, but at a significant cost.

Dissociative Personality

Several psychodynamic theorists have classified the essence of a dissociative mental structure under the nosological category of a Dissociative Personality (Brenner, 1996; McWilliams, 1994; van der Hart, Nijenhuis and Solomon, 2010). Nancy McWilliams (1994) was one of the first psychodynamic theorists to include Dissociative Personality as a discrete category of character structure and diagnosis. The primary feature of this character structure, according to McWilliams, is the tendency to deal with stress by using dissociation as a defense. This manifests in a self-structure that has been fragmented into partial selves, each responsible for particular self-functions. McWilliams considers a dissociative personality to be almost always provoked by severe and ongoing abuse in childhood, usually sexual abuse, which includes the bodily experience of extreme pain or confusing sexual arousal. She adds that the

child who goes on to develop a dissociative personality has likely been overwhelmed with affect in his/her early life, and has had no help processing, containing or learning to manage such intense affect. The parent in this scenario both abuses the child and then fails to help him/her understand the nature of what he/she has been through. The child has virtually been left alone in a state of extreme hyperarousal – what McWilliams (1994) describes as “primordial terror and horror” (p. 329). Further, McWilliams describes the double bind the child is left in when a parent abuses a child and then acts as if the abuse has not occurred, and expects the child to do the same. “There is often a kind of systemic family collusion to deny feeling, to forget pain, to act as if the horrors of the preceding night were all imaginary” (McWilliams, 1994, p. 333). The use of dissociation in such a context is adaptive, and becomes rewarded by the family who likewise conspires to not-know. The perpetual reliance on dissociation then becomes rigidified into a personality.

Ira Brenner is another analyst who has taken up the construct of a dissociative personality, what he calls a dissociative character (Brenner, 1996). His conceptualization of a dissociative character structure also posits a history of early and severe trauma that elicited dissociation as a defense against overwhelming pain. He considers dissociative characters to occur on a continuum, with a mild hypnoid state on the healthier end to Dissociative Identity Disorder on the more severe end of the continuum (Brenner, 1996). Like McWilliams, Brenner suggests that regardless of where a person with a dissociative character falls on this continuum, there is a chronic turning towards the inner world in search of comfort and soothing. He too argues that when dissociation as a defense against severe trauma is relied upon relentlessly, it becomes embedded into the personality.

In more recent years, The *Psychodynamic Diagnostic Manual* has categorized dissociative personality as a separate diagnostic entity (PDM; PDM Task Force, 2006). According to the PDM, dissociative personality is characterized by using dissociation as the primary adaptation to stress, and by pathogenic beliefs about the self, including that the self is weak and vulnerable to attack from the outside. A dissociative personality is thought to result from a constellation of pervasive abuse in childhood, usually by a primary caregiver, the constitutional ability to go into a trance, and the lack of opportunities to process traumatic experiences in a narrative, connected to feelings. This inability to process grave traumatic experiences leads those with a dissociative personality to be preoccupied by the conflicting needs to acknowledge and process the trauma on the one hand, and to disavow and deny the trauma on the other.

Theorists outside of the psychoanalytic model have developed parallel models of a dissociative personality. For instance, van der Hart, Nijenhuis and Solomon's (2010) theory of the "structural dissociation of the personality" represents a hybrid theoretical model that relies on the supposition that a dissociative mental structure is a universal response to traumatization. They explain that when people are exposed to trauma, the task is to process the traumatic event in a way that includes integration of bodily sensations, visual and auditory perceptions, emotions, and thoughts in order to create a coherent narrative. The person then must understand that the event happened to him/her (termed personification), and that the event happened in the past (termed presentification). When there is a failure in this process, the survivor is then and only then said to be traumatized. Van der Hart, Nijenhuis and Solomon's theory of the structural dissociation of the personality contends that all such defined traumatized people rely on dissociative processes. They explain, "It is a theory that accounts for the whole range of

traumatization and related degrees of dissociation of the personality. This implies, among other things, that not only the DSM dissociative disorders but all trauma-related disorders, including posttraumatic stress disorder as the most simple one, are recognized as being dissociative in nature” (van der Hart, Nijenhuis & Solomon, 2010, p. 77). They describe a detailed process of dissociation that occurs in response to a trauma that is not integrated nor understood as having happened in the past. The survivor’s personality is divided into two or more dissociative subsystems – parts that function autonomously and are closed off from one another. They label the first of these dissociative subsystems the Emotional part of the Personality (EP). This part of the personality lives in what van der Hart, Nijenhuis and Solomon (2010) call “trauma time”, experiencing the trauma always in the present, including an acute experience of the intense affects, needs, motivations and physical sensations associated with the original trauma. The other part of the personality is called the Apparently Normal Part of the Personality (ANP). This is the part of self that moves about the day-to-day world, going to work, taking classes, and likely showing up for therapy. The ANP experiences the EP as ego-dystonic, and attempts to avoid the traumatic material and often any inner experience at all costs. While the EP might present with flashbacks, nightmares, and highly emotional reenactments of the original trauma, the ANP presents with symptoms such as depersonalization, derealization, amnesia, or numbing. Van der Hart, Nijenhuis and Solomon (2010) suppose that this splitting of the personality occurs universally as a response to traumatization, however they also demarcate varying levels or intensities of the structural dissociation of the personality, with more severe dissociation related to more chronic trauma. Where there is more severe structural dissociation of the personality, such as in DID, there are multiple EPs along with the one ANP. Van der Hart, Nijenhuis and Solomon clarify that the survivor must employ ongoing mental and behavioral avoidance

strategies in order to maintain this dissociative personality structure and thus prevent the ANP from knowing potentially unbearable memories, experiences of self, and realizations about others. This dissociative structure preserves the functioning of the apparently normal part of self, but prevents the integration of the trauma – the very process needed to loosen the grip of the structural dissociation of the personality and cast away dissociation as an unneeded defense, once and for all.

Dissociation as a Mental Disorder

The construct of a dissociative personality is distinct from the way that dissociation is used and understood by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). The DSM includes five discrete categories of dissociative disorders: *Dissociative Amnesia*, the loss of autobiographical memory for certain events; *Dissociative Fugue*, amnesia for a part of one's life, loss of personality identity and physical relocation; *Depersonalization Disorder*, the experience of self as changed or no longer real, *Dissociative Identity Disorder*, the experience of two or more distinct identities, called host personalities or alter egos, that alternate in having control over conscious thought and action; and *Dissociative Disorder Not Otherwise Specified*, defined as some symptoms of dissociative disorders but not reaching the qualifications for any of the above diagnostic categories (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000; Kihlstrom, 2005).

While the DSM considers only five categories of dissociative disorders, recent trauma theorists have begun to speculate that dissociation as both a defense and mental structure plays a large role in many trauma-related and personality disorders, including Borderline Personality Disorder (BPD), Antisocial Personality Disorder and posttraumatic stress disorder (PTSD)

(Bromberg, 2011; Herman, 1992; Howell, 2005; Stein, 2010). Bromberg (2011) takes this supposition even a step further, and suggests that dissociative processes are the basis for *all* personality disorders. He explains, “It is this early warning system [dissociation] that, regardless of diagnosis, I believe accounts for most of what makes us experience certain patients as difficult, and it is also the cornerstone of all personality disorders” (Bromberg, 2011, p. 179). Bromberg considers the formal DSM dissociative disorders to be a “touchstone” for understanding all personality disorders, regardless of type.

Underlying this supposed relationship between dissociation and personality disorders is the assumption of dissociation occurring on a continuum from normative to problematic to pathological. Dissociative mental processes are more severe and rigid in DID and exist to a lesser extent in personality disorders, such as BPD, and trauma-related disorders such as posttraumatic stress disorder (Herman, 1992; van der Hart, Nijenhuis and Solomon, 2010). On the far end of the continuum are normative dissociative processes, including common and mostly benign occurrences of spacing out, daydreaming, or so-called highway hypnosis (Hartocollis, 2008). Bromberg (2011) argues that dissociation is a “normal hypnoid capacity of the mind” (p. 178), necessary to manage the overwhelming number of daily stressors that make contact with the brain. Howell (2005) makes a bold argument, noting, “In my view, DID is simply an extreme version of the dissociative structure of the psyche that characterizes us all” (p. ix). In this purview, dissociation is not just a form of psychopathology, but an essential mental function, and perhaps a major organizational property of the human mind.

Multiple Self States Model of Mind

The Multiple Self States Model of Mind (MSSM), initially articulated by Ryle (1997) as a model to understand BPD, furthers this notion of dissociation as a basic mental function. The

MSSM suggests that the mind is organized around dissociative shifts between self-states, and that self-states explain the nature of what is dissociated in psychopathology, particularly personality pathology and disorders of the self. According to this model, self-states imply a mental state that includes a unique constellation of symptoms, affect, memory, cognitive capacities, and particular role expectations. Further, this model of self-states is inherently dyadic. Included in each self-state is what Ryle (1997) calls a reciprocal role – an accompanying set of expectations for how an engaged other will respond to the unique self-state that one embodies at a given time. Ryle (1997) goes on to describe common self-state dyads seen in trauma, including the abuser-victim, and the idealized caretaker and perfectly cared-for possessor. In BPD, he posits that these self-states are partially dissociated; there is not total amnesia between states, but instead some impaired memory and often rapid and uncued shifting between self-states. In dissociative pathologies, there is more amnesia and little to no connection between self-states.

Bromberg (1998; 2011) likewise argues for a model of mind that is inherently dissociative. Although he does not explicitly espouse the MSSM model, he uses the language of self-states and dissociated self-states to describe dissociation as a norm and a necessity in mental functioning. He argues for the need for multiplicity, that is, that humans need to subjectively experience themselves as one self while actually being many. Dissociation then helps preserve this illusory perception of being one self, such that we can move about the world feeling whole. In this model, mild dissociation, or according to Stern (2003) *dissociation in the weak sense*, is a normal function to provide a subjective sense of consistency between different self-states. The result is a mind made up of a proliferation of self-states, different ways of being and engaging in the world that do not manifest simultaneously. In healthy development, these multiple self-states should be separate and yet accessible on command. They should have a fluid dialectic between

them and create a coherent, integrated configuration of unique but consistent and accessible self-states – essentially different experiences of self, but all accessible to one another, equally real, and experienced as fundamentally the same “me.” Switches between self-states should be flexible responses to changes in the external environment or strains of living, not emergency responses that are uncued or unconscious.

Dissociated Self-States

The nature of early trauma disrupts this dialectic between self-states. Howell (2005) explains “This illusion of unity [between self-states] . . . cannot be maintained under the press of psychological trauma, which is so cognitively and affectively overwhelming that information cannot be adequately symbolized, or schematized in a unitary fashion” (p. 103). In this case, dissociation moves in to “hypnoidally unlink” (Howell, 2005, p. 103) incompatible experiences of self, and self-states become severed from one another. A piece of the traumatic experience that may be too overwhelming or horrifying to bear is warded off from the functioning self and established as a “separate psychic state within the personality” (Davies & Frawley, 1994, p. 62). This dissociated self-state, as compared to the rest of the personality, emerges under wholly different contexts, and as such, is not associatively available to the rest of the personality. While there is no cognitive or conscious knowledge of what is held in a dissociated state, Davies & Frawley (1994) argue:

The adult survivor of childhood abuse will experience the dissociated traumatic states in the form of memories of the trauma that are unavailable at other times; recurrent intrusive images connected to the trauma but otherwise unrecognizable; violent or symbolic acting out; inexplicable somatic sensations; recurrent nightmares; anxiety reactions; and psychosomatic conditions. (p. 63)

A person who suffers with dissociated self-states might also experience rapid shifts in affective state that seem untriggered and difficult to understand. She might feel that her emotions are uncontrollable, or alternately, she may feel unreal or empty (Ryle, 1997). Some states are experienced with seemingly automatic behaviors, including feeling compelled towards self-harm, aggression towards others, compulsive compliance, or emotional distancing. While all of these clues exist, pointing the way towards the reality of the trauma held and known by the dissociated state, each dissociated self-state continues to function mostly autonomously, unaware of the existence of the others.

These dissociated self-states also unknowingly maintain one another. Switches between self-states occur automatically, often outside the awareness of the survivor, and thus leave little room for dissociated information to become known or new relational models to become integrated. Ryle (1997) explains, “Dissociation is persistent because, at the point when procedural revision might occur, state switches intervene and feared memories remain unassimilated and inadequate procedures remain unrevised” (p. 85). The process of dissociation is thus self-reinforcing. It keeps what is relegated to dissociated self-states from integration into the rest of the self. Stern (2010) describes the urgent and yet unconscious need to keep these parts of self severed from one other as “a separation motivated by an unconscious discomfort, or even a sense of doom or dread, about certain kinds of experience being simultaneously known, sensed, or felt” (p. 50). Such a dire, rigid and self-reinforcing separation between self-states leaves us with questions about how the content of these dissociated self-states can become known.

Unformulated Experience

Further complicating the separation between self-states is the nature of how information is encoded into dissociated parts of self. Stern (2003) conceptualizes the nature of what is held in the dissociated self-state as neither repressed nor processed. Instead he names the experience of the dissociated self-state *unformulated experience* – that which has not been symbolized by thought or language and is not yet knowable. The experience is not able to be reflected upon without threatening the integrity of the self, and so continues to exist by way of unformulated experience, cut off from the experience of “me” in order to survive in a dissociated self-state – “not-me”. Herein lies the ultimate irony facing those survivors of grave and early trauma that rely on such dissociative processes in order to survive – the very mental process that has successfully preserved them also keeps them prisoner to the trauma. They cannot access or “know” what is held in those dissociated self-states, and yet they cannot escape it either.

The goal of treatment with survivors of chronic relational trauma who rely on perpetual dissociative processes is integration – achieving once again the illusion of one unitary self with volitional access to other self-states such that they are both within one’s reach and within one’s control (Davies & Frawley, 1991). Chefetz (2010) explains that the mind adaptively searches for this, noting “Our minds seek coherence when there are fragments and raw chunks of our lives that are un-tethered to our personal narratives of living, dissociative living, implicit in its quality” (p. 230). Winnicott has suggested that this felt sense of integration and coherence lies at the heart of what it means to be in relationship. “To be known means to feel integrated at least in the person of the analyst [mother] . . . [A]n infant who has had no one person to gather his bits together starts with a handicap in his own self-integrating task, and perhaps he cannot succeed...”(as cited in Herbold, 2000, p. 65). The task of the clinician in therapy, then, is to help

the patient “gather his bits together”, holding them in mind simultaneously with the sense of being one unitary being. How can the clinician gather bits that are dissociated? That is, how can the clinician come to know the dissociated parts of the patient’s self? How can these parts be contained, formulated and the integrated into the treatment and thus into the patient’s experience of self? These are crucial questions that must define work with survivors of chronic relational trauma, such that these patients might begin to feel integrated in the person of the therapist and maintain once again, or perhaps for the very first time, the illusion of unity and felt coherence, the experience of being whole.

Relatedness and Dissociated Self-States in Psychotherapy

Clara presented on time for her usual session. She looked unusually sad. I was listening to her describe how her mood has worsened in the last week. She began to detail what she was experiencing, but it felt like nothing was happening. I couldn’t find her. I’m not sure what happened next, but suddenly I realized she was talking and I appeared to be listening, but I had no idea what she was saying. I had gone into a trancelike state. When I “came to,” I was aware of feeling lost and intensely disconnected from Clara. She continued to speak, though, as if unaware of my presence or absence. Then I heard her. Or more accurately, I found her. She was describing a longing to “just disappear.” She talked about a fantasy of walking away. When I asked her where she would go, she said she didn’t care. She hoped to walk with no particular destination in mind. She imagined herself walking into a forest, moving deeper and deeper within, and thus becoming more and more disconnected from the reality of her day-to-day life. She hoped to find a stream and wade in. She described her wish to be taken away by the water, to “float away” and “to disappear.” She seemed to wish that the water would drown out the

noise and the pain of her world. In her wish, the water would envelope her in a protective cocoon, both allowing her to live but without having to feel herself living. I realized suddenly that my trancelike state provided me with my own protective cocoon. And yet, it did not just protect me from the despair she was sharing, it also helped me to know it from the inside out. What was evoked within me was the closest I could come to understand what was within Clara.

Patients with a chronic trauma history and dissociative symptoms often communicate in what has been called “primitive” or implicit ways (Baker, 1997). Despite the effort and energy exerted in keeping certain parts of self and experience out of awareness, patients with a chronic trauma history have an urgent need to “share their minds with other minds in order to re-enter the stream of unconscious processing and ‘unfreeze’ their traumatic experience” (Sands, 2010, p. 365). There is a desperate need for an attuned other to know what is held in dissociated parts of the mind, and yet to do so would catapult the survivor of chronic trauma into the heart of his/her core dilemma between knowing and not-knowing, me and not-me. Further, certain parts of self and experience cannot be communicated easily or readily in verbal language, and thus even if the ambivalence about knowing and not-knowing were resolved, the survivor has no easy way to communicate experience that is by definition unformulated.

This dilemma is best illustrated by an image. Decades of attachment research have suggested that exposure to trauma, particularly trauma imposed by a caregiver early in life, often results in what has been termed a disorganized attachment style (Blizard, 2003; Hesse & Main, 2006). A disorganized attachment style is marked, among other things, by a unique way of approaching and communicating. Research using the Ainsworth Strange Situation experiment has shown that when the mother leaves the room and then later returns, the child with a disorganized attachment style will employ a confused and confusing approach-avoid strategy to

reconvene with the mother, for instance by approaching the mother backwards, literally backing towards her with his/her back first (Hesse & Main, 2006). This evocative image helps to demonstrate the depth of the ambivalence about connecting and communicating that traumatized people experience. While they desperately wish to communicate and connect, doing so activates dissociated states and provokes terror beyond words. The result is a simultaneous approach and avoidance that meets the need both to tell (know) and to not tell (not know) at the same time.

Far into a traumatized person's adult life, this duality of approach and avoidance persists. She continues to communicate her needs and memories in ways that both express and reveal her intentions simultaneously. Standard psychotherapeutic technique has no reliable way to capture such veiled intentions. Traditional talk therapies inevitably fail to acknowledge the patient's subtle attempts at connecting in the therapeutic relationship and neglect to grasp the patient's atypical or "backwards" ways of communicating. In order to help a patient with a severe trauma history and a dissociative mind to achieve an integration of self and object experience as well as a resolution of traumatic memories, the field must radically alter and update the current way we conceptualize *communicating*, *connecting*, *listening* and *tuning in* in the therapy dyad.

Dissociated experience, that which is unformulated and cut off from human relatedness, is resistant to being integrated into psychotherapeutic work. Standard psychotherapeutic technique, including talk therapy, interpretation and empathy, are rendered insufficient. Jody Messler Davies and Mary Frawley (1991) were the first clinicians to suggest that we must enter, rather than interpret the dissociative space of a patient's mind. In a seminal paper on the topic, they "take strong exception" to the classic analytic position of dispassionate interpretation of a patient's urges and impulses. They express concern that "adherence to such standard analytic fare" only fosters the compliance of the apparently healthy ego and inhibits the emergence of the

patient's dissociated states from appearing in the analysis. They explain, "Only by entering, rather than interpreting, the dissociated world of the abused child, can the analyst 'know,' through his own countertransferences, the overwhelming episodes of betrayal and distortion that first led to the fragmentation of experience" (Davies & Frawley, 1991, p. 293). Bromberg (2011) likewise takes exception to the classic analytic stance of interpretation. "The patient is seen not as someone in need of 'insight' that will correct faulty reality but as someone in need of a relationship with another person through which words can be found for that which has no verbal language" (p. 146). Stern, too, believes that unformulated experience must find its home in relatedness. It is only through the relationship with the analyst that dissociated self-states and unformulated experience might become known by both partners in the analytic dyad.

This assumed need for relationality in order to access dissociated and unformulated experience relies on the notion of dissociation as both "dyadically organized and dyadically organizing" (Levenkron, 2009, p. 197). Dissociation as a defense used by a young child first originates from a combination of hyperarousal and the lack of an attuned other to regulate or soothe this overarousal (Forrest, 2001). Howell and Blizard (2009) likewise recognize the etiology of dissociated self-states as a product of severely misattuned caregiver behavior, often considered under the rubric of a disorganized attachment relationship. They contend that the dissociation between self-states evolves from the child's need to separate his/her perception of the caregiver as "good" from his/her knowledge of the caregiver as abusive, depriving or misattuned in some way. Further, they argue that this dissociation between self-states is maintained by the lack of opportunities from caregivers to help the child integrate these fragmented states or experiences of self. Thus, dissociation as a mental process steps in when there is a marked absence of an attuned other; it grows from a failure in relationship. Later,

dissociation between self-states is maintained by, but also *maintains* the lack of opportunities for relational repair. Howell (2005) explains:

Although dissociation may originally have been a way of staying in a relationship, what is most crucially at issue in dissociatively based psychopathology is the collapse of relationality – both interpersonal and intrapersonal (or interstate). Dissociation, as a state of being divided and as a chronic process, is ultimately a barrier to relationality, both within and between selves. (p. 4)

A child who learns to deal with distress by withdrawing continues to withdraw when distressed, thus having limited access to opportunities for dyadic regulation of this affect even when these opportunities might exist. Dissociation, then, both grows from and cultivates a failure in relationality. The relationality must be repaired and revived in order for dissociation to be rendered unnecessary, and for what is dissociated to become known.

The process of psychotherapy presents an opportunity to access dissociated self-states and dyadically regulate traumatic affect, however, dissociation often appears in the therapy room and the therapy relationship, closing down the relational space and forestalling the opportunity for relational repair. For instance, when the reprocessing work of therapy begins and the patient and therapist draw nearer to what is contained or known in the dissociated parts of self, the patient is often destabilized by an intense fear of what is held by the dissociated self-states. The context of therapy itself then can initiate the same processes of hyperarousal and dissociation that were set in motion by the original trauma(s) and are now ingrained in the experience-dependent structures of the brain. “If gently pressured toward a fuller experiencing of dissociated affect, such clients often oscillate between extremes of constriction, numbness, deadness, and detachment from self and therapist, to floods of dysregulated pathogenic affects, including

intense shame, fear, and aloneness” (Lamagna & Gleiser, 2007, p. 36). The numbness and deadness often appear in the therapy room as dissociative trances or gaps in memory. Davies & Frawley (1994) explain, “A patient with dissociated traumatic material begins to ‘space out’ during sessions or describes dissociative experiences that occur between sessions, the therapist notes that the dissociation happens most frequently when certain subjects are raised in session” (p. 94). They then go on to share a case example:

For example, Lorna, whose father abused her for 9 years, presented to treatment with no conscious memories of her sexual abuse. After a few months of therapy, she began to dissociate during session. As time went on, the therapist realized that Lorna consistently dissociated after she mentioned her childhood relationship with her father, her own sexuality, or her current relationships with men. During a dissociation, Lorna’s eyes glazed over, she sat stiffly in the chair, and she was unresponsive to questions from the therapist. When she ‘came back,’ Lorna had no memory of what she had been saying before she dissociated, nor could she describe what happened internally during the period of dissociation. (Davies & Frawley, 1994, p. 94)

When a patient enters this state of trauma, what Gill (2010) has termed “the dead zone,” the normal thinking and reflecting processes shut down. He cannot take in cognitive insights or relationally connect. He cannot communicate in symbols, and thus cannot rely on the symbols of verbal language to obtain understanding or regulation (Davies & Frawley, 1994). And yet, an important moment for relational repair may be missed if the traumatic state is not regulated or the communication is not received. The communication that does or might occur comes only by way of nonverbal and implicit channels in the therapy dyad (Baker, 1997; Bromberg, 2011; Gill, 2010; Stern, 2010).

In the relational matrix, as the patient moves in and out of dissociative moments during the course of a therapy session, the therapist too enters this “dead zone.” He/she is susceptible to concomitant shifts in states of consciousness and emotional tone that often manifest as intense affects, such as sadness or rage, and dissociative moments of feeling dazed or disconnected (Gill, 2010; Howell, 2005). In work with survivors of chronic relational trauma, the therapist often experiences a dissociative countertransference reaction that results from the therapist’s attunement to traumatic affect that is either partially or wholly dissociated and then communicated by way of affective or somatic dimensions. Perlman (2004) describes this attunement to traumatic affect as an intersubjective phenomenon that occurs frequently in work with survivors of chronic trauma, and names this phenomenon “mutual dissociation” (p. 106). The therapist, like the patient, is susceptible to the need to distance oneself from the horrors of trauma that the patient has experienced, including the intense and frightening traumatic affect (Davies & Frawley, 1991). Ogden (1995) refers to this need for distance in the dyad as the ambience of “deadness” (p. 699). There is a subjective sense that nothing is happening, seemingly reflective of a mutual retreat by the patient and the therapist from that which is overwhelming and unbearable – that which compelled the dissociation in the first place.

The evidence of mutual dissociation in work with survivors of chronic trauma suggests that both members of the pair have fallen into the dead zone. But what if the dead zone isn’t dead at all? As noted, attachment research has evinced that survivors of chronic trauma activate processes of approach and avoidance simultaneously. Just as the young child intuitively approaches his mother backwards, satisfying the need to connect and the need to evade the needed and feared attachment figure, this child, now grown up and in a psychotherapy office, must rely on the same dialectical process of connecting and communicating. Likewise, research

on the neurobiology of trauma suggests that traumatized people remain hyperaroused, even when in a dissociative state (Schoore, 2001). This suggests that in the midst of a dissociative field, there are active mental processes occurring, and perhaps veiled attempts at communicating as well.

The dual function of dissociation, to not know while also to keep in parallel but segregated form aspects of knowing, helps to explain this paradox. Like the child in the midst of a traumatic and life threatening event learns to play dead – to dissociate – in order to promote bodily integrity and survival, the mind does the same when confronted with what appears to be a deadly, frightening relational encounter. The result is dissociated communication – communication that allows both partners in the dyad to not-know but in a parallel and segregated form, to know at the same time. Arizmendi (2008) describes this experience of mutual (but active) dissociation in session with a patient who has experienced chronic relational trauma. Despite the apparent feeling of paralysis in the room, he noted,

My sense was that something much more active was present. There was a type of nonverbal communication evolving that constituted a significant part of our work. The sensations of deadness, paralysis, and helplessness likely represented some attempt, on the part of the patient, to describe dissociated states she experienced during the painful traumatic episodes of childhood. (Arizmendi, 2008, p. 446-447)

Davies and Frawley (1991) agree with this supposition that some active kind of communication occurs in the midst of an episode of mutual dissociation in the dyad, and have likened the patient's dissociative experience in session to the way "Freud viewed the dreams of his early analytic patients – as 'the royal road' to otherwise unavailable, split-off experience and memory" (Davies & Frawley, 1991, p. 280). They consider the patient's dissociation to have an intersubjective function in the therapy dyad. The patient is able to communicate safely only from

within the dialectic of approach and avoidance. It is because of the mutual dissociation (avoidance) then, that important affective material can be approached in the dyad.

Relational psychoanalysts suggest that the analyst's subjectivity, including dissociative countertransference reactions, represents both a curious mirror of what is happening intrapsychically for the patient, as well as a crucial and otherwise unavailable form of communication in the dyad (Bromberg, 1998; 2011; Davies & Frawley, 1991; Howell, 2005; Levenkron, 2009; Stern, 2003; 2010). The therapist's attentiveness to the shifts in his/her own consciousness and affective state represent a fundamental part of psychoanalytic listening and knowing, especially with traumatized and dissociative patients. Bromberg argues, "Therapist's private experience becomes the channel through which the patient's full range of dissociated self experiences can first achieve linguistic access" (Bromberg, 1998, p. 199). That is, the therapist attunes to split-off traumatic affect, which then becomes manifest by way of the therapist's internal and subjective experience. Through the process of containing this traumatic affect, and then thinking through and about it, it can become something evolved from but different than the original traumatic experience (Bromberg, 1998). Davies and Frawley (1991) articulate this as such: "Only from within this shared field can the analyst hope to experience, contain, comprehend, and ultimately interpret the fragmented, ever-shifting projective, introjective, counterprojective processes that come, ultimately, to define our most profound levels of participation in the analytic endeavor" (p. 280). Stern more poetically summarizes: "The estranged parts of the patient's self are called out in the experience of the analyst, and it is from there that they are brought home" (Stern, 2010, p. 90).

Despite this widely held notion of intersubjectivity as a form of communication of dissociated self-states, there is very little empirical research to understand how this process

unfolds. What exist now are convincing theoretical arguments with limited case anecdotes, but scant empirical research to understand *how* dissociated content is communicated implicitly in the therapy dyad or how it becomes manifest in the therapist's subjectivity.

The Interpersonalization of Dissociation

I sat with Clara feeling disconnected and in a dreamlike state. I was trying to ward off a deep pull towards sleep. Without any conscious awareness, I looked down into my lap and found myself digging my own fingernails into my opposing hand. This was curious, I thought. I surely was trying to keep myself awake and attentive to Clara's needs. But why in this way? I hadn't found myself doing this in a session before, or in fact, in any context. Without much more thought than this, I blurted out, "Have you ever cut yourself when you're alone in your dorm room?" After a moment of my own intense mortification, my patient came alive again. Out tumbled a wealth of information about her past history of suicide attempts, her intense urges to harm herself when she is alone, and her more recent incidents of cutting her wrists with a scissor to avoid the overwhelming feeling of numbness that she can barely hold at bay. She desperately wanted me to know – to understand and evocatively feel – the depths of her suffering. She just couldn't find the words.

Enactments Defined

“Sometimes, we tell the story of the unbearable, the incoherent, with action. Perhaps at those times it's the only way we stand a chance of knowing what part of our mind can't bear to know, or is forbidden to know, but otherwise already knows, and in great detail” (Chefetz, 2010, p. 226). Chefetz speaks of the widely espoused belief held by relational analysts that what is unbearable and unspeakable – that which is known and contained by dissociated aspects of self –

cannot be spoken but only acted and enacted in the therapeutic dyad. Bromberg (1998) was the first theorist to specifically suggest that enactments are the vehicle with which dissociated self-states can become manifest in the dyad. He argues that what cannot be consciously known by the patient will be acted out in the minute interactions in the therapeutic relationship. Bromberg (1998) explains of dissociated self-states: “The phenomenon is not intrapsychic and can be observed only through living it with the patient in the joint creation of an intermediate reality that bridges the experiential void between the patient’s self-states . . . (p. 183). The phenomena in question, that is, the dissociated aspects of self, do not yet exist in the mind of the patient; they must first become *interpersonal phenomena* before they can exist as *intrapsychic phenomena* within the mind of the patient.

The concept of enactments underscores that patients (and all people) carry procedural enactive representations of certain kinds of relationships with an other, usually laid down from his/her earliest relationships with a caregiver. These expectations about how relationships look and feel generate the patient’s unconscious anticipation of a particular engagement with an other (Howell, 2005). In therapy then, a patient’s unconscious anticipation of a certain kind of relational pattern leads him/her to engage in actions that are symbolic, which then nudge the analyst to respond with a likewise symbolic action. This sets off a dance between patient and therapist that results in an enactment, a relational pattern that embodies the patient’s earliest templates for relationships. In this enactment lies both a hope that the relational pattern will be disconfirmed and made new in the therapeutic dyad, and a dread that the same traumatic interaction will occur again with this new relational partner. By entering the patient’s internal world of object relations and becoming a player in these enactments, the therapist can come to know the nature of both the dreaded relational pattern and the wish for a new interaction. This

knowledge is not obtained via verbal dialogue; this knowledge is often not even contained in the mind of the patient in a verbally know-able way. The therapist has access to this knowledge only by entering the relational matrix and playing a part in the narrative of a patient's internal world.

Enactments as the Interpersonalization of Dissociation

In the traditional Freudian and even to some extent the object relations analytic worldview, enactment is a dirty word. A Freudian analyst would view enactment as a failure of neutrality and a form of the analyst's acting out his/her own countertransference. An object relations analyst would see an enactment as a failure in the container function of the analyst. Bromberg (1998) was one of the early relational analysts to suggest that enactments are a needed and otherwise unavailable form of listening and knowing, and represent the only key to access what is locked into dissociated aspects of self. He explains that when under the grip of dissociated states, the patient has no capacity for self-reflection and no observing ego. He/she cannot talk about or tolerate discrepant experiences of self as belonging to his/her self, or else the illusion of unity of the self would collapse. At the same time, the patient desperately needs these aspects of self to become known in the therapeutic dyad in order to be cognitively processed. Chefetz (2010), a proponent of Bromberg's theory, explains that in such moments when disparate elements of experience exist, and thinking, feeling and integration are blocked by a dissociative process, then the only way to make sense of such disparate experiences of self are by *action* and *enactment repetition*. When the patient cannot access explicit cognitive knowledge and is devoid of a sense of vitality, then he/she can only communicate by way of action in the therapy dyad. Chefetz explains, "In other words, what we only know implicitly is condemned to be told mostly with action until it can be made explicit and coherent" (Chefetz, 2010, p. 231). Bromberg's theory suggests that dissociated aspects of the patient's self must become known

interpersonally in the dyad first, then formulated in the mind of the therapist as thinkable, verbally represented and symbolic knowledge, and then made explicit first in the dyad and then in the self of the patient.

Several years later, Stern (2010) buttressed Bromberg's argument, describing enactments as "the interpersonalization of dissociation" (p. 86). Stern explains that dissociated self-states are by their very nature unformulated – not symbolized by language and not able to be communicated in verbal or symbolic form. Because these dissociated states cannot be held simultaneously *within* the mind, they are held only *across* two minds – that is, the mind of the patient and the mind of the therapist. The consequence is that the patient holds one aspect of "truth" and experience, and the therapist holds the other. In order for both parts to become known, the pair must enact their respective parts in tandem. Stern (2010) explains:

Dissociated experience, we have learned, does not simply disappear quietly into some hidden corner of the mind. It is enacted. I will 'play out' the state of self I cannot tolerate experiencing directly, and I will thereby unconsciously influence those with whom I relate to adopt a variation on the same dangerous response that led me to dissociate the self-state in the first place. (p. 84)

The therapist, then, must live through this enactment. He/she must experience the patient's reality implicitly, not just explicitly through language, and thus come to know the reality for and with the patient. Enactment "involves a need to be known in the only way possible – intersubjectively – through playing out with the analyst, in some mutually creative way that is different from the old and fixed patterning of self-other interactions, a version of the situation that led to the original need for dissociation" (Bromberg, 1998, p. 172). Through enactments, the

implicit and unformulated experience of the patient can be made available for mentalization and dialogue in the treatment (Levenkron, 2009; Stern, 2010).

Both Bromberg and Stern suggest that underlying enactments are minute shifts in the patient's self-states, often signaled by barely perceptible changes in affective communication from patient to therapist. These affective shifts are typically communicated by way of changes in the patient's facial expressions, gesture, prosody, and gaze, and are received *implicitly* by the therapist. According to Stern (2010), the recognition of these affective shifts always precedes conscious awareness. The therapist instead reacts on the basis of having received this information, and thus finds him/herself acting in a way that appears to be subtly "not-me." Further, the therapist's own unconscious subjectivity is involved in the enactment, and thus the enactment *precedes* countertransference awareness (Aron, 2003). This construct suggests that the analyst does and must enact first, and only later try to understand the nature of his/her participation.

Limitations and Critique

Dissociated material becomes most readily apparent to patient and therapist alike when dissociated affect or somatic memories instigate behavior or enactments. In this case, the therapist or patient may find him/herself acting in ways that are alien, unveiling the presence of an activated dissociated self-state. It is probable that in clinical practice, enactments represent the *first or most obvious* way to acknowledge dissociated material, however it is not evident that enactments are the *only* way to access formerly dissociated aspects of the patient's self as Bromberg, Stern and other relational analysts suggest. For instance, if we consider how Bromberg and Stern conjecture that enactments evolve, it is evident that there must first be

recognition of a shift in the patient's self-state. This shift is typically evidenced by a barely perceptible change in affect in the room. Stern (2010) notes:

We sense the effects of the analysand's self-states in the way the clinical interaction provokes a kind of affective 'chafing' in our experience Something feels inconsistent to us, something counters an affective expectation we did not even know we had until that moment, something feels subtly 'wrong' or contradictory or just uncomfortable. (p. 52)

Here, Stern argues that the therapist, perhaps *prior* to acting or enacting, senses an "affective chafing," some subtle indication that new affective material is present in the dyad. Despite his argument that enactment precedes mentalization, it is clear in the above statement that the analyst is aware of and feels something inconsistent which differs from what the analyst expects or tends to feel. It is unclear if this affective chafing must always lead to an enactment, or could be contained and reflected upon prior to action.

Enactments are emotionally driven and emotionally laden. While this fits with what we know about traumatic memories, it is also widely held that traumatic memories need to be translated into a coherent verbal and personified narrative. Relational analysts suggest that enactments are the only vehicle to do so, as the analyst is able to consciously formulate and know *after* he has acted out the meaning in some repetitious way with the patient. However, this still implies that nonsymbolic content is somehow translated into symbolic content inside the subjective experience of the analyst. There currently exists no clear theory that explains how enactments are translated from procedural implicit knowing to explicit verbal knowing.

Furthermore, relying on the concepts of action and enactment as the only way that traumatic memories or dissociated self-states can be communicated effectively ignores the

widely espoused belief that traumatic memories are stored as both somatic states (actions) and *images*. Davies and Frawley (1994) argue that dissociated states “are likely to make their presence felt via the emergence of recurrent intrusive images, violent or symbolic enactments, inexplicable somatic sensations, recurrent nightmares, anxiety reactions, and psychosomatic conditions” (p. 31). Wilma Bucci (2003; 2005; 2010), a cognitive theorist who writes about the process of communication of subsymbolic mental contents, describes images as the pivot point crucial in translating subsymbolic mental contents into symbolic mental contents. Despite the centrality of images in both trauma theory, as well as cognitive science, they have curiously been left out of analytic formulations about how traumatic content and dissociated states are communicated. This absence further supports the argument that enactments may not represent the sole way that dissociated states can be communicated in the dyad.

Finally, enactments imply a doer-done to dynamic, rather than a true mutual exchange on the basis of two subjectivities (Hopenwasser, 2008). The concept of enactments relies on the idea that the patient is projecting something *into* the unknowing therapist, or *enforcing* or *goad*ing the therapist into an unwanted kind of action. This doer-done to dynamic is inherently a dissociated way of knowing, where each partner in the dyad holds only one piece of the knowledge, but not in an integrated or holistic way. Further, the construct of enactments involves a contradictory identification between patient and therapist (Sands, 2010). The therapist plays an opposing role in the engrained procedural enactive representation of a familiar relational pattern. A question remains about the possibility of patient and therapist embodying a parallel and analogous dissociated state that involves oneness and attunement, and thus may provide a better reparative function in the integration of dissociated states and the development of an improved ability to communicate. The literature on this process is underdeveloped, and there is a need for a nuanced

conceptualization of dissociative communication that allows for an intersubjective and integrated way of knowing that may more accurately capture the way in which content is communicated and connection is enabled in the dyad.

While the nature of alternative possibilities to formulating implicit and subsymbolic communication about dissociated content is not yet clear, it is evident that these alternative possibilities are needed. Relying on enactments as the only way to access the critical knowledge contained by the dissociated parts of the patient's self imposes many dangers on the treatment. Enactments inherently imply a breakdown of reflective space in the dyad. There is often no hope of movement unless or until the therapist can recognize that he/she is caught in an enactment, and then pull him/herself out and *think* through the nature and meaning of his/her participation in the interaction. Ginot (2009) has studied the neurobiological nature of enactments, and supports this argument. He notes:

At their most extreme, enactment can lead to untimely termination on the one hand, or to a stagnant, repetitious, and fruitless analysis on the other. What is largely absent in these instances is the reflective ability of both patient and analyst, each experiences their dysregulated emotional reality as the only possible one. (Ginot, 2009, p. 294)

Bridges (2003) likewise argues that in order for the therapist to avoid an enactment, he/she must be willing to tolerate the emergence of "rapidly shifting configurations of self and other" as well as intense and destabilizing affect. "The challenge for the therapist in such moments," Bridges (2003) continues, "is to identify and contain the feelings for the patient while resisting the sometimes overpowering temptation to translate these feelings into behavior" (p. 16). While the temptation to enact such rapidly developing and intense affects that are communicated nonverbally in the dyad is indeed overpowering, the patient benefits when the

therapist is able to acknowledge and contain these formerly dissociated affects, such that they can be processed and then made integrated, coherent and whole.

Countertransference and Unconscious Communication

The position that enactments represent the only way to access dissociated content rests upon the assumption that communication cannot occur implicitly from mind to mind in the therapy dyad without existing first by way of action. This theory runs in stark contrast to concepts about implicit and intersubjective knowing that have been formulated even in the earliest renditions of psychoanalytic thought. As early as 1915, for instance, Freud marveled, “It is a very remarkable thing that the unconscious of one human being can react upon that of another without passing through the conscious” (as cited in Bass, 2001, p. 685). Freud viewed this unconscious interaction between two human minds as integral to the analyst’s understanding of the patient’s unconscious. Sandor Ferenczi, a disciple of Freud’s, spoke of a *dialogue of unconsciousnesses* to describe the unconscious communication that occurs continuously as patient and analyst converse verbally and consciously (as cited in Martin Cabre, 1998). He wrote in a letter to Freud dated November 22, 1910, “Imagine, I am a great soothsayer, that is to say, a reader of thoughts. I am reading my patient’s thoughts (in my free associations)” (as cited in Bass, p. 689). This language suggests that on a nonverbal and implicit level, the unconscious phenomena of patient and analyst are interacting and speaking with one another unceasingly. Several decades later, Theodor Reik, an analyst who likewise espoused the subjectivity of the analyst as a way to understand the patient, published what he considered the first book of its kind to investigate the unconscious process of the analyst and theorize about what this process might achieve in therapy. His interest, he explains, is to know “what takes place in the mind of the

psychoanalyst – the same scene viewed from the other side, inside out” (Reik, 1948, p. x). He considered the communication in therapy to be both a heart-to-heart and a drive-to-drive talk, the content of which often manifested in subtle and nuanced ways just outside the conscious awareness of both patient and analyst. He thus urged clinicians, “The analyst hears not only what is in the words; he hears also what the words do not say. He listens with the third ear, hearing not only what the patient speaks about but also his own inner voices, what emerges from his own unconscious depths . . .” (Reik, 1948, p. 126). Reik went on to explain that the analyst’s only tool to understand this concealed language is to look within his/her own self – his fleeting thoughts, the emotions aroused within him, and his seemingly mundane reactions to what the patient has shared. “The analyst must become familiar with his own unconscious;” he says, “this is the instrument that communicates to him the concealed meaning of what he observes” (Reik, 1948, p. 192). These three early analytic writers suggested that the secret to accessing unconscious parts of the patient’s self lies not in action, but in the analyst’s own internal world.

Freud, Ferenczi and Reik each spoke about the permeability of subjectivities in the therapy dyad, and the way that the internal experience of the therapist can represent an attunement to some communication or internal experience of the patient. All three theorists, however, speak about *unconscious* communication, communication of that which was once conscious and formulated but is now repressed, as opposed to *dissociative* communication. Contents of the unconscious can be symbolic and verbal because they have once passed through the conscious mind. Dissociative communication, on the other hand, represents communication of that which is not yet formulated or symbolized by the conscious mind. The kind of unconscious communication that theorists such as Freud, Ferenczi and Reik espoused has not been applied to dissociated contents of the mind. It is as yet unclear if dissociated aspects of self

and fragments of experience from early life trauma can be communicated in a concomitant *dialogue of dissociated self-states* in the therapy dyad.

There exists scant theoretical writing or work on the communication of dissociated content outside of the constructs of projective identification and enactment as espoused by Stern and Bromberg. However, two psychoanalytic writers, Thomas Ogden and Wilfred Bion, have described the communication of “raw” and “sensory” mental contents in the therapeutic dyad. A brief examination of their work will offer insight into understanding how dissociated content can be communicated intersubjectively in the therapy dyad.

Ogden and Reverie

Thomas Ogden, like Freud, Ferenczi, and Reik, argues that important material about the patient’s unspoken and unspeakable experience is communicated nonverbally in the therapy dyad, and becomes manifest first by way of the therapist tuning in to his/her own internal experience in the session. He argues that the therapist can tune in not only to what is unconscious – that which has been thought and then repressed – *but also to that which has-yet-to-be-thought or known by the patient*. Ogden (2005) explains:

Some patients who consult an analyst might be thought of as suffering from (metaphorical) night terrors. Without being aware of it, they are seeking help in dreaming their undreamt and undreamable experience. The undreamt dreams of such patients persist unchanged as split-off pockets (or broad sectors) of psychosis or aspects of the personality in which experience is foreclosed from psychological elaboration. (p. 5)

Ogden uses the metaphor of nightmares and night terrors to differentiate between those who are able to link, integrate and process disturbing or wholly sensory elements of experience from those who are not. According to Ogden, nightmares are bad dreams in which the dreamer can

remember the content of the dream, feel an affect associated with the dream, and upon waking, still think and talk about the dream, no matter how bad it was. Ogden then argues that night terrors are not dreams. The sleeper awakens frightened, but has little recollection of the content of the night terror or alternately retains a single, visceral and disturbing image, such as being chased or being smothered. The night terror is not integrated into the person's narrative memory or experience of self, though it often retains a certain visual quality, which is often static and senseless. Ogden's metaphor of nightmares and night terrors parallels the differentiation between that which is unconscious and that which is more rigidly and statically dissociated. He considers most patients to be suffering from night terrors, or the inability to dream – that is, the inability to do unconscious psychological work. He goes on to say that these pockets of disturbing, sensory experiences grow from “unimaginable, unspeakable pain . . . pain so terrible that it is beyond the capacity of a human being to both take it in and remain fully emotionally alive” (Ogden, 2005, p. 23). Here, Ogden's work alludes to a patient's dissociated self-state that holds the unspeakable and unimaginable past. While Ogden never explicitly speaks of trauma or dissociation, a nuanced reading of his work can detect an acknowledgement of the split-off pockets of self that thwart the patient's efforts to integrate these experiences of self, or in Ogden's words, to dream.

Ogden also describes the particular state of receptivity that the therapist needs to embody in order to help the patient to integrate and process raw sensory elements of experience. He explains:

The analyst to whom either of these broad categories of people goes for help in dreaming their metaphorical night terrors and nightmares must possess the capacity for reverie, i.e., the capacity to sustain over long periods of time a psychological state of receptivity to the patient's undreamt and interrupted dreams as they are lived out in the transference-

countertransference. The analyst's reveries are central to the analytic process in that they constitute a critical avenue through which the analyst participates in dreaming the dreams that the patient is unable to dream on his own. (Ogden, 2005, p. 5)

The term reverie was first coined by Wilfred Bion to describe the state of mind of a mother in which she is capable of receiving the raw sensory input or projective identifications of her infant, and tolerating and modulating them so that the infant may take back and tolerate, too, the projected affect or self state (as cited in Eagle, Haynes & Long, 2007). Ogden elaborates Bion's concept of reverie for the analytic pair. He describes the process of reverie as an attuned state of receptivity to the patient, which includes the analyst's "ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions, images emerging from states of half-sleep, tunes and phrases that run through our minds . . ." (Ogden, 1997, p. 158). These reveries of the analyst, Ogden notes, are not formed in isolation in the analyst's mind, but instead are created by participation in the intersubjective experience of and with the patient. Thus Ogden believes that the reveries of the analyst are not simply distractions or avoidances that occur isolated in the mind of the analyst, but instead represent powerful communications born from the dance between patient and analyst. Ogden (1994) explains:

I have attempted to demonstrate that these reveries are not simply reflections of inattentiveness, narcissistic self-involvement, unresolved emotional conflict and the like. Rather, this psychological activity represents symbolic and protosymbolic (sensation-based) forms given to the unarticulated (and often not yet felt) experience of the analysand as they are taking form in the intersubjectivity of the analytic pair (i.e., in the analytic third). (p. 82)

Ogden alludes to the dissociative nature of reverie, although does not explicitly make this connection. Here, the “symbolic and protosymbolic (sensation based)” aspects of the reverie can represent the unarticulated, unfelt experience – what Stern has named unformulated experience – of the patient’s dissociated self-state. Ogden further states that the analyst’s reverie is often the first indication that the patient is caught in something unbearable that cannot be spoken about. Ogden (1997) later describes the analyst’s process of holding onto a reverie as akin to “tearing off a layer of skin, leaving us with a diminished stimulus barrier with which to protect the boundary between inner and outer, between receptivity and overstimulation, between sanity and insanity” (p. 44). This description bears a striking resemblance to the patient’s own process of trying to hold onto an experience of self that is not yet formulated. He likewise describes his reverie state as feeling simultaneously like me and not-me, explaining that while reverie is crucial to his being an analyst, it is precisely the way in which he is *not* being an analyst at the time (Ogden, 1994). Ogden’s concept of reverie can shed light on the process whereby the dissociated states of the patient can find their home in the seemingly unrelated and mundane workings of the analyst’s mind.

There lies a danger of misunderstanding reverie as a mystical kind of psychic mind-reading. This is heightened by the fact that Ogden did not illuminate the nature of how affect and contents of mind become permeable and transferable within the analytic third. However, a robust appreciation of the relational theory of intersubjectivity can defend the concept of reverie from being written off as quackery. With relational theory as a frame, it is clear that the reverie represented in the mind of the analyst is partially a reflection of the analyst’s own subjective reaction to the patient. It is not a precise mirror of the patient’s mind, and as such, is not mind-reading. The affect or quality of the content in a patient’s mind is held and communicated

through the patient's facial expressions, tone of voice and body posture, and as a result, is perceived nonverbally in the mind of the analyst, often just outside of his/her awareness. This affective content perceived by the analyst then interacts with the subjective mind of the analyst, and is changed. It evokes within the analyst's own mind associated affects, memories and fantasies that emerge as an analytic reverie, evolved from but also distinct from the patient's subjective experience.

Ogden's construct of reverie holds vast potential for understanding the way that dissociated content is communicated intersubjectively in the therapy dyad. There is no empirical research to support his claims, however, and further, Ogden's theory does not clearly demarcate the process of how unspoken or unspeakable contents of the patient's mind become manifest in the reveries of the analyst. More research is needed to expand upon Ogden's early work and apply it to the field of trauma and dissociation.

Bion and Alpha Function

Wilfred Bion, a psychoanalyst rooted firmly in the object relations camp, likewise theorizes about mental contents that are subsymbolic and not-yet-formulated. His theoretical writing, while not explicitly speaking to dissociation, can lend credence to the position that dissociated contents of mind can be communicated intersubjectively in the therapy dyad without or prior to action. Bion's theory developed out of his analytic work with psychotic patients. He observed that in the midst of these patients' primary process and often incomprehensible material in therapy, there were also fragments of visual images or other raw sensory impressions that were graspable and remembered, though not necessarily digested, by the patient. He termed these fragments *beta-elements*, the unprocessed sense impressions of the mind that are incoherent and devoid of meaning (Bion, 1962). According to Bion, beta elements cannot be linked with one

another or with the self in order to create meaning or a coherent narrative; instead, beta elements only store experiential information in a disconnected way (Bion, 1962). Bion also noted that beta elements provoke hasty evacuation (Bion, 1962). Symington and Symington (1996) explain that beta elements “feel like debris of which the mind wants to rid itself” (p. 62). Herein lies a striking similarity between Bion’s beta elements and the more recent work on dissociated self-states and unformulated experience. Both consist of raw, sensory impressions, cut off from the conscious experience of self that exist in parallel, fragmented parts of the mind, and both resist being thought about or contained in the mind and are compelled to be acted out by way of enactments.

This is where Bion’s theory departs from that of Stern and Bromberg, however, and can provide preliminary support for the belief that unformulated content can be communicated by ways other than action or enactment. Bion argued that beta elements, prior to being expelled or evacuated, can be transformed into *alpha elements* – elements of experience that are conscious, think-able, and linked with one another – by way of the *alpha function* (as cited in Ogden, 2005). He defined the alpha function as the as yet unknown set of mental operations that transform raw sense impressions related to an emotional experience into units of meaningful experience, available for conscious thought (Bion, 1962). Bion suggested that alpha function translates inanimate, sensory contents of the mind that exist untethered to the self into subjective phenomena (as cited in Symington & Symington, 1996). Both dreaming and reverie, for instance, constitute forms of alpha function. Both processes make contact with raw sensory data and affect, and translate them into symbols, usually internal visual images or other internally initiated senses that can then be linked to the self.

Preliminarily, Bion suggests that the process of the alpha function occurs across two minds. In his 1962 book on *A Theory of Thinking*, Bion contends that both at the beginning of life and in psychoanalysis, it takes two people to think (as cited in Ogden, 2005). He compares this to the infant depending upon the mother to process unbearable and inchoate sensory experiences, which the mother performs through her capacity for containing and then giving back to the infant the formerly unbearable state, now in modified form. The containing is itself part of the alpha function. It is not only a state of mind, but also a process of doing unconscious psychological work. Outside of these insights into the process of alpha function, there is scant research or literature available to parcel out the component parts of this process, or understand it in the context of clinical practice, particularly as it relates to dissociated aspects of self. Bion himself admitted that this process of the alpha function contains a set of mental operations that are *as yet unknown*. More study is needed to understand how raw, sensory elements can be made conscious, and how this process relates to context that is dissociated as opposed to that which Bion termed psychotic.

Bucci and the Referential Process

Both Ogden and Bion have constructed theories that speak to the communication of raw mental content between two minds. In all of the available theory, what remains missing is insight into how raw mental contents transfer from one mind to another. Wilma Bucci, a cognitive theorist and psychoanalyst, has developed a cognitive theory based on advances in cognitive science that describes the multiple information processing systems of the human mind that allow us to “know” and communicate in multiple and nonverbal ways. Her theory bridges the gap between analytic theories of implicit knowing and cognitive science, lending credence to the

position that implicit and nonverbal communication can proceed intersubjectively without enactment.

Bucci begins by demystifying the psychoanalytic theories of unconscious communication, which she believes have grown increasingly obscure over the years. She explains, “The emphasis on projective identification and related concepts has deepened the epistemological mystique surrounding the question of how the analyst can ‘know’ the patient’s experience and further widened the gap between psychoanalysis and scientific psychology” (Bucci, 2001, p. 41). Instead, she argues that the interactions that according to theorists like Ogden or Bion appear supernatural or uncanny may in fact be accounted for by way of observable sensory means (Bucci, 2001). She explains that the analyst might come to “know” through means of conscious but nonverbal cues such as the patient’s gestures, body movements, peculiarities of dress, changes in pitch of speech and variations in emphasis of speech and pausing. The analyst also relies on total sense impressions that are noted unconsciously, much like an animalistic sense of direction. These impressions occur outside of awareness and cannot be expressed in words (Bucci, 2001). Bucci explains:

Advances in cognitive science, both theoretical and methodological, have brought changing perspectives to the study of mental operations and have broadened our understanding of what it means to ‘know.’ Classical information processing models were based on symbol systems. We now have additional models, characterized as connectionist or subsymbolic, that are built on a fundamentally different type of processing format and that account for the type of holistic and intuitive processing that lies at the heart of analytic communications, as described by Arlow and Reik. (Bucci, 2001, p. 47)

Here, Bucci refers to processes of communication that proceed nonverbally, unconsciously, psychobiologically, and perhaps dissociatively.

Bucci (2010) explains that the human psyche is comprised of three major processing systems: the symbolic verbal mode, the symbolic nonverbal mode and the subsymbolic mode. Verbal symbolic processing is communication by way of words and language. In this case the words are the symbols, and they can be combined to generate an infinite number of new forms. The symbolic nonverbal mode is comprised mostly of images that act as symbols. Like words, they can be combined and can refer and relate to other symbols, which can be images or words. The subsymbolic mode is processing and communication without symbols. This system most readily refers to the *emotional* information process system, and to that which is dissociated and unformulated. Subsymbolic processing is analogic and holistic – that is, it is not generated from discrete elements or separate symbols but instead is made up of total impressions (Bucci, 2001). This kind of processing most often occurs in sensory modalities and in visceral and motoric functions (Bucci, 2005). Famous athletes and artists, Bucci avers, rely heavily on the subsymbolic process for their craft. They often cannot verbally tell others how they do what they do. Instead, they show others – they know it viscerally in their bodies (Bucci, 2001). Those of us who are not famous for our subsymbolic skills still rely on them for everyday functioning, according to Bucci. Backing out of a parking spot, for instance, relies on the subsymbolic process. It would be difficult to explain to a new driver which way to turn the wheel in order to make the car turn backwards in a particular direction. This is because subsymbolic processing occurs outside of awareness or conscious thought. Attention can be directed to this process, however, such that one could intentionally think through which way he/she would turn the wheel, and then put language around this process in order to explain it to an observer. This piece

is extremely important. It means that although subsymbolic process is not represented in words or symbols, it can *become* represented in words and symbols by way of intentional attention.

Bucci (2010) explains:

I have pointed to a world of complex thought that is nonverbal and even non-symbolic; that occurs in its own systematic and organized format, primarily continuous and analogic; that is rooted in our bodies and sensory systems; *and that can be consciously known and comprehended; but that is not directly representable in words* [emphasis added]. (p. 205)

Bucci then applies the multiple code theory to communication processes in psychotherapy. Like the analytic theorists who came before her, Bucci believes that communication occurs in the therapy dyad both verbally and nonverbally, consciously and nonconsciously, and symbolically and subsymbolically. Like Reik, who urged that the analyst listen with the third ear, and Ogden who proposed that the analyst be in a state of reverie to receive the patient's yet-to-be-thought-or-known aspects of self, Bucci contends that translation from the subsymbolic to the symbolic modes of thinking and knowing occurs intersubjectively, across and between the patient and therapist. She, like Bion, attempts to describe how this process occurs.

Bucci espouses the *referential process* as the major integrative process of the multiple code system, which can enable translation of subsymbolic experience into nonverbal symbols first, and then into verbal symbols (Bucci, 2001). This referential process underlies all human communication. She explains, "The connections from the subsymbolic to the symbolic domain are necessary to enable sharing of experience, to put down signposts in the shared terrain, and to open new exploration" (Bucci, 2010, p. 211). The referential process enables the therapist to translate the subsymbolic communication into symbols and then words. It allows her to digest

the formerly indigestible, know the formerly unknowable, and speak what was heretofore been unspeakable to the patient. There are three phases to this referential process as it occurs in psychotherapy. First, there is an arousal of experience dominated by subsymbolic elements, either sensory, somatic, motoric or affective. This stage requires that the analyst or therapist know his/her own affective state and be able to track the “affective core” as it manifests in his sensations and visceral experiences (Bucci, 2001, p. 56). The analyst, upon recognition of the affective state aroused within him, translates the subsymbolic affective experience into symbolic form, first by way of images, and then words. In this stage of the referential process, Bucci refers to Ogden’s concept of reverie, the seemingly mundane thoughts or musings of the analyst that may appear irrelevant, but in actuality become symbols for the affective core that was activated in the analyst (Bucci, 2001). The contents of the reverie are metaphoric objects, sometimes a random thought, the words of a song, or a flash of a memory, but most often they take the form of images. Bucci (2001) explains, “images, with their transitional properties – modality specific, like subsymbolic representation; discrete and generative, like words – are *pivots* of the referential process, organizing the nonverbal system and facilitating connection to words” [emphasis added] (p. 51). Thus the subsymbolic elements that have been activated connect first to the symbolic images that arise in the analyst’s mind, which then connect to other symbols, and eventually to words. “The transformation from knowing in the bodily, motoric sense to knowing in the symbolic mode, first images, then words,” Bucci (2001) asserts, “occurs within the analyst’s inner experience, in the context of the analyst’s own emotion schemas, before ‘emotional inference’ to the patient’s experience is made” (p. 59). The final stage of the referential process involves the analyst reflecting on the meaning of the imagery, and using his/her own internal experience to think through how this might indicate something about the patient’s internal state.

Bucci's theory of the referential process is akin to Bion's construct of alpha function. Both theorists attempt to describe the process of translating raw sense impressions, in Bucci's term the subsymbolic mode and in Bion's language beta elements, into meaningful, think-able experience. Both theories identify Ogden's concept of reverie as an important part of this process, and both conclude that this process occurs across two minds, and in the case of psychotherapy, across or between patient and therapist. Both theorists believe that some important process of communication occurs between patient and therapist that is not verbal. Bucci (2003) notes that this form of communication is especially important for patients who have experienced early life trauma and suffer from symptoms of dissociation. In these cases, Bucci (2003) explains, "the person may experience the amplified subsymbolic, bodily memories without the symbolic ones, without their emotional meaning, without knowledge of why the sensory or bodily experience are occurring" (p. 549). The analyst's task, then, is to enable the patient's referential process to proceed by way of his/her own referential process. In my estimation, this is what Ogden (2005) means with the language of dreaming the patient's undreamt dreams. Bucci (2001) explains that the analyst's goal is to:

Intervene in such a way as to activate the imagery that is missing for the patient, to enable the referential process to proceed. Imagery is the pivot of the referential process, symbolizing the subsymbolic contents and enabling connections to words. If the words are effective, they will evoke imagery for the patient that connects to his own somatic and sensory experience. The imagery may be shared between analyst and patient to some extent but must be generated by the patient. Emotional communication evolves from the interaction of two separate referential processes operating in two representational systems. (p. 63)

This theory of the referential process provides preliminary support for the intersubjective communication of dissociated and raw mental contents between two subjectivities in the therapy dyad. Bucci's theory also provides descriptive detail about how this process occurs across and between minds. There is no empirical evidence that suggests this process occurs, however, and further it has not been explicitly applied to the realm of dissociated self-states resulting from early life trauma. Relational analysts have adequately captured how therapists entered the subsymbolic mode through action, by way of projective identification and enactment, with patients who have a desperate need to symbolize and integrate unsymbolized affect, memories, and aspects of self. However, there is a need to expand the understanding of how therapists can enter the subsymbolic mode, and thus engage dissociated content by way of images or other internal processes of reverie.

Neurobiology and Implicit Knowing

Over the last several decades, there has been a widening gap between psychoanalytic theory and scientific, positivistic knowledge that has further alienated the historical wisdom of unconscious knowing that occurs between two subjective selves. There is little empirical research that examines the phenomenon of nonverbal, implicit or dissociated communication in the therapy dyad. However, the burgeoning fields of infancy research and neurobiology can be applied to support the contention that dissociated states are, and indeed must be, communicated in nonverbal and unconscious ways in the clinical relationship.

Right Brain Communication

Allan Schore (2001; 2010) has written prolifically about the neurological and clinical implications of the right brain – the hemisphere of the brain responsible for processing

socioemotional information and regulating affective and bodily states. He makes the case that the right brain evolves in the earliest stages of preverbal development, generating the implicit self and representing the biological substrate of the dynamic unconscious. The right brain, known for processing information holistically, is involved in the automatic processing of nonverbal cues in human interaction. This nonverbal communication includes facial expressions, prosodic vocalizations, coordinated visual eye-to-eye messages, tactile and body gestures, posture, and tone of voice (Applegate & Shapiro, 2005). Schore (2010) has asserted that humans can appraise facially expressed emotional cues in less than 30 milliseconds, a rate far outside conscious detection. As he puts it, “The right brain is important in the processing of the ‘music’ behind our words” (Schore & Schore, 2008, p. 14). In the same article, Schore and Schore cite work by Grabner, a neuroscience researcher, who indicated that the right hemisphere operates in a fashion similar to free association and primary process communication, comparing this to states such as dreaming and reverie. This assertion implies that during reverie, the analyst’s brain is in a state of *right brain receptivity*, which primes the analyst to stay attuned to his/her own seemingly mundane internal reactions that might indicate communication sent from the patient’s right brain and received in the analyst’s right brain. “Just as the left brain communicates its states to other left brains via conscious linguistic behaviors so the right nonverbally communicates its unconscious states to other right brains that are tuned to receive these communications” (Schore & Schore, 2008, p. 14). This right brain communication is emotionally based and dominated by imagistic thinking. As a result, images are more affect-laden than are words (Fosshage, 2010). These assertions about right brain function provide empirical support for the processes of implicit intersubjective attunement and communication.

There is some evidence suggesting that right brain communication is particularly apparent among patients with an early relational trauma history, especially when the trauma occurred prior to the development of verbal language. In such instances, traumatic affect and self-states can be represented only in the unconscious, implicit language of the right brain, which is thought to contain the emotional, traumatic, subsymbolic, and preverbal experiences of the infant and the mother-infant dyad (Schore, 2010, p. 185). The implicit memory system, which involves the right brain, is thought to exist from birth (Fosshage, 2010). This memory system requires neither conscious thought nor the involvement of the hippocampus in the encoding of memories. As a result, preverbal experiences are retained as memories in the right brain, but are dissociated from language. Functional MRI research has supported this assertion, indicating that when patients are actively dissociating, it is predominately the right hemisphere of the brain that is activated (Schore, 2007). This combination of findings reinforces the notion that the analyst must be open to engaging in right brain to right brain communication, and then helping the patient to integrate this right brain, affective and bodily based traumatic knowledge with a verbal, conscious and coherent narrative structure composed in the left brain. Schore's research provides preliminary support for the existence of right brain, nonverbal communication in the dyad that is crucial to enabling the therapist to simultaneously auto-regulate the intense traumatic affect stimulated in the therapy process while still maintaining attunement to the shifts in his own and the patient's self-states (Schore, 2010).

Mirror Neuron System

There exists further neurobiological research that underscores one of the primary processes that enable this dyadic right brain communication to occur. In the early 1990's, a group of scientists including Gallese, Fadiga, Fogassi and Rizzolatti (1996) accidentally

discovered that when a primate observed a human engaging in a particular action, such as eating, the same neuronal pathways were activated in the primate as if the primate had engaged in this action himself. Several years later Iacoboni applied this discovery to humans. He found that human beings, like primates, have premotor neurons that fire when an action is observed being performed by someone else. Several researchers have suggested that human beings also have mirror neurons that mimic another person's emotional state (Gallese, 2009; Iacoboni, 2008). Conceived in this way, mirror neurons enable us to translate what is observed visibly, which initially is an action devoid of any meaning, into something the observer is able to understand (Gallese, 2009). This is the neurological process responsible for the human capacity to anticipate another person's next action as well as to understand the mental state of others (as cited in Buk, 2009). Bloom and Farragher (2011) explain: "We mirror emotional expression, tone of voice, gestures, mental images when we talk to someone, and facial expressions, and in doing so we come to know what someone else's intentions are and what another person is feeling" (p. 93). In fact, neuroscience research has shown us that when we observe others expressing a basic emotion, the same brain areas are activated in us as if we were experiencing the emotion ourselves (Gallese, 2009). As such, the mirror neuron system can be understood as the basis for both empathy and morality (Iacoboni, 2008).

While research on the mirror neuron system in humans is still in its infancy, it can add valid scientific language to the theoretical and clinical concepts of attunement (Siegel, 2010). Gallese (2009) offers: "A direct form of understanding of others from within, as it were – intentional attunement – is achieved by the activation of neural systems underpinning what we and others do and feel" (p. 524). The therapist's process of understanding what the patient is experiencing internally but not verbally stating rests upon the therapist's ability to observe the

patient expressing or portraying an emotion. This process automatically triggers the therapist's brain areas associated with the expression of this emotion to be activated. The therapist then maps his patient's actions, emotions and sensations onto his own somatosensory and motor representations, such that he can make sense of his patient's internal experiences first by sorting through his own (Gallese, 2009; Siegel, 2010). Ginot (2009) elaborates:

It is possible to see the role of the mirror neuron system not as structures that faithfully replicate observed emotional reactions, but rather as neuropsychological processes that result in mutual, idiosyncratic attunement to each other's visceral/feeling states and intentions. At times, depending on the degree to which reflectiveness is lost, this mutual involuntary reactivity will culminate in enactments. (p. 300)

Ginot's statement has profound implications for the therapy dyad. First, Ginot suggests that the mirroring that occurs does not produce an exact replica of the original feeling state. Siegel (2010) refers to this as the "sponge system", such that "we soak up what we see in others and actually make it uniquely our own" (p. 38). Second, Ginot argues that the process of attunement to the patient's internal visceral and feeling state occurs automatically, but the maintenance of reflective space, what Sands calls the observing third, must be intentionally and painstakingly guarded by the therapist. This research on the mirror neuron system underscores both what happens neurobiologically during moments of attunement, but also during moments of enactment and projective identification when this reflective space is shut down. These findings provide preliminary support for the occurrence of attunement to traumatic and nonverbal affect in the therapy dyad, and also elaborate on the need to understand more about the component parts of this process, particularly as it relates to the mirroring of dissociated self-states in therapy.

Dissociative Attunement as a Theoretical Construct

As I was sitting with Clara, I noticed the loud noise of a paper shredder in an adjacent office, however I was not initially aware what this noise was. My mind took me to a vivid image of my mother and grandfather using an electric knife to carve a turkey on Thanksgiving Day. I could hear the ambient noise of a football game in the background and my family members laughing joyfully. I could smell the turkey and potatoes. There was a gripping physical sensation in my body, and for a moment, I was transported to my childhood home and surrounded by the people I love most. When I “came to”, I realized that the noise was a paper shredder – not an electric carving knife – and I became overwhelmed by nostalgia and a deep longing to be in that moment of love and connection.

During this particular session with Clara, I had brought a new and larger couch into my office, which necessitated me shifting my chair to a different angle. Clara could not sit directly opposite me as she was accustomed to and demonstrated intense physiological discomfort in response to this. I acknowledged the change in the furniture layout early in the session and attempted to explore with her how she experienced this change. My attempts were unsuccessful. She alluded to frustration with herself for being unable to answer my questions, and at one point admitted, “Many things are outside of my awareness”, thus acknowledging her sense that something was happening inside of her that she felt unable to know or communicate. Instead, she perseverated on the furniture arrangement, sharing her wish to move her chair directly across from me or shift her body to maintain better eye contact. Through this, she revealed in the best and most open way she could, her wish to be closer to me, her longing for things, including the furniture in the room, to go back to the way they were, and her rage at the felt experience of having an intimate connection abruptly taken away. Beneath these words lay her longing to have

a close and intimate connection with an other, her terror upon change, and her intense feelings of abandonment and loss. She did not express this verbally. While she alluded to her wish to be closer to me through the language of furniture arrangement, she engaged in several other nonverbal strategies that revealed what was happening for her. Her body language was tense and rigid. She displayed rapid and furtive glances around the room while making no eye contact with me. She described her perception of hearing a voice in the corner of the room laughing at her. Her tone of voice was cold and guarded and she provided many one-word answers, all of which led me to feel helpless, stonewalled, rejected and essentially alone in the room. There were likely many other communications happening outside of my conscious awareness. The cumulative effect led me to experience a state of sadness and wistfulness for connection and safety. This affective experience, induced by Clara but essentially my own, became manifest in my vivid reverie of being with family on Thanksgiving Day, wishing to have a more intimate connection but feeling still grossly alone. I tuned back in to what Clara was sharing and I sensed a deep longing for her own connection to family, safety and love in the space between her words. I wondered if perhaps my momentary lapse into fantasy was not just a distraction or an avoidance, but instead a powerful experience happening between us, a longing both mine and hers, co-constructed in the therapy space.

Dissociative Attunement

Theories of implicit and nonverbal attunement to dissociated aspects of self, as constructed by Ogden, Bion, Bucci and Schore, have developed separately and remained isolated from one another over the past twenty years. As such, the belief that enactments are the only way to access early life traumatic affect and dissociated self-states has maintained a strong hold on the relational analytic community, despite the advances in neurobiology that have identified the

perception of sensory signals at a rate beyond conscious detection, and despite the advances in the traumatic stress field that have revealed the nature of traumatic memories as famously sensory-loaded with *affect* and *images*. Additionally, the relational analytic trauma community has yet to reintegrate the dissociated knowledge of earlier writers such as Ogden and Bion, who decades before their time, alluded to the way that the analyst could attend to the patient's dissociated states of unbearable pain by way of his internal experience.

In 2008, Karen Hopenwasser began to mend this chasm by applying an understanding of unconscious and implicit knowing to the dissociative field. In her work with chronically traumatized patients with dissociative symptoms, she describes a process of “synchronized, simultaneous awareness of knowing that is nonlinear and fully bi-directional” (Hopenwasser, 2008, p. 351). She uses observations from her clinical work to develop the theoretical construct of *dissociative attunement*, a process she defines as “an implicit knowing of information within the therapeutic relationship that may or may not be available for mindful awareness” (Hopenwasser, 2008, p. 354). She juxtaposes this construct with that of enactments, countertransference enactments, and projective identification – constructs that she perceives as failing to capture the fully mutual way in which traumatized people communicate states of unbearable pain. Instead, she positions her theory of dissociative attunement firmly in the camp of mutuality. Communication, she argues, occurs by way of attunement, sharing states with the patient. Further, she argues that this attunement does not always represent empathy, and indeed at times looks and feels like a misattunement. While she does not assert this directly, it is plausible, and indeed likely, that what feels like a misattunement is actually the presence of the dissociative field, manifested by way of a dissociative transference and countertransference.

Hopenwasser provides an evocative case example, but never fully develops the construct of dissociative attunement. She explains that dissociative attunement is comprised of *empathic attunement*, *dissociative transference* and *affective resonance*. She does not define these component parts or differentiate them from one another. Hopenwasser relies heavily on allusion to the physiological process of entrainment to make her point. Entrainment is the oscillating synchrony between systems that emerges from biological rhythms and muscular bonding, such as soldiers learning to step together in time. This process calls upon implicit knowledge and memory systems, as well as nonverbal communication processes between people. In psychotherapy, she says, we call this process of entrainment, *attunement*. Attunement refers to the state of reciprocal recognition between two people which includes a congruence or synchronicity of inner experience, with the understanding that the two people are not sharing the *identical* state, but rather sharing an affective experience in a different modality or intensity (Benjamin, 1995; Siegel, 2010). In therapy, attunement demands that the therapist be fully present in the moment with his patient, and allow himself to be in rhythm with the nuanced shifting of his patient's emotional states. This requires both a state of being open, as well as focused attention and clear perception (Siegel, 2010). Siegel (2010) describes two components of attunement: the *physical component*, "the perception of signals from others that reveal their internal world", such as eye contact, tone of voice, posture and facial expressions, and the *subjective component*, the "authentic sense of connection, of seeing someone deeply, of taking in the essence of another person in that moment" (p. 34). Hopenwasser argues that it is this very process of attunement, especially when it occurs in the midst of not-knowing and mental confusion in the dyad, that lies at the basis of dissociative attunement. The therapist must be affectively attuned to the patient and willing to listen to implicitly derived knowledge in order to

maintain contact with traumatic or dissociated states. Further, Hopenwasser argues that the therapist must then “abandon the caution that accompanies reflection,” acknowledging that affective and implicit communication remain unsymbolized and pre-reflective knowledge. The therapist must know, affectively and implicitly, before she thinks. Through this intentional process of attunement to shifting dissociated states, the therapist can stay connected to the patient, and thus help the patient regulate traumatic affect and integrate dissociated parts of self.

Hopenwasser is the first theorist to make such a radical departure from the prevailing wisdom that dissociated states can be communicated only by way of action and enactment. Despite the radical and influential stance Hopenwasser takes, the construct of dissociative attunement requires further development. Hopenwasser doesn't parcel out the component parts of the process of dissociative attunement. She likewise doesn't detail the function or significance of the dissociative attunement, or the impact of this process on the treatment. At the end of her paper, Hopenwasser (2008) herself admits, “There remains much we cannot explain about the mysterious process of healing unbearable pain” (p. 360). More research is needed to explore the process of attunement to traumatic affect and dissociated states in the therapy dyad in order to develop a more comprehensive understanding of this construct of dissociative attunement.

Dissociative Unconscious Communication

In 2010, Susan Sands described this same process of dissociative attunement, although terms this process *dissociative unconscious communication*. Like Hopenwasser, she describes the process of nonverbal and nonconscious attunement to traumatic affect and dissociated states of chronically traumatized patients. The development of her construct is sophisticated and nuanced. Sands clearly defines dissociative unconscious communication: “This form of implicit communication, an emergent property of the analytic process, is characterized by a powerful and

visceral resonance between patient and analyst, as something dissociated in the patient grabs hold of and enters into deep communion with something dissociated in the analyst and opens up a channel of unconscious empathy” (Sands, 2010, p. 365). Like Hopenwasser, she considers this kind of dissociative communication to be necessarily *implicit* and *mutual*, where patient and therapist are engaged in “communion” rather than rigid opposing identifications inherent in an enactment. Despite her emphasis on oneness, she also argues that this state of oneness must be quickly following by an “observing third”, that is, a left brain process of thinking in order for the patient to feel held and contained (Sands, 2010). Here, Sands goes a step further than Hopenwasser by integrating Schore’s formulation of right and left-brain communication, and in directing the clinician in what to do with attunement to dissociated content.

Sands also integrates work from the field of traumatic stress by arguing that the process of dissociative unconscious communication must occur by way of deep engagement with *traumatic images* and *somatosensory fragments* in the patient and analyst’s dreams and dream analysis in the dyad. Sands argues that the process of dissociative unconscious communication *must* occur by way of dreams and dream analysis in the dyad. She explains that dreams, with their visual and sensory nature, are particularly suited to the transmission of traumatic memories, which are famously affective, sensory, bodily and visually laden. She further notes that dreams act as a hinge between the conscious and the unconscious, offering a transitional bridge for the patient to get in touch with dissociated parts of self in a forum that is not entirely deliberate, and not entirely “real”, and therefore ensuring a certain degree of safety. She summarizes, “Dreams’ visual, metaphorical qualities; their superprocessing and connection-making capabilities; their unique access to dissociated experience; and the relative safety offered by their transitional status give them unparalleled power to elicit and gather up dissociative material within the analytic

relationship” (Sands, 2010, p. 361). She argues that through analyzing a patient’s dreams and her own reactions to the dream, the therapist can encounter experience-near empathy for the patient’s dissociated self states, and expand and improve her own containing and selfobject functions. Both enable the patient “to tolerate the terror of emerging out of the dissociative membrane and into a dangerous world” (Sands, 2010, p. 362). Sands views this process of dissociative communication, or attunement to dissociated states, not only as an inevitable part of the treatment with survivors of chronic trauma, but also as a deeply reparative and indeed essential part of any treatment that aims to reach a patient who has been relegated to “dead zones” filled with aloneness and fragmentations of a self.

Sands’ version of dissociative unconscious communication shares several elements with Hopenwasser’s construct of dissociative attunement. Both theories emphasize affective attunement in the midst of a dissociative field as a way to attune to dissociated aspects of a patient’s self. Both theories allude to this attunement being manifest in the therapist’s subjectivity in visual images, intense affective experience or somatic sensations. Both theories espouse a model of mutuality in which access to dissociated states occurs in moments of communion and deep synchronicity with the patient. Sands, unlike Hopenwasser, holds that this communion must coexist with an “observing third”, a part of the therapist’s self that can formulate the heretofore unformulated self states into symbols and language that can then be tolerated by one and both in the pair. Hopenwasser, on the other hand, considers affective attunement alone to be sufficient for the communication of dissociated states. Sands holds that dreams are the vehicle that can bring dissociated content into the therapy room, while Hopenwasser holds that attunement to dissociated states occurs in any dissociative field, and is indeed ubiquitous. There is lack of theoretical clarity about what conditions need to be met in the

treatment in order for dissociative attunement to occur, as well as gaps in our knowledge regarding how raw affective content is translated into identifiable verbal knowledge held in the mind.

Published Case Examples

As noted, Hopenwasser was the first (and only) theorist to espouse the construct of dissociative attunement. Sands uses different language, dissociative unconscious communication, to develop a similar and parallel understanding of the way dissociated content is communicated through communion and attunement in the dyad. Outside of these two writers, there exists very little theoretical formulation of this construct, and limited empirical research to support the phenomenon of dissociative attunement. Despite this, there are several published case examples in the analytic literature that describe this process of dissociative attunement in psychoanalytic work without directly labeling it as such (Arizmendi, 2008; Bridges, 2003; Kieffer, 2011). An examination of three published case examples will help to illuminate potential component parts of the process of dissociative attunement, thus highlighting important areas for research.

Arizmendi (2008) argues that patients who have experienced early life trauma often rely on primitive processes to communicate with the analyst via sensory experiences, referring to these processes as body communication. He relies on the psychoanalytic theories of unconscious communication as well as relational neurobiological research to argue for the presence of nonverbal and implicit communication in the therapy dyad. He then notes:

I will attempt to illustrate a subsymbolic, nonverbal (sensory, visceral, and motoric) body communication through the use of extensive clinical material from an ongoing psychoanalytic treatment involving trauma. The focus will be on the idea that the patient attempts to communicate via body experiences and that the therapist receives them via

his own body experiences. (Arizmendi, 2008, p. 444)

He goes on to describe a patient who he calls Cathy, a depressed woman in her thirties who suffered emotional and physical abuse at the hands of her alcoholic father. Cathy had difficulty communicating and connecting in the first two years of the treatment, often concealing her face with her long hair and expressing hopelessness, helplessness and a sense of paralysis – behaviors that closely mirror traits of an infant with a disorganized attachment style. Arizmendi (2008) notes, “At times, Cathy would ‘fade away’ into a dissociative state, triggering my own form of paralyzed retreat” (p. 446). Here Arizmendi observes Cathy entering the so-called dead zone and dragging him into it with her. Although he does not describe it as such, Arizmendi appears to be experiencing a dissociative countertransference in session with Cathy when she dissociates. Despite this, in the midst of these episodes of mutual dissociation Arizmendi (2008) argues that “something much more active was present” (p. 447). He continues, “The sensations of deadness, paralysis, and helplessness likely represent some attempt, on the part of the patient, to describe dissociated states she experienced during the painful traumatic episodes of childhood” (p. 447). He understands this as a resonant process of attunement to her dissociated states.

Beyond the suggestion that Arizmendi experienced states of mutual dissociation that conveyed the patient’s internal experience of self, he goes further to suggest that the patient’s dissociated states are communicated in a more evocative way. He describes one particular session with Cathy in which she was speaking about a constant body sensation that frightened her. She detailed a fear that her “anus was ripping” each time she had a bowel movement, and Arizmendi related this to her history which included her parents forcing her to take oral laxatives as a child. As she was describing this body sensation, she drew a picture of a figure that had

jagged edges protruding in a concentric fashion. Arizmendi, watching Cathy draw this figure and listening attentively to her words, experienced a vivid reverie. He explained:

As I listened, I winced as if a sharp protruding object had pierced me and began having images of a circular saw ripping through an object and of someone ripping two objects apart. The pain I experienced was intense and I was only able to recover while viewing a second picture of what looked like a more intact circle without the jagged edges. In my attempt to avoid further pain, I compared the two circles and told her that ‘It looks to me as if things are getting better.’ (Arizmendi, 2008, p. 447)

He understood the vivid image he experienced as well as his own physiological reaction to the image as important information that Cathy was communicating to him. Later, he alluded to a history of sexual violence perpetrated against Cathy, a memory that she had defended against and kept in a dissociated part of self. He explained:

What her body communicated to me was a specific sensation of intense, sharp pain. At that point, that was all her psyche could tolerate but it was all that was needed once I surrendered to my own body signals. Most critical was the sense of being overwhelmed which was, I believe, her communicated memory of being overwhelmed herself. I recognized this by the intensity of my pain and the urgent need to ‘make it better’ for *me* not just for her. I felt helpless and needed to find a means to escape and to provide hope where it seemed as though none existed. (Arizmendi, 2008, p. 448)

Arizmendi argues that in spite of, or perhaps because of, the dissociative field in the therapy dyad with Cathy, he experienced an imagistic reverie that grew out of an affective and motoric resonance with the patient. This resonance elicited subsymbolic experience within Arizmendi himself, thus triggering a process of counter-dissociation and an attempt to avoid the intensity of

the affect that was being communicated. Arizmendi demonstrates this avoidance when he attempts to convince Cathy (and himself) that she seems to be getting better. At the same time, however, Arizmendi's resonant affective experience triggered an image, which served as an important precursor and link to the symbolic (and thus verbal) mode of thinking and knowing (Bucci, 2003). Arizmendi used the evoked image to translate this dissociated content into words, and then integrate it into the treatment. He concludes, "The transformation in me from subsymbolic to symbolic verbal and my communication back to her seemed to resonate with an affective state in her and ostensibly to transport her closer to important images which she either could not bear to communicate or just could not bring to awareness at that moment" (Arizmendi, 2008, p. 453). Arizmendi's dissociative countertransference co-existed with and perhaps opened space for attunement to traumatic and dissociated affect, manifest first as the symbolic images in Arizmendi's reverie.

Bridges (2003), a psychoanalytic social worker, likewise has hypothesized about the role of affective resonance in the communication of dissociated content. She uses the constructs of projective identification and enactment as a framework to understand the way that affect is communicated nonverbally in the therapy dyad. Bridges provides several case vignettes in her publication. The first describes a client who is a successful businessman. She describes an unusual encounter she had with this man during one of his first psychotherapy sessions. She explains:

A short time into the session, his state of consciousness shifts and he becomes mute, clearly dissociated, and falls into what appears to be a self-fragmented state. I am understandably alarmed and concerned for this man and not sure how to proceed as I have little information about this patient and no clear ideas about what might be helpful.

Then, my patient rises from his chair and walks out of the office into the waiting room and crouches in a corner. Now, I am in a state of near terror and uncertainty myself.

(Bridges, 2003, pp. 15 – 16)

Bridges details her urge to become more active and take control of the session. She briefly contemplates ordering the man to return to her office. Instead, she refrains from acting, and instead pays close attention to her internal experience. She notes, “I assume that my patient shares my sense of terror and worry that I might intervene in a hurtful manner. I begin to speak with my patient about my emotional experience” (Bridges, 2003, p. 16). In this example, Bridges supports the contention that dissociated content can be communicated not only by way of action and enactment, but also by a process of deep introspection and tuning in. In the patient’s dissociated state, Bridges experienced a resonance of affect – fear and powerlessness – and used these resonant experiences to engage the patient from a place of having lived through his experience without necessarily knowing it.

In a second case vignette, Bridges describes an initial evaluation with a divorced man who was the parent of a preschool aged-boy. When Bridges greeted him for the first time in the waiting room, she noted a sense of discomfort and a perception that he was “undressing me with his gaze” (Bridges, 2003, p. 20). She shared that as the client proceeded to describe his concerns in the session, she began to focus on her internal experience. She notes, “My mind wanders to my childhood. I recall images of myself as a young adolescent and fantasize about a recurring uncomfortable moment, walking past the high school boys leaning on the drug store window and feeling undressed and viewed as a sexual object” (Bridges, 2003, p. 20). This vivid memory, triggered on the basis of Bridges’ own countertransference response of feeling sexually objectified, appears to have been evoked on the basis of some nonverbal interaction between

Bridges and this client. Bridges (2003) indicated that she understood this visual image as “both a potential point of identification and an indication of a nonverbal projective process between my patient and me” (p. 20). While she experienced an intense reluctance to affectively experience this state of feeling objectified, she argues that doing so allowed for the emergence of deep states of resonance with the patient and possibilities for relational repair. Indeed, later in the treatment, the patient revealed a history of previously dissociated traumatic memories from childhood of being sexually abused and objectified by his father. Bridges comments on the difficulty that clinicians experience in maintaining attunement to affect, particularly traumatic affect, on the basis of what this stirs up in the subjectivity of the clinician’s self, life and experiences. However, she argues that the work lies in the clinicians’ willingness to hold these feelings and translate them into symbols, rather than quickly moving into action and enactment, thereby “slam[ming] the door shut on my internal experience and keep[ing] my patient at arm’s length” (Bridges, 2003, p. 19). Bridges’ work here, while not directly tied to trauma or dissociation, supports the theory of affective resonance and containment as component parts of the process of dissociative attunement.

Kieffer (2011), also an analytic writer, describes an experience of “mutual dissociation” in a session, which included a reverie and an image of the patient. She formulated these experiences as both empathic attunement and a form of dissociated communication. Kieffer presents a detailed case example. She describes a patient, Carla, who is a thirteen-year old girl who presents to treatment with episodes of rage and acting out, often directed towards her eleven-year old autistic brother. Carla had very few friends and was often mercilessly bullied by her peers. She viewed both her schoolteachers and her parents as ineffectual, unable to protect her or maintain order and safety in her environment. After years of four times per week analysis,

Carla began to object to continuing in treatment. She began arriving to sessions late, and at times would scream at Kieffer, “You are taking over my life;” “This isn’t helping – it’s too much;” or “I am leaving.” (p. 337) She would storm out of Kieffer’s office and slam the door. Carla also made a habit of waiting in Kieffer’s waiting room for some time after being greeted by Kieffer and invited back to the office to begin the session. Sometimes this waiting would last for several minutes and other times Carla would wait through half of her session time prior to walking back to meet Kieffer in her office. Carla at one point admitted that she liked to think she was annoying her analyst and making it impossible for her to do her job. She then sheepishly admitted her fear that Kieffer would use this found time to think about her other patients – revealing her overwhelming fear that other patients (siblings?) would get the lion’s share of Kieffer’s attention and care, and that she would be left forgotten and neglected.

Kieffer then describes how she understood the thought processes that emerged for her as she sat waiting for Carla, at times while Carla was sitting in her waiting room loudly flipping through magazine pages. She notes:

The periods in which Carla defiantly sat in my waiting room were rich with connection and meaning for both of us. As I would sit and wait, I was aware of entering into what Bollas (1987) has described as musing, and Ogden (1994) as reverie, an unformulated experience in which I could alternately focus on the patient and simply ‘space out,’ unable to focus meaningfully on other things. (Kieffer, 2011, p. 340)

Kieffer understood her internal experience as an enactment of Carla’s standing experience (and fear) of being with a preoccupied caretaker. While Kieffer stays closely grounded to Stern and Bromberg’s language of enactments as a way to attune to dissociated content, she also brings in the constructs of reverie and mutual dissociation as part of the way she understands this process.

Further, she goes on to symbolize her affective experience of waiting on Carla into an image and fantasy of Carla as a “diva”, performing as a musician and keeping all of her fans waiting. She imagined herself as a “groupie”, waiting on Carla, hanging onto her every word, and thinking and talking about Carla in supervision. This image helped Kieffer to evoke and then live in a self-experience, complete with affective components and self-other configurations of relating, that mirrored Carla’s internal but dissociated experiences of self. Kieffer explains that what had been dissociated in Carla came to be represented within her. She continues:

While I was most acutely in touch with my sense of heightened vulnerability and fear of shame (remembering that Carla was a control case) – particularly when she sat defiantly in the waiting room – I also could locate my own ‘inner diva,’ along with a sense of indignation about being kept waiting when I was trying so hard. (Kieffer, 2011, p. 344)

Kieffer first resonated affectively with Carla’s internal experience of shame and vulnerability, which then mingled with Kieffer’s own subjective experience of these affects, taking shape ultimately as the image of Kieffer as one of Carla’s groupies. Kieffer understood the process of mutual dissociation as a foray into Carla’s internal and relational world, allowing Kieffer to become affectively immersed and attuned to dissociated aspects of Carla’s self.

Component Parts of Dissociative Attunement

These three case examples taken from recent psychoanalytic literature lend credence to the proposition, put forth initially by Karen Hopenwasser and continued by Susan Sands, that dissociated content can indeed be resonated with affectively and formulated in the subjectivity of the analyst. All three accounts refer to a process of *mutual dissociation* – that contact with a patient’s dissociated affect reliably activates a dissociative countertransference and elicits a heavy dissociative field in the dyad. All three accounts also refer to a process of *reverie* – the

evocation of vivid images or fantasies in the mind of the analyst that are thought to represent some resonance with the mental contents or affective state of the patient. Finally all three accounts rest their assumptions on the basis of *affective attunement* – the nonverbal and often nonconscious attunement to the affective state of the patient. These three processes appear to be intimately related to the process of dissociative attunement, however it is unclear how these three processes interact as part of a cohesive, fluid process of communication between two people. Further, it is unknown if other mutative and essential ingredients of dissociative attunement as a theoretical construct exist. My research attempts to address these gaps in the available literature, and translate esoteric analytic ideas into a cohesive theoretical construct that has the potential to demystify the process of attunement to dissociated states in the therapy dyad.

Review of Empirical Evidence

There is scant empirical data on the in-session experience of therapists working with clients with a chronic relational trauma history. Much of the available research emphasizes potential distressing reactions of therapists who attempt to engage with the highly traumatic material patients bring to session. For instance, recent empirical literature notes the negative impact that trauma work has on the therapist's world view (Cunningham, 2003), relationships with significant others (Pack, 2010), and on marital relationships and gender identity (Goldblatt, Buchbinder, Eisikovits, & Arizon-Mesinger, 2009). Further, trauma work is thought to induce strong countertransference reactions in the therapist and flood his/her ability to contain intense affect (Goldfeld et al., 2008). Research has also examined the risk for vicarious traumatization, secondary posttraumatic stress, and burnout resulting from prolonged exposure to patient's trauma stories (Marriage & Marriage, 2005). While this research represents a notable start in

understanding the impact of trauma work on the helper, it frames this impact in a wholly negative light. It captures the fallout that engaging in trauma work imposes upon the therapist, but ignores what meaning the therapist makes of this work, and likewise neglects the mutuality of the work of psychotherapy, namely that the therapist is bringing something to the interaction too. Further, available research accounts for only the generalized, totalistic impact that engagement in trauma work has on the therapist outside the therapy room, and neglects the inner experience of the therapist in session with a survivor of chronic trauma.

There is no research to date that examines the moment-to-moment inner experience of the therapist in session with a patient with dissociative symptoms or a patient who dissociates in session. However, several available studies have examined the inner experience of therapists confronted with “difficult situations” in session. A study by Hayes et al. (1998) explored events in therapy that elicited countertransference reactions, and found that countertransference was widespread and customary. Even among a group of “expert” clinicians, strong countertransference reactions were reported in 80 percent of the 127 sessions observed. The researchers also noted that these countertransference affects, including anger, frustration, sadness, and inadequacy had a paradoxical effect of either bringing the therapist closer to the patient, or causing the therapist to avoid the patient’s affect and disengage emotionally. This finding lends preliminary support to the contention that a dialectic of approach and avoidance in the countertransference might represent a presence of dissociative attunement.

A similar study by Smith, Kleijn and Hutschemaekers (2007) also found that vivid countertransference reactions were common in work with traumatized patients, with the majority of therapists reporting a predictable reaction to the patient’s trauma, including shock, anxiety, feeling destabilized and overwhelmed. Interestingly, there was a relative absence of these strong

feelings amongst therapists trained as trauma therapists and working at a trauma institute. This finding prompts suspicion about a dissociative process that may occur amongst therapists who have experienced intense countertransference responses in prolonged trauma work.

A related study by Oliveira and Vandenberghe (2009) found that therapists responded to difficult encounters in session by feeling helpless and silenced. Despite this, the researchers elaborated, “On the other hand, several times the therapists’ distress gave them new information that allowed them to review and deepen their understanding of the clients’ problems” (Oliveira & Vandenberghe, 2009, p. 239). The researchers noted the possibility for the therapist’s countertransference responses to derail the therapy, while also holding space for the possibility that moments of strong affective response and resonance in the therapist might strengthen the therapeutic alliance and reflect an important pathway to obtain otherwise unavailable information about the patient’s experience.

The available research on in-session countertransference awareness is split, alternately espousing these experiences as either helpful or hindering to the treatment. Williams (2003) found that patients rated their therapists as less helpful when therapists rated themselves as more self-aware during the session. However later research by Williams and Fauth (2005) found the opposite, noting that patients rated therapists more highly when therapists rated themselves as more self-aware. Williams and Fauth (2005) went on to explain that as therapist self-awareness in session increased, so did therapist levels of exhilaration and excitement, suggesting that with increased self-awareness came increased engagement in the process of therapy. This quantitative study, however, did not include important nuances about the impact of these moments of self-awareness on the therapeutic alliance or the therapist’s understanding of the patient.

Geller and Greenberg (2002) more specifically explore moments of in-session self-awareness, which they term *therapeutic presence*. The authors found that during these moments of self-awareness, therapists attended to their inner experiences in session, including internal images, feelings, and memories. The therapists also reported altered states of consciousness and a sense of absorption and timelessness that involved a merging or “sharing sacred space” with a patient. A later study by Cooper (2005), which explored in-session moments of “relational depth”, also found that therapists described altered states of consciousness, a sense of timelessness and a feeling of mutuality with the patient. The therapists described feeling deeply immersed and free from distractions, while also experiencing a “meeting of minds” in which the therapist’s inner experience was thought to resonate with the patient’s. These two studies suggest that the therapist’s inner experience can be both reflective of and contributory to moments of relational connection with the patient. This finding challenges the notion that engagement with a patient’s affect can be dangerous and unduly burdensome to the therapist. Instead, it frames the therapist’s attention to his/her inner experience as providing both a protective distance from the patient by way of a dissociative countertransference, and a potential for affective resonance. Despite its potential for both attunement and insight, scholarly attention to the in-session experiences of therapists is sorely lacking.

In this study I attempt to address these gaps in available theory and empirical research by examining the nature of the in-session, inner experience of therapists working with a patient with a chronic trauma history, and exploring the extent to which their inner experiences represent distractions, burdensome reflections of secondary posttraumatic stress, or moments of relational attunement and connection to the patient’s nonverbal experiences.

Research Question

This study seeks to both explore and expand the theoretical construct of dissociative attunement. The aim is to gather qualitative data about the in-session inner experience of therapists that occurs when patients who have histories of early life trauma dissociate in session. I seek to explore what kind of attunement might occur in the dissociative field and what potential this attunement holds to communicate dissociated images, affect or somatosensory experience that otherwise cannot be spoken about.

The primary research question of this inquiry is: **What is the reported internal experience of the therapist when a patient with an early life trauma history dissociates in session?**

There are several sub-questions to guide this inquiry:

What does the therapist's reported internal experience when a patient dissociates in session illuminate about the process of communication of dissociated content in the therapy dyad?

What can the reported in-session experience of the therapist illuminate about the process of attunement to a patient's dissociated aspects of self?

What are the component parts of the therapist's experience of attunement to a patient's dissociated aspects of self in the moment-to-moment experience of a therapy session?

How does the therapist understand the impact of this process on him/herself, the treatment and the therapeutic relationship?

CHAPTER III

METHODOLOGY

The preceding research question requires an approach to inquiry that provides a nuanced and in-depth understanding of a complex process of interaction between two people. My interest is in understanding deep and private thought processes that are not usually spoken about, but that continually guide decisions in the treatment and influence the therapist's ongoing engagement with the patient. The responses generated in gathering data for the study were unique, fluid and dynamic – different for each therapist-patient pair and different within the context of each session. Such responses are not easily quantifiable nor can they be adequately represented by aggregate data. Therefore, this inquiry lends itself well to a qualitative approach. Additionally, the nature of the interview questions represented a personal, and at times, taboo matter that was best explored in the context of an interviewing relationship marked by trust and a non-judgmental stance.

Research Approach

I employed a qualitative research approach using grounded theory. Grounded theory is useful specifically in the instance in which a theory is not available to describe a process, or the theories available are incomplete in some way (Charmaz, 2006; Creswell, 2007; McLeod, 2001). Creswell (2007) explains, “In this type of study, the researcher generates an abstract analytical schema of a phenomenon, a theory that explains some action, interaction, or process” (p. 239). Through a constant comparative analysis of the data, I planned to develop a specific theory to account for and explain the process of attending and attuning to dissociated content in the

therapy dyad. My inquiry emphasized the therapist's experience of the *process* of dissociative attunement, and thus grounded theory was an appropriate lens to help refine this theoretical construct on the basis of emerging data, and to identify its steps and component parts.

I locate this inquiry within a constructivist epistemology. I relied upon Charmaz's (2006) constructivist grounded theory to guide my inquiry. Constructivist grounded theory acknowledges the constructed nature of reality, that is, that knowledge is mutually created by viewer and viewed. According to constructivist grounded theory, the researcher interprets and constructs theory from the data, as opposed to discovering theory within the data alone. Charmaz (2006) explains: "Rather, we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives and research practices" (p.10). Charmaz's version of grounded theory views the emergence of theory in the data as an interactive, as opposed to an objective process, and therefore offers a parallel to the interactive nature of communication I investigated in the context of the psychotherapy dyad.

Sensitizing Concepts and Nominal Definitions

I relied upon several concepts that have emerged from the review of relevant literature in order to guide my inquiry. These concepts can be understood as sensitizing concepts – abstract and general concepts that sensitize the researcher to identify particular theoretically relevant phenomena in the data and provide a starting point for analysis of the data (Charmaz, 2006). The following list of sensitizing concepts have provided a loose frame to direct the kinds of questions I asked participants and how I interpreted the data, although I was careful not allow them to unduly influence or constrict what content emerged from the data.

Early Trauma History: Trauma is understood as a terrifying or horrifying experience in which the experience itself or the intense affect engendered threatens psychological survival (Howell, 2005). In order to designate an “early” and “chronic” trauma history, I proposed that traumatic experiences must have occurred prior to the age of ten years old and to have been repetitive in nature, with “repetitive” as determined by the patient’s therapist.

Dissociative Symptoms: Dissociation refers to a disconnection of thoughts, behaviors, sensations and emotions that would normally be connected (Cozolino, 2002; Howell, 2005). Dissociative symptoms include depersonalization, derealization, dissociative amnesia and identity confusion/identity fragmentation (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). For the purposes of this study, dissociation will not refer specifically to Dissociative Identity Disorder, but instead refer to a broader range of symptoms commonly captured under the diagnostic criteria Dissociative Disorder NOS.

Dissociative Mind/Dissociative Personality: A personality structure resulting from habitual reliance upon dissociation as a defense. This personality structure assumes a history of trauma early in life that is chronic and severe, usually perpetrated by primary caregivers. Indicators of this personality structure include the dissociation of bodily experience, knowledge or memory, as well as amnesia, central affects of fear and rage, and experiences of shifts in consciousness that the person cannot explain or understand (PDM Task Force, 2006).

Dissociated self-states: Highly discrete experiences of self, including unique affects and memories, that are cut off from the moment-to-moment conscious experience of self. The separation of these experiences of self is unconsciously enforced, motivated by a sense of

doom or dread about certain kinds of experience being known simultaneously (Bromberg, 2011; Stern, 2010).

Attunement: A state of reciprocal recognition between two people which includes a congruence or synchronicity of inner experience, with the understanding that the two people are not sharing the *identical* state, but rather sharing an affective experience in a different modality or intensity (Benjamin, 1995; Siegel, 2010).

Intersubjective: Mutual, including the subjectivities of both partners in the dyad.

Subsymbolic and Implicit Communication: Nonverbal communication of affective states or other knowledge in a dyad. This communication is systematic and organized, but continuous, analogic and often rooted in somatic and sensory modalities (Bucci, 2003).

Dissociative Attunement: Implicit knowing of information in the therapeutic dyad that includes an embodied connection and synchronous resonance between two subjectivities which occurs in the midst of a dissociative transference or countertransference (Hopenwasser, 2008).

Research Methods

In keeping with the interactive constructivist approach of this research, my primary method of data collection was the face-to-face interview. In addition, I asked participants to document an experience working with a patient who dissociates in session within four weeks of the initial interview via a written account.

Interview Sampling Criteria

My goal was to obtain a sample of therapists who had the experience of a patient dissociating in session and were able and willing to speak in detail about their own internal experience during this dissociation. I made every attempt to recruit therapists who were currently treating a patient who had dissociated in session in order to provide a more experience-near account of their internal responses during the dissociation. As recruitment proceeded, I decided to be flexible on these inclusion criteria in order to increase my sample size. In these cases, each participant reported on a prior experience of a patient dissociating in session provided that they could recall this experience in detail. Additionally, I focused my efforts on recruiting experienced therapists, and therefore required that potential participants have a minimum of three years of clinical experience. Finally, I sought to recruit a diverse sample of therapists and therefore did not limit my inclusion criteria to a particular training or theoretical orientation.

Inclusion criteria for this study were:

- Psychotherapist (psychologist, clinical social worker, psychiatrist or professional counselor) with three or more years of experience providing psychotherapy
- Psychotherapist who is currently treating at least one adult patient who has dissociated in session. This adult (over the age of eighteen) patient must also be a survivor of early life trauma (trauma occurred prior to the age of ten years old) in which the trauma was repetitive in nature and who presented to treatment with symptoms of dissociation (depersonalization, derealization, amnesia, or identity fragmentation or a diagnosis of a Dissociative Disorder according to the DSM)
- Psychotherapist who is willing to describe candidly and in detail countertransference responses and his/her internal experiences in session

Recruitment of Participants

I made an attempt to recruit participants with many years of experience in psychotherapy and those who considered themselves experts in the areas of trauma and dissociation. As a result, the recruitment process was arduous. It took a period of eight months to generate my sample of eleven participants. I began by distributing an IRB approved recruitment letter (See Appendix D) to two list serves: one comprised of clinical social workers in Pennsylvania and the second comprised of psychoanalytic psychologists in the region of Philadelphia. I also had a colleague forward my recruitment letter to two list serves of psychologists in the Pennsylvania region. These efforts generated four participants in the first two months. Additionally, I individually contacted over thirty local Philadelphia therapists who specialize in the treatment of trauma and PTSD. I identified these names through the use of professional contacts, as well as by utilizing the Psychology Today website and the profiles listed on the Philadelphia Society for Psychoanalytic Psychology. These efforts yielded an additional five participants over the course of four months. Finally, I requested that my recruitment letter be distributed in three additional outpatient and social work departments in the Pennsylvania region where colleagues were employed. These efforts resulted in an additional three participants.

When each potential participant was identified, I conducted a brief phone screening to ensure that each participant met the above-noted inclusion criteria (See Appendix E). I then explained my interest in conducting a one to two hour intensive interview about the nature of the therapist's inner experience when working with a patient who has a chronic trauma history who has dissociated in session. I defined "dissociated in session" as a moment of disconnect from reality or continuity of thought or memory, which may be evidenced by a blank gaze or an inability to remember what he/she has just been talking about. After determining that the

potential participant had the experience of being with a patient who has dissociated in session as defined here, I asked the potential participant about his/her comfort level in discussing his/her own countertransference responses, personal thoughts and reactions, and therapeutic interventions made in such cases. I scheduled each intensive interview approximately two weeks subsequent to the initial phone screening. During this intervening time, I asked that each participant pay specific attention to his/her inner experience in session and countertransference responses when a patient dissociates in session in the upcoming two weeks, prior to meeting for the scheduled intensive interview. This enabled participants to be better prepared to reflect on and respond to questions about their inner experience – experience that is often quickly discarded or not responded to as meaningful or memorable. In the initial phone screening, I also asked each potential participant about his or her comfort in having the interview recorded. I assured him or her that this audio recording would be destroyed two years subsequent to the conclusion of this study. I informed each potential participant that I would remove all names and other identifying information from the transcript. Finally, I indicated my interest in having each participant complete a brief written account subsequent to the interview and I explained what this entailed.

In keeping with theoretical sampling that is part of grounded theory, I began to open code the data early in the recruitment process. This enabled me to generate a list of potential themes and categories that I tested out as focused codes. In focused coding the first transcript with these identified themes, I identified twenty focused codes. In moving to focused coding the second transcript, I identified an additional six focused codes and condensed two codes into one. In focused coding the third transcript, I identified an additional two codes and again condensed two codes into one. In focused coding the fourth and fifth transcript, I found no additional focused codes. In focused coding the nine written accounts I received, no novel focused codes were

identified. Instead, it began to become more apparent how the codes were related to one another and how they fit together to form themes and categories. At this point, I determined that the data were saturated and decided to cease my recruitment efforts and move towards analyzing the data. At the time this occurred, I had already completed eleven intensive interviews and had received nine written accounts. Two written accounts were not returned to me by participants.

Description of Research Participants

Ten of the eleven participants were female and one was male. Five participants were doctoral level psychotherapists: two with a Ph.D. in psychology and three with a DSW in clinical social work. The six remaining participants were masters level psychotherapists: four with an LCSW, one with an LPC and another with an MA in psychology. Participants' experience level ranged from three to thirty one years, with a mean of eighteen years of experience in the field. Eight participants identified their primary practice location as private practice, while two identified college counseling centers and one identified an outpatient mental health agency. Ten participants were located in the state of Pennsylvania, with nine located in Philadelphia or the Philadelphia suburbs and one located in Pittsburgh, Pennsylvania. One participant was located in New Jersey, also in a suburb of Philadelphia. The participants each identified multiple and varying theoretical orientations, including relational, psychodynamic, cognitive behavioral therapy, dialectical behavioral therapy, family therapy, family systems, interpersonal, eye movement desensitization and reprocessing, strengths-based, and feminist orientations. Six participants espoused a psychodynamic theoretical orientation, while three identified a cognitive behavioral orientation, and four identified an interpersonal or relational orientation.

Data Collection Procedures

I conducted face-to-face intensive interviews with eleven experienced clinicians who had worked with or were currently working with an adult patient reporting an early and severe trauma history and active symptoms of dissociation, and had the experience of this patient dissociating in session. I relied upon a semi-structured interview guide to collect data pertaining to the therapist's inner and in-session experience when the patient evidenced dissociative gaps in session. The interview guide (see Appendix A) was developed on the basis of themes and questions discovered through review of existing theoretical literature and was modified as I continued to collect data and themes began to emerge (See Appendix B). I used these intensive interviews to collect data about the nature of the therapist's inner experience when a patient dissociated in session, what meaning the therapist made of his/her experience, the concurrent context occurring in the session, as well as the therapist's construction of what was happening for the patient in these moments. I also specifically explored the therapist's possible experiences of empathic attunement, dissociative countertransference, and reverie. The interview guide was adhered to in a loose way, allowing for discussion and discovery of themes that each participant found meaningful. Each of these eleven interviews was audio recorded and then transcribed verbatim.

In order to triangulate the data and to procure a longer period of engagement, I additionally asked each participant to complete a written account subsequent to the intensive interview detailing an additional experience of working with a patient who has dissociated in session (either an experience working with the same patient discussed in the interview regarding a different in-session experience of dissociation, or an experience with a different patient who dissociated in session). I provided an open-ended questionnaire to each participant at the

conclusion of the intensive interview (See Appendix B) and I requested that they complete this questionnaire in order to document a written account of their experience of a patient dissociating in session. I asked that participants complete this written account immediately following the session in which a patient dissociated in session in order to get a more experience-near account of their internal responses. The questionnaire was brief in order to reduce the time burden placed upon participants. I asked that each participant de-identify any patient information in the written account. I also requested that these written accounts be sent to me by mail using an addressed, stamped envelope that I provided to participants during the intensive interview. I asked that participants complete the written account within one month following the intensive interview. I requested this additional follow up in order to have each participant be primed to attend to experiences in which a patient dissociates in session in a more intentional way after the intensive interview was completed. Additionally, the follow up written accounts provided a more prolonged engagement (Lincoln & Guba, 1984) with each participant and a varied source of data collection from each participant.

Setting

Ten of the eleven interviews were conducted in the private offices of the participant. Meeting with the participants in a location that was familiar to each of them offered privacy as well as comfort that enabled the interviews to proceed easily and remain uninterrupted. The remaining interview was conducted in a private office space at the university where I work, which again offered privacy and a neutral space free from distractions. The interviews lasted between 61 and 93 minutes, with a mean interview time of 73 minutes.

Participant Compensation

Participants were compensated a total of fifty dollars for participation in this study. This amount of compensation was determined by considering that experienced practitioners who engage in private practice may collect up to two hundred dollars per clinical hour. Although the compensation of fifty dollars may appear modest in comparison, my rationale was that fifty dollars was a reasonable amount to attract more experienced clinicians who are intent on contributing to scholarship and research and to compensate them for the dedication of their time while not inserting undue influence upon the choice to participate in this study. Compensation was broken down into two parts. I compensated each participant thirty dollars in cash for completing the intensive interview. Upon receipt of the written account, I compensated each participant with a check for an additional twenty dollars, mailed to the address that they provided me.

Statement of Human Subjects Protection

This study incorporated several procedures to protect human subjects. The study solely involved psychotherapists and mental health providers. I asked these participants to describe their inner experience in session with a patient who dissociates in session, but I did not ask for or retain any identifying information about the patients, or copious detail about the nature of the patients' trauma histories. Instead, I focused on understanding the nature of the *therapist's* in-session experiences. Additionally, I offered to redact any information that any participant had inadvertently shared about their patient's identity. One participant did choose to redact several pieces of information she had shared about her patient's history that she felt were too identifying.

Although psychotherapists and mental health providers are not considered a protected or vulnerable population, I did ask participants sensitive questions about their private and internal experiences. In several instances, participants commented on feeling uncomfortable about having disclosed so much to me about their internal experience, and their perceived treatment errors or inadequacies as a clinician. In each case, I offered the opportunity for each participant to redact any information from the transcript. In one case the participant asked to see a copy of the transcript prior to publication of any findings. I mailed the transcript of her interview to her office address, as per her request, and redacted any information she was uncomfortable sharing. I also contended with each participant's discomfort by framing the interview from the outset as an inquiry into how information is communicated in the dyad, and explicitly stated that this inquiry would not be an evaluation or exploration of clinical skills. Further, I was careful not to probe into sensitive material about the participants' personal lives. I also clearly indicated that each participant could withdraw from the study at any time.

I required each participant to sign a consent form prior to participation in this study. I clearly detailed the potential risks and benefits of participation and reviewed all procedures to protect participants' confidentiality and the anonymity of the data (See Appendix D). I provided my contact information in the case that a referral for more ongoing support services was necessitated. Finally, this project received approval from the University of Pennsylvania Institutional Review Board before any data were collected.

Data Management

I managed all of the data for this study. Each interview was audio recorded. I loaded each audio file onto a password-protected computer, and saved each file as "Interview 1", "Interview 2" et cetera. Each audio file was then deleted from the digital recorder. I transcribed each

interview verbatim in a Microsoft word document, again labeled and saved as “Transcript 1”, “Transcript 2” et cetera. I then assigned each participant a pseudonym. I was careful to redact or alter any identifying information, such as practice location or names of local hospitals referred to, from the written transcripts. I have retained several documents, such as the participant’s signed consent forms and written accounts that include each participant’s full name. These documents are being kept in a locked filing cabinet that only I have access to. I have destroyed all documents that could link each participant’s identity to their reported data.

Methods of Data Analysis

I analyzed the transcripts and written accounts using an inductive approach in which the patterns and themes emerged from the data, rather than being imposed onto the data (Bowen, 2005). I used a constant comparative method of data analysis in which I examined the transcripts line by line as a way of opening up the data to examine all possible interpretations. I began my analysis with line by line coding of five initial interviews. I chose these five interviews intentionally for diversity of data, including several very experienced therapists, several more novice therapists, and therapists of varying theoretical orientations. I simultaneously engaged in memoing, defined as “a process in which the researcher writes down ideas about the evolving theory throughout the process of open, axial, and selective coding” (Creswell, 2007, p. 67). Memoing aided me in keeping track of my preliminary hypotheses about the emerging categories, themes or overarching theory and helped me to keep an audit trail of how my ideas about the theoretical construct of dissociative attunement evolved from engagement with the data.

Line by line coding of the five initial interviews generated 1,690 open codes. I then began to compare these open codes to one another and group them together on the basis of similarity. This enabled me to generate a smaller number of themes, called focused codes (Creswell, 2007), that appeared consistently throughout the data and helped describe the component parts of the process of dissociative attunement. I began by comparing open codes from one transcript at a time, and then comparing the open codes across transcripts. In organizing the open codes from the first transcript, I identified twenty focused codes: Long term treatment, Therapist not all knowing, Therapist attempting to reach patient, Enactments, Therapist Images, Reasons for Dissociation, Containment, Distancing Impact of Dissociation, Empathy, Timelessness, Being with Patient, Co-Created, Competency/Inadequacy, Detecting Dissociation, Suicidality, Patient Identity not Integrated, Anger, Anxiety, and Mutual Dissociation. I then organized the open codes from the second transcript and added six additional focused codes to my initial list, renamed one focused code, and condensed two focused codes into one. I engaged in the same process for the third transcript, and added two additional focused codes and again condensed two focused codes into one. I engaged in the same process for the fourth coded transcript, and added only one additional focused code. I found that the focused codes I had already generated adequately captured all of the remaining open codes. I engaged in the same process again for the fifth coded transcript, and found no additional focused codes. I then reviewed the data from the written accounts. I triangulated the data from the interview transcripts with the data from the written accounts and found that the written accounts yielded no additional focused codes. Instead, I began to have ideas about how to combine and refine these focused codes into categories and subcategories. This gave me an indication that I should move from line by line coding into focused coding, applying my focused codes to all eleven transcripts and nine written

accounts. I began this process with a list of twenty-two focused codes, several with subcategories under each focused code. I list my preliminary focused codes here:

1. Severity of case
 - a. Lack of Integration
 - b. Suicidality
 - c. Long Term Treatment
2. Aloneness
3. Anger and Frustration
4. Therapist Anxiety
 - a. Surprise
5. Therapist Competency/Inadequacy
6. Reason for Dissociation
 - a. Function of the Dissociation for patient
 - b. Function of the dissociation for the therapy dyad
7. Detecting Dissociation
 - a. What Dissociation Looks Like
 - b. Therapist Feeling/Gut Sense
8. Mutual Dissociation
 - a. Timelessness
9. Therapist as Placeholder
10. Being with patient
11. Attempts to reach patient
12. Distancing/Disjunction
13. Closeness/Empathy
 - a. Parallel Experience
14. Duality
 - a. Level of Focus
15. Nonverbal/Implicit Communication
16. Therapist Imaginings

17. Accepting the Dissociation
18. Containment
19. Enactments
20. Therapist cautiousness
21. Therapist feeling of responsibility
22. Therapist feeling like the holder/caretaker of patient

I attempted to treat each of these focused codes as preliminary categories and I used the process of focused coding to determine whether or not the focused code constituted a category. I also engaged in ongoing memoing to begin to clarify what the categories consisted of and to specify the relationships between the categories.

I then moved to a loose form of axial coding to re-contextualize these emergent themes as they existed in the data, to develop subcategories and to show the associations between categories (Charmaz, 2006). I compared these emerging categories with the data in subsequent interviews in order to maintain an iterative process and stay grounded in the data. Axial coding enabled me to use narrative and language to more closely define each category, look for the conditions in which each category arose and was maintained, and illustrate how each category was related to other categories (Charmaz, 2006). This process enabled me to move from categories to themes and finally to theory development. This left me with a slightly modified list of themes that I organized in order to develop my theory. I include my final list of themes here:

1. Severity of case
 - a. Lack of Integration
 - b. Suicidality
 - c. Long Term Treatment
2. Triggers for Dissociation
 - a. Termination

- b. Putting together the trauma narrative
 - c. Revisiting the trauma
 - d. Affective overload
- 3. Functions of the Dissociation
 - a. Intrapsychic Function of Dissociation for the Patient
 - b. Function of the Dissociation in the Therapy Dyad
- 4. Therapist Anxiety
 - a. Therapist Guilt
 - b. Therapist Competency/Inadequacy
 - c. Therapist Dread/Doom
 - d. Therapist Losing Track of One's Own Sanity
- 5. Therapist Being Left Alone
 - a. Retreat into one's own subjectivity
- 6. Therapist Hyperarousal
- 7. Therapist Mutual Dissociative Experience
- 8. Distancing/Disjunction
- 9. Therapist Closeness/Connection
 - a. Accepting the Dissociation
- 10. Therapist as Placeholder
- 11. Induced Feeling
- 12. Perception of Nonverbal Signals
- 13. Authentic Connection
- 14. Parental Role and Responsibility
- 15. Containment
- 16. Implicit Communication
 - a. Nonverbal Communication
 - b. Parallel Experience
 - c. Therapist Imaginings

With the exception of enactments and therapist cautiousness, each of the original focused codes is represented in some form in this final list of themes. Therapist cautiousness was folded

into the therapist anxiety theme. The enactments focused code did not generate enough examples throughout the data to rise to the level of a theme. Several focused codes were also folded into larger themes, such as Being with patient and Attempts to reach patient, which are now represented in the theme Authentic Connection. Likewise the focused code Therapist feeling like holder/caretaker of patient, is now folded under the theme of Parental Role and Responsibility. Further detail about the meaning and relationship between these themes can be found in the Findings Section.

Methods to Ensure Rigor

The discipline of qualitative research includes multiple standards for assessing the quality, in quantitative research named reliability and validity, of the inquiry. These standards include credibility, dependability, confirmability and reflexivity (Hall & Callery, 2001; Morrow, 2005). *Credibility* is analogous to internal validity, that is, how believable the account seems to those studied and to the reader (Mays & Pope, 2000; Morrow, 2005). In order to assure credibility, I triangulated the data by using both intensive interviews as well as written accounts with each participant. Nine of the eleven participants returned written accounts. Using two forms of data collection with nine of the participants also enabled me to have more prolonged engagement with each of them and thus further ensured credibility of the data. This longer engagement afforded me the opportunity for more depth of data collection and enabled me to develop “thick descriptions” – detailed and rich accounts of the participants’ in-session experiences, as well as their perception of the surrounding contextual factors (Morrow, 2005).

Dependability refers to the consistency and transparency of the study design, such that it can be replicated over time (Morrow, 2005). In order to ensure dependability, I kept a meticulous

audit trail of all of my research activities, including how I recruited participants and my process of coding the data. I also employed memoing while open coding the data in order to keep my thought process transparent as I came to identify emerging themes in the data.

Confirmability refers to the extent to which the researcher has remained grounded in the data as she constructed theory, as opposed to imposing her pet theories onto the data (Morrow, 2005). I engaged in several strategies to manage my bias and retain the integrity of my findings. A fellow doctoral student employing a qualitative research design using grounded theory engaged in a peer review of both my audit trail and my process of data analysis. This peer researcher engaged in open coding of one randomly selected transcript in order to compare codes. Upon initial inspection, 221 codes matched word for word or nearly word for word, while 33 codes were mismatched. I also found 58 additional codes in my transcript that the peer researcher did not code at all, and I found that the peer researcher had 55 codes that I did not code at all. Of these, I added 40 codes that the peer researcher included that were absent in my own coding and chose not to add 15 of the peer researcher's remaining codes as I found them to be irrelevant to my data analysis. I also altered the words used in five codes in order to come to a closer agreement between codes. After these adjustments, 267 codes were matched nearly word for word while 33 codes remained mismatched, contributing to a concordance rate of 87.6 percent. I also attempted to make my process of analyzing the data transparent by recording as much detail as possible about my thought process and actions in moving from the raw data to developing open codes, focused codes, and then themes and categories.

Finally, *reflexivity* is a standard for assessing qualitative research that is particularly suited to constructivist grounded theory. Reflexivity refers to the way the researcher's background affects the inquiry, including the questions asked and the topics pursued in the

interview, as well as the framing of the findings (Malterud, 2001). In order to make my interaction with the participants and the construction of the findings more transparent, I engaged in an ongoing process of reflexivity. I began by reflecting on the ways in which my biases might be informing my interpretation of the data and I spoke with my peers and dissertation chair in order to manage these biases. I have also utilized ongoing memoing in order to document my involvement in the construction of the theory. I have also included a reflexivity statement below that clearly explicates my expectations to the reader, such that he/she can understand the way I have interacted with the emerging data and shaped the findings.

Reflexivity Statement

I identify as a trauma therapist familiar with the work of relational trauma analysts, such as Phillip Bromberg and Donnel Stern. Their work posits that the therapist's countertransference reactions hold potentially valuable information about the patient and represent a way to evocatively know the experiences of the patient that are dissociated or unformulated (Bromberg, 1998; Stern, 2010). While there is limited empirical research to suggest that the theoretical ideas of Bromberg or Stern carry any weight, I am intrigued by their ideas and have anecdotally experienced truth to their claims in the course of my work with survivors of chronic trauma. I have found that while a patient dissociates in session, particular feelings or images come to my mind in a state of consciousness that feels almost dream-like. At times, I have noticed that the content of the session that follows may be related to a thought, feeling, or image that briefly passed through my mind in a moment of disconnect from the patient. It has led me to wonder about the nature of what happens when the patient and I both fall into the "dead zone" in session. I sense that there is some process of communication happening just below the surface of

awareness. Furthermore, new research in relational neurobiology has begun to explain such uncanny, mind-to-mind communications by way of mirror neurons and right-brain-to-right-brain communication (Schoore & Schoore, 2008).

My interest in conducting this inquiry was to make sense of the experiential nature of this communication by gathering data from therapists who can speak to these moments of mutual dissociation or dissociative attunements in psychotherapy and can elaborate on them in great depth and detail. I was vigilant in guarding against my bias that moments of mutual dissociation hold great insight for the treatment. I carefully posed open-ended questions about the nature of the therapist's internal experiences in session, listened and probed for concrete details, and was open to responses that confirmed or disconfirmed my own anecdotal experiences. I engaged in memoing to track the progression of my thoughts as themes and theories emerged from the data. A close review of my memoing aided me in monitoring and managing my bias as it occurred.

While I was conducting the face-to-face interviews, I found that my skill set as a psychodynamic psychotherapist transitioned easily to the tasks of qualitative research. I am comfortable with asking open-ended questions and waiting in silence for a patient to respond by sharing their thoughts and experiences. I relied on this skill of asking open-ended questions and resisting the temptation to insert my own thoughts or opinions into the conversation with participants. I also have developed an ability to make people feel comfortable and safe through my work as a psychotherapist. I leaned on this skill during the intensive interviews in order to enable participants to feel comfortable enough to share of their inner experience, oftentimes revealing what they considered to be shameful or embarrassing thoughts and actions through the course of our conversation.

While many of my skills as a psychotherapist aided me in this research, I also at times struggled to move out of the clinician role and into the interviewer role during the face-to-face interviews. At times, I would offer validating statements to participants such as “That sounds like it must have been awful for you,” thereby inserting a word around their experience that they had not used as a label. I also had difficulty refraining from offering comfort to participants when they described experiences that were admittedly difficult for them or revealed aspects of themselves or past behaviors they found shameful. I improved in my abilities to withstand the temptation to insert myself as a clinician as the interviews progressed, however there remains a possibility that my insertion of validating statements or comforting remarks biased the participants to reframe or re-label the account of their experiences through the remainder of the interview.

In the process of analyzing the data, I believe my skills as a psychotherapist again aided me in the work of constructing meaning out of the raw data. Through my training in psychodynamic theory and treatment, I have become skilled in the art of listening for the meaning behind a person’s words and understanding what has been left unsaid. This skill enabled me to quickly sort through the many details of each account to unearth what I considered to be the essence of each participant’s experience. I also have become skilled in the ability to discern patterns and themes through my work as a psychotherapist. I relied heavily on this skill during my data analysis, and found I was able to readily discern the pertinent themes of each participant’s narrative and then compare these themes across participant accounts.

The following three chapters will detail the patterns and themes that emerged through the process of data analysis and the meaning I constructed of the participants’ experiences.

Organization of Findings

The purpose of this qualitative study was to gain an in-depth understanding of the nature of the therapist's inner experience when a patient dissociates in session and to explore the extent to which the therapist's reported inner experience illuminates a process of attunement to or communication of dissociated content in the therapy dyad. The findings of this dissertation are derived from the analysis of semi-structured interviews with eleven experienced psychotherapists and the analysis of written accounts provided by nine of these psychotherapists.

The findings of this study are organized into three chapters. The first chapter, Context of Psychotherapy, describes the framework of psychotherapy that each participant reported on, including the type of patient and the nature of the dissociation that the patient displayed. The second chapter, Dissociation as an Interpersonal Process, details how the dissociation became an interpersonal phenomenon, including the way that participants described their own internal experiences and responses to the patient's dissociation. The third chapter, Dissociative Attunement, describes how the therapist was able to come into attunement with the patient during her dissociation in session. This section has several subsections, each of which represents a component part of the therapist's process of dissociative attunement.

Throughout each chapter, passages and quotations have been chosen and displayed verbatim in order to illustrate the main ideas for each concept. All participants have been assigned pseudonyms and any identifying information about the participants has been altered to protect their privacy. In several instances, researcher comments and questions are provided in order to offer context or meaning to each participant's contributions. Researcher comments are indicated with the letter "J." On occasion, I have chosen to highlight a particularly meaningful segment of a participant's quotation by placing this text in boldface print. Additionally, there are

several instances in which I have used the same quotation in multiple sections in order to illustrate different components of a participant's verbalization. Care has been taken to provide rich and varied examples from all eleven participants, though some participants were more verbose or eloquent than others, and as such, have been quoted more frequently.

CHAPTER IV

FINDINGS I: CONTEXT OF PSYCHOTHERAPY

A Severe Case

Each of the eleven participants was interviewed on the basis of having experienced a patient with an early trauma history dissociate in session. Though care was taken not to probe into the nature of each patient's trauma history in any detailed way, nine of the therapists interviewed commented on the severity of the patient's trauma and the ensuing difficulty this created in the therapy context. I will provide several examples of the participants' descriptions in order to provide a contextual frame of the treatment environment and the complicated nature of the therapist-patient matrix being discussed.

Eight participants named the type of trauma the patient suffered. In every case, the trauma was interpersonal in nature, almost always perpetrated by a person who was meant to be a safe haven – a coworker, an uncle, a father, a mother. Each time a participant chose to name the patient's trauma, it was in an effort to display how significant and ultimately, deleterious, the trauma was. For instance, Elise shared about the patient in question:

She has significant trauma. She was, umm, molested, abused, every day from age five to age thirteen by a much older uncle. She worked for him, she helped him around his house and he had sex with her. She's a very damaged woman, lovely woman, but very damaged.

Elise's description of her patient was typical of the other participant accounts. The traumas they reported were severe in nature, and often long-lasting. Another participant, Anna, described her patient's trauma as the most severe she has ever seen in her long career of treating trauma survivors. She described a patient who was involved in a complex and horrifying human trafficking and child pornography ring from birth. She went on to say, "Okay this is a young

woman . . . **whose trauma is the most severe that I've ever ever treated, or even read about or heard about. She's in a category, umm, it's practically beyond comprehension.**"

Other participants refrained from describing the nature of the patient's trauma history, but instead relayed a complicated symptom picture that constituted one of the most difficult patient presentations they had confronted in their clinical practice. All eleven of the participants described dissociative symptoms in the clinical presentation, ranging from brief episodes of dissociative trance in session to severe and chronic dissociation both in and out of session. Three of the participants talked about a patient diagnosed with DID. Five participants noted either passing or constant suicidality or self-injury in addition to prominent dissociative symptoms. Marcy, for instance, shared, "She, in a dissociative state, she would wander into Rite Aid and buy razor blades." Elise shared one time in which she had to call 911 to send the police to her patient's house to check on her after the patient had called and said: "It's just not worth it. I want to die."

In addition to these chronic symptoms of dissociation and suicidality, the participants described a striking level of fragmentation and disorientation that pervaded their patient's lives and spoken narratives. Anna explained, "Someone who's had this level of trauma, it's very fragmented. It's in and out. The timeline is way off. It's hard to grasp any kind of continual information, you know?" Tasha also noted this fragmentation, what she called a "psychotic feature about her depression" that left her patient with "trouble keeping her thoughts together."

Tasha went on to name this disorientation as not having a core, or not having a "there there":

T: . . . Something in her presentation . . . it's like, the energetic hit on her, just how it feels to be with her, **it feels scattered. It feels like, is there a there there?** And yet she is relational and she'll talk to you. And I'll think, there is a there there. . . . It's just, it's like she either lost something or never had it. It's sort of that thing that keeps people together in the middle.

J: And it sounds like it's hard to even put your finger on even what that thing is?

T: I don't know. So, you know um, you could call it, so you could call it ego strength. You could call it having an integrated, uh having, being integrated body, mind, emotions, spirit. You know. You could call it having a core. **Like there is no there there. There is no core in this person.**

Tasha's words beautifully capture the extent of fragmentation that these patients contended with, often leaving the therapist grasping to hold the disparate pieces together.

Pursuant to these complex clinical presentations, the patients described in this study were veterans of psychotherapy. Five participants commented on the long-term nature of their treatment with the patient in question. Marcy said she's been seeing this patient for at least five years. She explained, "It speaks to how long this work takes." One participant referred to the long-term nature of the work three separate times throughout the interview. Several other participants commented on the way existing treatment modalities failed to offer the patient any relief, challenging the therapist's prevailing notions about treatment. For instance, both Kaitlyn and Tasha described their patient's extensive use of mental health services at various levels of care:

We extended her, so she, normally the programs are like eight weeks long but she stayed for MUCH much longer than that. Which is really like uncommon but she was so acute and she was stuck. (Kaitlyn)

This so, this particular patient has had depression for most of her life as you might imagine. And she's been in the hospital many many times. She's had ECT. She's had multiple trials or runs of various psychotropic meds and uh you know quote nothing works. Meaning you know it all helps her some, but, and uh so she's a very experienced patient. You know she doesn't come to this, um, it's not new to her. (Tasha)

Like Kaitlyn and Tasha, Stephanie also commented on the failure of all psychotropic medications to alleviate her patient's depressive symptoms. Ultimately, Stephanie ascertained that these existing treatment modalities failed her because of her "abuse history."

Because she was depressed, we had tried some antidepressant medication. So she did have that addictive thinking that the medication is going to fix this. That was another reason why I thought this woman was abused as a child. There was no medication that fixed her affective problems. We tried everything on the market. She was a bright woman. She was actually in the therapy business, so she knew when a new antidepressant came on the market and she, she'd say, I want to try that. And we'd try that, and after a number of years, when she finally started to get these pieces and disclose about the abuse history. I finally just sat her down and said, "There is no medication that is going to fix this. This is about your abuse. This is what your depression is about and there is no pill that is going to change what happened to you."

These participant comments highlight the extent of the patient's needs and the failure of traditional therapies to provide relief for these patients with such a severe, extensive and early trauma history.

The comments that participants made about the length and the difficulty of the treatment seemed intended to describe both the grueling nature of the work and to simultaneously apologize for their own perceived treatment failures and the frustration they at times experienced with the patient and the treatment process. Several participants even admitted to feeling drained by engaging in such demanding psychotherapeutic work with patients with such a severe trauma history. Marcy called this "about the hardest work I've ever had to do." Kaitlyn described the work as "always just intense" and admitted to feeling drained after each session. Stephanie likewise experienced this work as incredibly demanding. Ultimately, she admitted to her desire to extricate herself from the patient she described. She explained:

We worked together for three years, regularly. He came, never missed a session. And we had to end because his insurance changed. I was no longer an approved provider for him. And this was a client with abandonment issues, Axis I, Axis II, huge borderline abandonment, huge. So when his insurance changed, um they did give us six months transition time, wow. That was huge. So I had to transfer him. I didn't have a choice. **But I gotta say, that was enough. That was very intense work with him (laughs). And I was ready to be, I was ready to pass him to someone else after three years of very intense work (sighs).** I learned so much about working with adults abused as children, um, and it was really intense. **I was ready for a breather.**

These verbalizations make clear the impact that engaging in an intense therapeutic relationship with a highly traumatized patient holds on the therapist. In no way does the theory that follows constitute “typical” therapeutic work with a “typical” patient. Instead, these data refer to the interpersonal process that occurs while engaging in intense therapeutic work with those who have been injured and damaged in primitive, preverbal and what at times seems like irrevocable ways by those that were intended to care for and protect them. The therapist, then, enters into this matrix attempting to be a new kind of caregiver, to offer what could be understood as a corrective experience. And yet, entering this matrix is always thorny, leaving the therapist prey to projections, misinterpretations, transference, and a dark, affective world of feelings without thought, narrative or sense. What follows represents the journey of the therapist who enters into this dissociative world.

How Dissociation Enters the Dyad

During each interview, therapists began by describing the context during which the in-session dissociation occurred. This section will describe the therapist’s perception of why and how dissociation entered into the therapy matrix at the time that it did, and detail the way that the therapists made meaning of this dissociative process as having both an intrapsychic function for the patient and an interpersonal function for the therapy dyad.

Triggers for Dissociation

Engagement in trauma narrative. Eight of the eleven participants reported that the patient fell into a dissociative trance just as he/she was piecing together new fragments of a traumatic memory. Most often, the patient began to enter into his/her trauma memory within the context of the therapy session. The participants understood the patient’s immersion in the trauma

memory as the trigger for her dissociation in session. Six of the participants clarified that they were not pressing for the patient to enter into the trauma memory, but rather that the patient tumbled into it on her own. For instance, Kaitlyn explained that she was surprised by how quickly the patient began to think about her early traumatic memories, and how intensely she fell into these memories. She explained that as the patient “started to unravel,” she felt the urgent need to “get it [her symptoms] under control.” Kaitlyn continued:

And then she went to why she couldn't get it under control, like fast. So it wasn't even that I solicited like let's go deeper, let's talk about your trauma. But she almost couldn't keep it in anymore because she was unraveling so fast. So when she started to talk about it, it just was like, she um, she talked about her father and she was saying like, “But he, and he, hurt me.” And then she just started to dissociate. So I almost felt like she wanted to put more out there, like she wanted to talk through some of it but she couldn't actually do it and that's when she started to just ...(voice trails off).

Kaitlyn felt her patient desired to process the trauma memory, but just wasn't ready to do so so quickly.

In one case, the patient dissociated on her way to the session, in anticipation of engaging her trauma memory. Tasha explained that following an intense session, her patient dissociated while driving her car on her way into the next session. Tasha explained how she understood this:

My hypothesis is that we had had a very very intense session the week before. And she had a lot of um trauma um reaction. She had a lot of um traumatic memories and in reaction to that session she had difficulty during the week and I think she was afraid to come.

Engagement with the trauma narrative, either prior to or during the session, was the most commonly cited trigger for the patient's dissociation. Participants clarified that it was not simply that patients were recalling a traumatic memory, but instead that they were entering into “trauma time.” They were not able to stay grounded in the safe presence of the therapist, in the here and now, but instead slipped back into the experience of being traumatized. They weren't thinking about being traumatized, or even remembering being traumatized, *they were being traumatized*,

all over again. This is illustrated in the following dialogue with Kaitlyn, which reflects her assumption that her patient was re-experiencing her early life trauma right before her eyes.

J: So did you have a sense, or a guess, about where it was that she went when she was in this place?

K: Oh, no, I found out later that it was that she did go back to the trauma with her father.

J: Was she able to describe at all what it was she was picturing?

K: Umm not all of it, but some of it. Like the brutal sexual trauma that she experienced with him and that he would rape her in her bed every night.

Later Kaitlyn continued:

K: I knew she was going back to her trauma.

J: Did she talk about how she was replaying that?

K: She would be on her bed and her dad would be abusing her. . . . it felt like it was happening right in that moment.

Here, Kaitlyn made the distinction between talking about the trauma and *being in the trauma*. According to the participants, it was being in the trauma that triggered the patient's dissociation. Darlene was able to most clearly articulate what happened to her patient when she fell into trauma time. As her patient traveled back in her mind to early childhood memories of a traumatic experience, she lost her ability to maintain a safe connection to the present. Darlene elaborated:

Yeah, I think she was going into old material that I don't think she had shared with anybody. That was some early memories about her childhood. . . . And so I think she started to get into sorta kind of almost being there in that time period meaning those feelings and memories, and yeah to the exclusion of the present here.

Moments later, Darlene clarified:

. . . **Well I think of it as getting into the depth of a memory and possibly having it feel so real that it sort of drowns out what is present around.** Sort of becomes vivid and. . . I guess I know that when someone dissociates they're thinking about this other thing so much and being in that experience so much that it's kind of making it

hard to be present so that they don't have the dual attention to dip into the past and also be present here. So they've lost that.

Darlene used this language of “dual attention” to describe the ability to think about a memory while remaining safely in the present. When the trauma memory was so horrific or so wholly unprocessed, the patient lost this ability for dual attention and entered into a dissociative trance.

Relational enactment of the trauma narrative. According to participants, a second trigger for the patient's dissociation was some kind of re-enactment of the original trauma scenario in the here-and-now context of the therapy dyad. For instance, two participants described the way that their patient's dissociative episode in session followed a conversation about termination, which hearkened back to each patient's early feelings of abandonment and neglect. In these cases, the patient's early traumatic scenario was recreated in the therapy relationship, again leaving the patient feeling that he/she was reliving the trauma in present time.

Kaitlyn provided a good example of this phenomenon. While working at an intensive outpatient center, she made the decision that her patient required a higher level of care. The dissociative trance occurred immediately after Kaitlyn shared her clinical opinion that her patient needed to be transferred to a new treatment team at a different facility, and then attempted to help her patient process her reactions to this news. Kaitlyn explained:

. . .So when I talked to her about that [the transition], she like, **I lost her for a really long amount of time.** Um I think because that's where she really felt like um.(sic) I think that's where, if I look back on it now. **I think that's where she reverted in her mind, like she, everything was out of her own control.** That's what she felt in that moment and that's where I think she just completely like went to a whole other place.

When I asked Kaitlyn to describe how she imagined her patient responded to the pending termination of their relationship, Kaitlyn shared:

But when it came to the time that she needed to talk about a higher level of care and everything just felt like, **I think for her in that moment, it felt like her world collapsed on her and she went back to a place of just being out of control.**

In this example, Kaitlyn's decision to terminate the treatment relationship propelled her patient into trauma time. The "place of being out of control" was the patient's experience of being sexually abused and then abandoned by her mother. The relational encounter with Kaitlyn was a re-enactment of this original abandonment in her time of need. The patient could no longer maintain the "dual attention" to differentiate the present from the past, and then entered into a prolonged dissociative state.

Ruth likewise shared an example of how an unintentional relational re-enactment of the original trauma scenario triggered her patient's dissociation. She described a final session with a patient that she was ending treatment with due to insurance changes. The dissociation occurred after Ruth initiated a conversation about the upcoming termination and attempted to process her patient's feelings about saying goodbye. The following dialogue illustrates how this conversation prompted her patient's dissociation.

R: We were talking about ending. So I mean this was something that this particular individual was not comfortable with talking about. At all. And really minimized, really minimized.

J: And what do you think it was that was triggered, that was coming up for her?

R: What I think? Or what she thinks?

J: Either one.

R: Abandonment issues. I mean, she would not identify, I know she would not identify that as such. . . . I mean issues involving neglect, abandonment.

J: And what thoughts do you have about how it was that those thoughts for her parlayed into dissociation?

R: . . . I was the one who initiated talking about the relationship and about termination. She was focused on a different issue. She had made her decision [to terminate the relationship]. She had made her decision but at no point in time did she want to talk about the relationship. And what meaning that had to her. That was something very difficult to talk about. And about how her decision would impact her, if it would in any way. She

didn't want to go there. Okay? Um, so I think of her, if I think back to the session, I think I was the one who initiated conversation about that particular piece, and I believe it was right after I had brought that up, opening up the possibility of the conversation about THAT piece of it, that that was when this[the patient's dissociation] had happened. . . . Instead of her being able to enter into the conversation, she then started to dissociate.

Again in this example, the patient was not able to differentiate past from present. She experienced the ending of the therapy relationship as a replication of the abandonment in the original trauma. As time collapsed on her, the patient entered into a dissociative trance.

Progress and integration. Participants described a third trigger for dissociation that occurred when the patient began to inch towards progress, integrating formerly split-off memories or feeling states. Four participants commented on the way their patient's dissociation followed a small triumph of integration – progress towards a more clear understanding of self, the perpetrator or the trauma memory itself. Anna, for instance, described how her patient entered into a dissociative state upon getting new information about her traumatic memory. Anna explained that her patient began to identify fragmented images and memories of her abuse beyond that perpetrated by the woman who raised her. Instead, Anna's patient was beginning to recall another man who abused her, and many other children who were abused alongside of her in a trafficking and child pornography ring. Anna added that her patient was coming to understand new information about her role in the trauma for the first time, which then prompted her dissociative state in session. She explained:

She's starting to tell me what she remembers. There's the van and my job and I had to clean up blood and all this awful stuff. The biggest piece of it, I'm realizing, is that she's been carrying around this belief that she's bad and she did terrible things to these kids. So what was clear was, is that she was given some kind of job where she had to go in and shut them up if they were crying and screaming.

As Anna's patient came into contact with more details of the trauma memory, including ways she was forced to harm other children, she began to construct a clearer and more verbal narrative of what happened to her. This was perhaps too much to bear, and she began to dissociate.

Stephanie shared another example of her patient moving towards integration of her trauma narrative, which prompted her dissociation in session. Stephanie noted that her patient was beginning to incorporate a more left-brained and cognitive structure around her trauma narrative by asking questions of her family members to get the facts about what happened to her. Here, Stephanie described her patient's dissociation as occurring just as she began to integrate formerly fragmented components of her trauma memory. Stephanie explained:

You know and she was getting bits and pieces and she was starting to put the bits and pieces together. . . . and she also started talking to some of her family members, so as she got bits and pieces, she was grounding the bits and pieces in what do you remember? About mom? About the household composition? About foster care? About this man that was in the house? What do you remember about this? So she was putting the pieces together very consciously and cognitively.... So she was in the process of doing that and talking to different people about what do you remember about this period of time, and so then you know, so little pieces were beginning to emerge as she was doing this and putting conscious memories together with these new bits and pieces that were coming up. And (snap) all of a sudden it was just right in front of my eyes. She was, she got that dissociative look that I know from other clients. And I had never seen on her. I was like, ooh.

Stephanie later explained that what felt different at this time was that the patient not only became aware of more information about her trauma memory, but that these fragmented pieces of information clicked together for the first time, perhaps in a more narrative form. She said, "Well I think it was her putting pieces together in a way that she had never done before. And yeah **they just kind of came together in such a way that she was more there than here.**" This example illustrates the way that the patient's dissociation emerged after integration of a structured verbal trauma narrative, suggesting that the patient became affectively overloaded by this new progress. As a result, she, too, entered into trauma time.

Jeff provided an example of treatment progress marked not by an integration of trauma memories, but instead by an important interpersonal realization. He described how his long-term patient entered a dissociative state in quick succession after realizing that her mother – who had been inconsistent, engulfing and intermittently cruel to her throughout her life – likely had borderline personality disorder. Jeff explained:

Okay, so as she's talking umm at this point her affect was kind of **in amazement**, like that a lot of things seemed to fit her mother and her experience of her mother. Umm and umm **I have to say I thought she was aware, though I don't recall her saying it explicitly, how remarkable it was that she was doing this because this itself was such an act of disloyalty.**

Jeff explained how his patient's realization about her mother represented both an important piece of progress in her differentiation of self, as well as an extremely uncomfortable and formerly forbidden "act of disloyalty." Jeff went on to explain how this "disloyalty" prompted the patient's immersion into a traumatic memory and then into a dissociative state.

Affective overload. While there was no singular theme that triggered the patient's dissociation in every case, in all of these examples what remains constant is that the patient became affectively overwhelmed. This affective overload was variably provoked by immersion in the trauma narrative, a relational enactment of the trauma narrative that prompted familiar affective states, or through contact with formerly unintegrated parts of the trauma narrative. The participants witnessed this affective overload in their patients, alternately naming it being "overloaded," "emotionally ripped open," "too vulnerable," "afraid of feeling," "unravel[ed]" and "totally overwhelmed."

Jeff was able to describe in detail how his patient became "overloaded." He explained that as his patient came to integrate formerly split-off information about her mother, remembering the ways that she had injured the patient, the patient then suddenly recalled a

particularly horrifying memory of her mother picking up their barking dog and smashing it against a well in their backyard. It was at this moment that the overload occurred and the patient dissociated. She said “and animals,” which Jeff assumed referred to this memory of the family dog, and then her voice trailed off. Jeff explained, “She was overloaded in that moment and that she’d had enough.” He went on to explain that her ability to contain her displeasing thoughts about her mother and the feelings associated with these new thoughts failed her. She became overloaded, and then shut down by way of dissociation. Jeff explained this process as such:

I imagine um that while earlier as she was talking to me she was able to tolerate um a kind of fear and guilt and perhaps shame about her mother. And her own anger toward her mother. All of that. I mean I don’t want to presume I know too much about her experience, but I think all of that. She could tolerate enough to tell me about it and I think that the thing with the dog, the “and animals” was an overload, like that was what I imagine. **That she was overloaded and could no longer sort of acknowledge what it was she was . . . thinking about her mother and containing those feelings at the same time. . . . so, by overload, is those feelings of shame and guilt and hurt and rage and all that stuff was too much and then she went blank.**

Ruth, too, was also able to describe her patient’s process of becoming affectively overloaded, and then needing to shut down. In this case, the affective overload was not prompted by a trauma memory, but instead the overwhelming feelings were directed towards Ruth herself. Here, Ruth shared that during their final session, their conversation about termination “totally overwhelmed her,” and triggered a dissociative trance. I continued by asking Ruth what she imagined the patient was experiencing during the dissociation. Ruth again confirmed that the patient was overwhelmed. She said, “**I imagine she was experiencing complete overload. That she was totally overwhelmed** and that she had no idea what to do with the material that I put in front of her face, meaning the question I had asked her [about termination].” In this segment, Ruth alluded to her own role in the patient becoming overloaded. I asked her to clarify what she meant by “the material I put in front of her face.” Ruth continued:

R: I would imagine that there was so much feeling connected to what it was that I was asking her about that she felt the need to check out. Because contending with whatever it was . . . **was a no-fly zone. No go.** That she probably never allowed herself the experience to actually process or maybe she had. . . . But um, yeah, she was probably feeling sadness, disconnectedness, um, anger? Frustration?

J: With you?

R: Oh totally. **Although she couldn't touch that with a ten foot pole.** I attempted to have a conversation with her about that and that was a no-fly zone as well.

This dialogue illustrates how the patient's affective overload could be prompted by the therapy relationship, particularly encounters that evoked the original trauma memory. This dialogue also presents a precursor to the function of the dissociation – serving as both an intrapsychic shutdown as well as an interpersonal communication. These functions will be elaborated on in the following section.

Although the context of each therapy session and each therapeutic pair differed vastly, each participant understood the dissociation as a response to the patient being overwhelmed by affect that was either generated by living in trauma time, in a recreated traumatic scenario in the therapy dyad, or through integration of new memories or progress associated with the traumatic story. In this way, each participant viewed the dissociation as serving a very real function for their patient – protecting her from the affective overload associated with the trauma and moving her into the safe solace of blankness.

Function of the Dissociation for the Patient

The participants had similar conceptualizations of the function that each patient's dissociation served. Almost all participants understood the dissociation as an affective shutdown, helping the patient to reestablish his psychological equilibrium and shut off the overwhelming affect. In this case, the therapist first witnessed the patient physiologically shutting down before

his/her eyes, and then understood the dissociation as serving an important intrapsychic function for the patient – that of a “no fly zone – no go” as Ruth aptly described.

Ruth clearly stated her view that the dissociation was a way her patient learned to manage overwhelming feeling by the use of total cut-off. She said, “Intrapsychically it cuts her off from having to deal with overwhelming feeling and emotions.” Catherine understood her patient’s dissociation as a “desire to not have to experience feelings.” Catherine went on to explain, “Something is getting triggered that feels like it’s going to be too much and so she just blanks. And and disconnects from a) that potential fear as well as whatever triggered it.” Jeff used the language of a “shut off valve” to explain how he thought his patient moved from a state of affective overload to dissociation. He explained, “Intrapsychically I think it served the function of a **shut off valve. Like it was too much.**” He also offered the language his patient used to describe her use of dissociation. Jeff said, “But she did say, um well I’m sure it wasn’t an exact quote. But it was something like, **‘I’ve had enough.’ She said something like ‘I’m full.’ And she definitely used a feeding language. ‘I’m full.’**” These participant quotes highlight the primary function of the dissociation according to the participants – to shut off this affective overload when the patient had had enough.

During these dissociative gaps, participants mostly understood their patient as completely “blank” – devoid of thought, feeling and processing. Marcy, for instance, shared that during the dissociation, her patient “goes numb.” She explained, “I think she goes to a place where she doesn’t have any idea what she’s feeling.” Catherine likewise explained that she imagined her patient experiencing “nothing” during the dissociation, “like almost a tv tuned to static.”

The participants understood their patient’s dissociation as a response to affective overload that included a process of first feeling, then becoming too “full” of feeling, and finally

turning off the feeling, most often in an automatic and unintentional way – the way a shut off valve would function automatically as it became overloaded. Jeff vividly detailed this process. He explained that his patient was making new interpretive leaps and holding new information in mind about how she could understand her abusive mother and herself. He elaborated:

Like she was pleurably kind of telling me this, you know, but like, pleasurable about not that her mother was this terrible person, pleasurable that she could think about her mother as an independent person. . . . **That she was feeling pleased she could think about her mother and her experience about her mother. That that was what seemed so incredible to her, and that's what stopped at the moment [when she dissociated]. . . She stopped thinking. She's not there. She stopped relating and stopped thinking and there's nothing.**

As such, the participants saw this process of stopping thinking and relating as enormously protective for the patient. Tasha understood this protection as a way her patient “didn’t have to experience everything fully. And so she didn’t have to think about everything.” Catherine saw her patient as utilizing the dissociation more preemptively in order to protect herself. She explained in her written account, “Her affective experience feels as if it might **expose truly terrifying feelings** and so she shuts down at the earliest sign of these feelings.”

Nancy shared her view that her patient’s dissociation was not only protective, but also offered him some relief. She said that the dissociation “disconnects him from his anxiety and perhaps even gives him a sense of control, a feeling of control.” When I asked her to clarify how the dissociation offered him a feeling of control, she explained:

That he can manage a situation where his anxiety is high or where he um isn’t able to articulate or if he doesn’t want to answer the particular question or if the particular question means something to him that he doesn’t wish to respond to or participate in.

Nancy’s understanding of her patient’s dissociation appears to be more conscious or intentional than the function of the shut-off valve. Still, the participants all concurred that the intrapsychic

function of the dissociation was a pervasive and powerful one. Tasha even understood her patient's dissociation as serving a life-sustaining protective function for her. She explained:

So I think this thing about dissociating is it's mysterious. **People have the ability to take their soul and make it go away somewhere so that they are less at risk through huge huge tribulation.** And um the process of bringing a person's soul back to them is something that is, I mean, they sort of could go see a medicine man, a medicine woman, and they could do that for them.

Tasha alluded to the spiritual component of this work -- that of accompanying a person to and then back from horrifying memories of trauma. Ultimately, participants saw the dissociation as an important function that developed to enable this journey, and protect the patient when this journey went awry.

Function of the Dissociation in the Therapy Dyad

As both Jeff and Nancy began to allude to, the participants also saw their patient's dissociation as serving an important interpersonal function. Jeff explained that when his patient dissociated, *she stopped relating*. Nancy said that her patient used the dissociation to *stop participating in the conversation with her*. While almost all of the participants understood the patient's dissociative gap as reflecting something about the patient's own ability to manage and tolerate overwhelming affect, nine of the participants also saw the patient's dissociation as communication for the therapy dyad. These participants began to wonder about why the dissociation occurred when it did, what they had just been discussing in session, and what the therapist might have done (or not done) to provoke a dissociative response. As a result, the participants described thinking about the dissociation as an interpersonal process, and even a way the patient was trying to communicate needs in a preverbal way. Elise elaborated that the patient's dissociation began to feel like "our dissociation" – reflective of something unique occurring in the therapist-patient pair. She elaborated:

. . . In the beginning, if, let's say they dissociate in the first session. I'm going to be concerned and I'm going to think, "Can I work with this person? I don't know if I can. I don't know. Do they dissociate?" And I guess when I think about it, it's like, that's how they are in the world. . . . It's like, "Oh they're going to dissociate with anyone."

Whereas, after a while, it feels like this is OUR dissociation, so it feels more personal and more part of the relationship, as if someone's saying, "You know Elise, you're going to have to back off this subject right now. Can we talk about something else?" And I'm saying "Yeah. Sure. That's no problem. We will get back to this at some point, but yeah, if that's what you need." And it feels like there's more of an understanding.

Elise was clear that this kind of understanding was not immediate; it developed over the course of their relationship. The dissociation then, came to serve a particular function and hold a unique meaning in the context of this patient-therapist dyad.

One of the interpersonal functions the patient's dissociation served, according to participants, was communication of the patient's desire to slow down both the content and the intimacy of the therapy relationship. For instance, Elise shared her belief that the dissociation is "communicating a need for space and a need for my timing to slow down." She elaborated on this by noting:

We are communicating through the dissociation. We're just. Dissociation is going to be part of the way they say, "Oh you know what, I really don't feel like talking about this right now. You really hit a nerve. Or, I'm not ready yet. Or that's hard for me."

Nancy shared a similar belief, noting that her patient's dissociation was "a way to slow us down initially." She elaborated on what exactly it was her patient was attempting to slow down:

I think that my inquiry, my efforts to know him, um, to determine what would be helpful, perhaps was too overzealous or too quick and it made him feel in some way pressured and he has his life very structured so that it is managed on a certain kind of pace and tempo. And I think that this was a new space and he didn't have any way to manage or control this space. And he's not, he doesn't have any assertiveness skills. **He is not able to do that in other ways.**

Nancy's patient was not able to use the skills of verbal language to communicate his desire to slow down. Instead, Nancy got this important message through his dissociation.

Catherine more clearly described the way her patient used the dissociation to reduce the intimacy in the therapy relationship, essentially telling the therapist to back off. The following dialogue illustrates Catherine's understanding of her patient's dissociation.

J: And was there any function you think the dissociation served interpersonally?

C: Uh sure. I think it was a **don't go there, don't touch.**

J: What gave you that message?

C: I guess the disconnection and the lack of eye contact and the lack of processing There was nothing that was said as an indicator, like "I don't know if I want to talk about this." Like she wasn't saying, "This feels kind of tough", or you know "That's kind of a bad topic for me." Instead **it was a very overt like, we're not, clearly we're not talking about it because I'm no longer here.**

Catherine understood her patient's withdrawal through dissociation as speaking loudly about her desire to disconnect from Catherine.

In addition to the directive to slow down or disconnect, seven participants remarked that their patient's dissociation also enabled them to come into contact with the full extent of the patient's fear and vulnerability. Catherine explained that her patient's dissociation "let me know just how scared she is." Catherine went on to say:

And she is somebody who doesn't present as scared and she is certainly very um strong and um in the way that she shifted her life very accomplished and competent and organized and determined. **Um and so it really opened me up to the vulnerability that would have promoted that need for protection and, um, it's helped me feel a lot more empathic and a lot more hesitant, not hesitant, but like very um maybe more tentative about getting into trauma.**

Catherine's statement highlights a crucial function of her patient's dissociation – it helped Catherine to see a more vulnerable part of her that she tried so hard to hide. Catherine's ability to see the fragile parts of her patient during the dissociation ultimately gave her important information about her patient's need for a more titrated exposure to her trauma narrative and a paced treatment. Catherine, like several other participants, was able to experience her patient as

both scared and vulnerable during the dissociation, giving her contact with a part of the patient that was often left outside of the therapy room.

Several other participants described a similar function of the dissociation, allowing them to see a vulnerable side of the patient, however they used language describing their experience of the patient as a *child*. For instance, Nancy noted that when her patient dissociated in session, she came to understand that “he was a very frightened, very anxious child and no one knew that. No one in his family knew it.” Kaitlyn disclosed that during the dissociation in session, her patient regressed into a fetal position in her chair. She went on to explain:

I think I saw her as a child. . . . I definitely saw her vulnerability and experienced her um her brokenness. Cause like in in her life, like, umm she’s she’s like director of I actually forget the place, but like director of like services, like, she’s put together. She’s controlled. She’s actually everyone would describe her as very like, um, like a hardass. Like this is the way things go. **And then throughout my work with her I just saw her as a child and really vulnerable and really really really broken.**

Here Kaitlyn described the way she came to know a different, perhaps dissociated, part of patient’s self by being with her in this dissociative state. Knowing this part helped Kaitlyn gather up her patience and empathy, and then pace the treatment to protect her patient. According to the participants, this interpersonal function of the dissociation helped the patient to reveal a vulnerable, childlike part of self, enabling the therapist to deeply understand the patient’s needs and ultimately feel pulled to meet these needs.

While many of the participants understood their patient’s dissociation as communicating a need to slow down and exposing a hidden level of the patient’s vulnerability, one participant also understood her patient’s dissociation as a way her patient was attempting to communicate

new layers of her traumatic memory. Anna understood one of the functions of her patient's dissociation as a need to tell her story and to re-experience the trauma in the safe presence of the therapist. Anna explained:

I think it's beyond that need to just cathart. You know, to let the wound because it's building up. **I think she needs to make sense of it.** Because one of the things she was saying last week is, "I want answers." She must have repeated it six times. Now that she is getting much more clarity about what these people did, she wants answers. "How could this happen? How did I spend my whole life not on the radar of anybody in the backwoods of Alabama with no schooling and basically spending my life in a closet? How did that happen?" Now she's not communicating it the way that I just did to you, but she wants answers. She wants to know why. She wants to know why her. You know there are things, and she was adamant about it. So when she goes on that kind of a journey verbally with me, it says to me that even though she may know there are no answers. What she's really trying to say is, **"Help me make some sense of this."**

Anna then clarified that her patient was not verbally sharing this information with her, but instead, Anna was aware of a felt sense that was communicated nonverbally. She had difficulty articulating this to me:

I don't always get, especially when she's dissociated, **"Yes I need to tell you." Um, but sometimes her dissociated part will express that somehow nonverbally.** And it's kind of hard for me. I don't know how to really define that to you.

Anna shared that her patient doesn't disclose anything about her trauma history in any other context. Anna explained, "So to me, it is pretty clear that there is a part of her that not only feels safe, but needs my interpretation. Needs me to hear her." Anna was the only participant who explicitly described her view that the dissociation itself communicated her patient's need to share her trauma memory, leaning on the therapist's ego and interpretive mind to provide a safe and containing way to re-experience a horrifying memory. Though none of the other participants went so far as to experience such a direct nonverbal message through the patient's dissociation, the majority of the participants did experience the patient's dissociation as having both some impact on and function for the therapy dyad.

Summary

All eleven participants described a psychotherapy session with a highly traumatized patient with dissociative symptoms. In many cases, these patients were highly fragmented and disorganized. They did not communicate their narrative or needs in a coherent or organized way. This made it difficult for the therapist to know what her patient needed, or how quickly. In each case, the patient entered into a dissociative trance following an experience of affective overload in the session. He/she used the dissociation, often unconsciously and automatically, as a way to modulate overwhelming affect and protect him/herself. Many of the participants also experienced their patient's dissociation as serving some important interpersonal function – communicating the need to slow down, creating needed distance in the therapy relationship, or exposing a vulnerable or childlike part of self. While the therapists often experienced their patient's dissociation in session as both frightening and grueling, every participant understood the dissociation as holding a powerful intrapsychic and protective function for the patient. The majority of participants also understood the dissociation as serving an interpersonal function – providing a way the patient was able to communicate about a part of self or a need without words.

CHAPTER V

FINDINGS II: DISSOCIATION AS AN INTERPERSONAL PROCESS

All eleven of the participants described the patient's dissociation as an interpersonal experience. As Elise noted above, at some point the patient's dissociation became "**OUR dissociation**" – reflecting some idiosyncratic meaning for both the patient and the therapist, as well as for the pair. In every instance, the patient's dissociation held a powerful impact on the clinician. The clinicians I interviewed were reflectively and honestly able to describe how their patient's dissociative experience in the room impacted them both as a clinician and as a human being. The following chapter will explore this impact on the clinician, describing the predictable sequence of responses that the participants reported in the face of their patient's dissociation.

Ruth was the participant who most clearly articulated the way her patient's dissociation impacted her differently than any other clinical encounter. She named the dissociation an intersubjective experience, explaining, "It's something that I experience in myself as well as in the person." She went on to say that she is both "witnessing the person looking checked out and that I'm experiencing myself doing something different with it." When I asked her to elaborate on what she found herself doing differently, she replied:

R: I'm becoming more thoughtful of what it is that's going on. Um, and that **I'm allowing the space for different things to happen, not only in the room, but also in myself.** Yeah. I mean that's truly, that's different. So I'm not just sitting with the silence. That's what is different.

J: Okay. Does it feel like there is something more active that you are doing in this as opposed to sitting in the silence?

R: . . . I found myself being aware of the fact that she was checked out. That one might call it dissociation. Um, I was thoughtful first and foremost about what we had been talking about. I found myself wondering about it. Um **I found myself wondering about myself and what I was experiencing. . . . Kind of like the intersubjective experience**

of it. Does that make sense? Like, um, because based on who she was and what I knew about her history, I might be able to put words to it, but I knew that she couldn't. So it's being thoughtful about that, but also you know in that time and space I was also very like present with myself and saying, whatever kind of like pops up for me, I wanted to be able to, what I was feeling, what I was thinking. So all this was going on simultaneously. So not only trying to be respectful of her and what was going on for her but I was also trying to be respectful of me and what was going on for me, because I felt like that was important too.

Ruth described her impression of how important it was to tune in to her own internal experience in the midst of her patient's dissociation. She did this not at the expense of being respectful of her patient's experience and needs, but instead, she saw the dissociation as an interpersonal process that must be experienced mutually in order to be usefully understood.

Therapist Anxiety

There was a reliable and sequential process that the participants described moving through as they became aware that their patient had indeed dissociated in front of them in session. This process always began with intense anxiety, worry, and feelings of helplessness. There were four unique manifestations of therapist anxiety: worry and guilt about having caused the patient's dissociation, concern about one's competency and ability to help the patient, a primitive experience of doom and dread, and finally fear about losing one's own sanity. I will utilize participant examples to describe each manifestation of anxiety below.

Did I Do This?

Nine of the participants described worry and ultimately guilt about having caused the patient's dissociation. The participants lamented over whether they had done something to hurt the patient, unintentionally replicating cycles of harm that followed the patient throughout her life. This anxiety was more present among novice therapists or between therapist-patient pairs that were just beginning their treatment relationship. Kaitlyn, a more novice therapist with three

years of experience, described the first thought she had when she became aware her patient was dissociating in session.

I'm trying to picture myself back in the room. Sitting with her. The thought that was like, **“Crap, did I do this?”** Like, um, kind of that feeling like, did I push her too hard for her to start talking to me about this stuff? . . . It seemed like it was just bubbling over and there was nothing, but like, did I give her enough? Had I been aware enough to give her containment like early on? Like right when I first started talking to her about her father and I realized it was something that she felt like anxious about and there was a detachment there and stuff. Should I have just gone right to containment around that and trying to help her figure out how to um manage those emotions? Cause then it was just unraveling in front of me. **So I guess the first feeling that I had, it's kind of selfish, but it was like “Oh no, what did I do?” Yeah like guilt is a good way of saying it. Like “Oh my gosh. This got out of control!” Or something, and “Did I do this?”**

Kaitlyn displayed both worry and guilt. Like many other participants, she began to mentally review her treatment decisions, wondering if she had pushed her patient too much or too quickly. Her experience of questioning herself, “Did I do this?” was a pervasive one for the participants. For instance, Catherine asked herself when her patient dissociated in session, “Am I doing something that's hurtful? Um something that's painful?” Elise asked herself similar questions: “Did I do something? Did I hurt her?” Tasha likewise worried about having somehow caused her patient's dissociation, admitting that she had “prematurely treated her.” While Kaitlyn, Catherine and Elise struggled with the *fear* that the dissociation was their fault; Tasha ultimately decided that she did in fact make a treatment error that prompted the patient's dissociation. Tasha explained how her patient had been overwhelmed during their previous session. She admitted to what she saw as a treatment error on her part of not providing enough titration and containment. She described this treatment error in two parts. First, she admonished herself that the exposure to the trauma narrative was “too much.” She explained, “It was too hard to go back there. It was too short a time period. I think it was premature although she said she wanted to work on it. . . The trauma is totally overwhelming, totally overwhelming.” The second

treatment error, according to Tasha, was her failure to provide containment at the end of the session during which her patient had divulged details about her trauma history. As she explained:

I guess the other treatment error I made was I didn't close it up well enough at the end [of the previous session]. I closed it, but I didn't do a good enough job. And she, this is how she is a very adaptive patient, in the middle of the week she said to me, I thought about the container, and she said so I just took all of that stuff I shut my eyes and I put it in the container and then I was okay. (laughs) I was like, why didn't I think of that? Very resourceful and that, **I should have done that. That was my error. I should have done that.**

Ultimately Tasha shared that immediately after her patient dissociated, she engaged in what she called a "self-attack." She said to herself, "You screwed up. Why didn't you think of this? She shouldn't have had to do that." Tasha's process of wondering "Did I do this?" ultimately ended with the reproof that she did.

Darlene also struggled with a feeling of responsibility for her patient's dissociation. Unlike Tasha, she did not see herself as having made a treatment error, and therefore she denied feeling guilt. Instead she explained, "I was doing the best I could because I don't know that I could have done any better." Still, like Tasha and Kaitlyn, she began to review the treatment decisions she made, wondering if she should have seen the dissociation coming. She wondered, "Was I competent enough? Why didn't I see that? Should I have seen it? I would doubt myself and I would feel like I let her down somehow. . . ." She explained that she felt "scared and bad like somehow I didn't see what was going on and led to this, and being responsible. I just remember feeling like bad." Like Kaitlyn, Darlene attempted to convince herself it wasn't her fault. She said that feeling bad came from her "emotional mind." She went on to say:

My reasonable mind would say like 'Hey, you know, you brought an expert evaluator in and didn't fully understand the history, you know, and you haven't seen it in all the time you met her.' I think I could also reassure myself that if it could have happened to me, it could have happened to anyone.

Despite these attempts to reassure herself, Darlene was left with the feeling of responsibility. When her patient dissociated, she just felt “bad.”

This process of questioning oneself after the patient’s dissociation was pervasive among the participants. They struggled with worry that they pushed the patient too far or too fast, failing to offer enough containment. In his written account, Jeff named this a “guilt over having allowed [the patient] to get affectively overloaded.” They began to question themselves and catalogue their treatment decisions, often with an accusing finger pointed towards themselves.

What Do I Do Now? And Can I Help Her?

The participants described a tremendous feeling of responsibility, self-doubt, and anxiety regarding the patient’s well being. Several participants asked themselves a long list of questions in rapid succession, designed first to explore their own level of responsibility and next, to try to figure out how to help the patient. Six participants described this urgent pressure to act in service of saving the patient, as Stephanie said, to “get [the patient] back and grounded.” Kaitlyn clearly described how her internal experience shifted from initial anxiety about having harmed the patient into anxiety about what to do next. She began by describing her attempt to “think logically through” her guilt, convincing herself that the patient’s dissociation was just part of her presentation and would have happened anywhere and with anyone. She explained:

I was like, uh, I think probably, quickly moved to try to kind of think logically through it. Like, no obviously this is something that has been coming up for her. Like we’ve seen it in group where she will just – not dissociate – but somewhat detach, so it wasn’t, it was coming. So I kind of moved to more logical. Like okay, then move into action a little bit. And here you are sitting with somebody you need to work through trying to help them.
So guilt first, then maybe startled, then like okay. But you can’t just sit here.

Kaitlyn’s comment illuminates her process of working through the feelings of guilt and responsibility, and landing in a place of an urgent need to act – telling herself, you can’t just sit here. Tasha likewise moved from her “self-attack” during the patient’s dissociation and into a

place of problem solving, a rapid and pressured process of figuring out what to do next. She explained:

I'm thinking, okay so I need to figure out what is going to be helpful to her. What's going to be helpful in this situation? And so you know I'm thinking about, what kind of information do I need? And sort of how to test, you know, is she about to crumble? Is she going to cry? Does she need to cry? Is she, does she have the strength to take an action? Does she need a glass of cold water?

Catherine also experienced this urgent need to act. She was able to make a link between her feelings of guilt and responsibility for "causing" the dissociation, and her anxieties regarding what to do next. First, she described her worry that she had "attacked" her patient unknowingly by asking questions that elicited the patient's traumatic memory. She explained, "I didn't want to be intrusive. I didn't want to stomp on something that for her she was already protecting against, something that I clearly didn't even know I had attacked with. . . ." Catherine then wondered about how to proceed.

Now I know there is something fragile there and I definitely don't want to go knocking on that door and so then, what do I do? How do I, there is this elephant in the room that is incredibly delicate and now I know it's there and I don't want to hurt her more and I don't want to pretend like something very much out of the ordinary didn't just happen and that it's very meaningful and that sort of tension and being frozen in between do I allow this to be sort of nothing? Do I label it as important and investigate?

Catherine then clarified the questions she entertained about what to do to help her patient.

Some of the worry is **what should I be doing? Do I interfere with that? How long do I wait with it? What do I say after? How much do I ask about it? Um how aware is she of what it is and why it's happening? Yeah. How do I go about addressing it? But also worry of, a bigger worry of how is this case going to be? How is our whole relationship going to go? What do I do in this next 45 seconds but also what do I do in the next 45 weeks?**

Here, Catherine began to forecast the future. Her worry transcended the initial moments of how to intervene in the dissociative gap and morphed into a larger worry about *how* and *if* she can help this patient.

Like Catherine, many of the participants described their initial anxiety about what to do transforming into questions of their own competency as a clinician. The initial question *what do I do now?* often parlayed into a related worry – namely, *can I help her?* Seven participants reported this particular anxiety about their competency to deal with such a frightening clinical encounter. This anxiety was especially salient for more novice clinicians, however it manifested on several occasions for more experienced clinicians as well. Kaitlyn, a more novice clinician, admitted that during the first time her patient dissociated, “I questioned myself and if I could actually help her in that moment.” The second time her patient dissociated in session, Kaitlyn continued to struggle with questions about her own competency. She described her patient’s dissociation as “really really really scary.” She went on to say, “I almost went and got my supervisor . . . I questioned myself. . . .Were my skills enough to do this right now? To bring her back? It was really scary.”

Darlene is a more experienced clinician, though she admitted that this was the first time she “lost” a patient for such a prolonged period of time in session. She identified similar questions about her ability to intervene and help her patient adequately, explaining:

I was scared. I was like oh no...you know? I was scared because I was like I knew she had some history. . . . I immediately thought that it could be a medical emergency. Even if it was dissociation, **I thought what if I can’t get her out of this?** I thought like, I don’t know what this is. I was frankly scared by it. ’Cause you know, I had never, knock on wood, had to call 911 in a session, but I thought in this case that was possible because I didn’t know if something was really wrong and if it could turn into something so serious that I couldn’t get her back.

Both Kaitlyn and Darlene struggled with questions of their competency, specifically around the urgent need to “get the patient back.”

According to the participants, anxieties about one’s ability to help the patient were more pressing in early stages of professional development. For instance, Anna reflected back on earlier

experiences in her career when questions of competency felt more salient to her when a patient dissociated in session:

Because when it, in the early times, it's like, okay I need to do the right thing with this. I'm having those kinds of thoughts when I first started to work with dissociative people. Um, I don't necessarily have that so much [anymore], but it's just it's a bit of an unease [now].

Elise shared that her anxiety in response to a patient's dissociation is more likely to occur with a newer patient that she does not know well. In this way, clinician anxiety was not only correlated with the developmental level of the clinician, but also with the relative state of comfort that has developed in the therapy relationship. She explained:

In a way, when I don't know someone that well and they do things that scare or concern me or that I don't understand, I'm way more apt to get scared. And I don't like to be scared. I'd rather be comfortable and feel like "Oh I know we can handle this together."

Several minutes later, Elise articulated how her anxiety in response to a patient's dissociation changes over time. She feels much less frightened and much less likely to revert to her own insecurities and feelings of incompetency when she knows the patient better. She explained:

Whereas if someone comes in dissociated, I'm like "Ooh. I don't understand them. I don't know what's happening. I don't know when I'm going to hit the landmine." It almost feels dangerous. And when I get to know them instead of a landmine, it's like stepping on a pebble or something. It's just not as intrusive, for me. And I don't think I go into my own stuff.

The patient's dissociation incited both a pressure for the therapist to act and anxiety about her ability to be helpful to the patient – to get her back from the dissociation. These anxieties reveal the high level of responsibility the therapists felt for their patient's well being and the pressure they felt to protect them.

Is Something Bad Going to Happen?

For more experienced clinicians or more experienced patient-clinician dyads, the anxiety that arose for the therapists did not focus on what the therapist did wrong or what the therapist

should do next, but instead, the anxiety reflected a primordial sense of dread and doom.

Participants spoke of a guttural sense that, “This is bad” or “Something bad is going to happen.”

Tasha explained that as the initial questions about her role in the patient’s dissociation were quieted, what came in its place was what she called the “*oh shit response*.”

So um, um so when she she says she is dissociated, you know I know I mean it’s fodder. Partly because okay the person is starting the session by telling me they are having a problem right now. So okay great. This is perfect. Perfect grist for the mill. Lets go. So that’s that’s fine. So my affective experience is okay. Let’s start the session. I feel competent. I’m you know, I know how to handle this. I know what to do. And I know what I want to know. **So then comes kind of the “oh shit” response. Oh my god. This is really, she is having a hard time. This is bad.**

Marcy shared a similar kind of dread that she said often occurs with patients who have had such intense and early life trauma.

M: Umm, well I know I felt anxious, at least at first. . . . **Umm, I mean I often feel a sensation in my stomach. Just this sort of umm tightening in my stomach and a sense of kind of dread. . . .**

J: You often felt it with her?

M: I feel it with people who are more, I hate to use this word, but in the primitive end of things. You know when there is, when you know you are going to encounter some kind of preverbal umm trauma and preverbal need.

In addition to dread, Marcy described a sense of doom – an intuition that something bad was about to happen. She explained:

I mean I call it a **minefield** (laughs). **Like if I misstep then something is going to blow up.** And I never ever know, I don’t know where the mines are. And one week we can talk about the same thing as we’ve talked about the next week and the next week it’ll blow up.

Seven participants in total identified this sense that something bad was going to happen.

In some cases, it was an inchoate doom that remained nameless and formless, and at other times, the doom focused on a particular calamity that the therapist worried about. For instance, Elise articulated a specific worry about the remote possibility that her patient might sue her, as the

patient had admitted to contemplating suing a former therapist. These fantasies about being sued were particularly salient when her patient was dissociated. She explained:

So whenever she feels like she is going to be victimized, she has two responses. One is “oh my god I’m bad. Just yell at me. Hit me.” And then she gets furious and then accuses people of abuse. She had seen a therapist before she started seeing me. And another few months, whole sessions would be why did that other therapist. Why didn’t she help me? Why did I go to her? I hate her. I felt maybe she was going to sue her but she doesn’t go that far. It goes to “She fucked me up. She didn’t care about me.” And I was thinking, recently I was thinking, **“I’m next if I don’t deal with this dissociative piece. If I don’t bring it into the room, I’m next.”**

In Elise’s follow up written account, she identified a different fantasy of something bad happening when her patient dissociated in a later session. The patient requested an emergency session and had to bring her twelve-year-old son with her. She said that when her patient dissociated, she began to feel anxious. She reported, “I started to worry that the patient’s son would overhear us, even though this was unlikely. I wasn’t listening well, but was rather anxious.” This second experience of dread with the same patient suggested that it was not an isolated occurrence, but instead a more common felt sense transmitted in this dyad. Both instances conveyed to Elise a fear of something bad happening as well as a more specific feeling of vulnerability and being watched.

Nancy was another participant who entertained specific fantasies about something bad happening, in this case, images of her patient harming himself or others.

N: Yeah there was a time when I felt fearful that I because he also endorsed uh significant suicidal ideation. So there were times that I was fearful that I didn’t know how likely he would be to attempt or commit suicide. I also didn’t know if he, if his energy was hostile and he would be a person who would hurt someone else. So curiosity was sometimes supplanted with fear about whether he would hurt himself or if he was the type of person who could hurt someone else.

J: And those worries about him, they occurred in the moments that he was dissociating?

N: Perhaps it’s where they started but then they pervaded kind of the post dissociative moments.

The participants' fears about something bad happening did not have a common thread. Instead, they were uniquely derived from each patient's constitution and the nature of each patient-therapist dyad. What remained consistent across the accounts of these seven participants was the eerie sense that a tragedy was about to befall them, leaving them with intense anxiety and trepidation during and often subsequent to the patient's dissociation

Where Does that Put Me?

The final type of fear that participants referred to was similar to these sensations of dread and doom. Four participants described a fear of losing track of one's own sanity in the midst of the patient's dissociation in the room. The participants described this very self-focused fear as incredibly threatening and inducing a temptation to withdraw from the patient.

Tasha, for instance, described feeling fearful when her patient dissociated and understood this fear as connected to her worry about "being afraid of people's craziness. Being afraid of being drawn into their craziness." Stephanie described how "disconcerting" it felt to be confronted with such a highly dissociative patient, noting, "It pretty much freaked me out." She explained that she felt "out of control" during the patient's dissociation and feared the loss of contact with her own cognitive process.

Anna described how it felt for her to be confronted with a population living "on the brink." She wondered if this fear of confronting such a frightened and disturbed population, and the ensuing fear of how this will disrupt one's own life, is what really causes many clinicians to avoid trauma work in their clinical practice. She explained:

The other thing I think I've learned, for trauma therapists, I think they might be overly worried about the material that they're hearing. I'm not saying that it's not unbelievably disturbing. **What I think is more disturbing to us is that feeling that they are on the edge. And what are we going to do about somebody who is just so quote unquote far gone, or on the edge, on the edge in terms of um how they function or how**

suicidal they are, or you know, how fragmented they are. And I don't know that, I have a feeling that a lot of people want to stay away from this population, are believing that it's because they don't want to hear all the horror stories. And I'm not saying they're great but I really think that more of an issue is **how do we live with that population on the brink? And how do we not get sucked into having to have that on their minds all the time and jump in and rescue and save all the time.**

Anna commented on the fear of getting sucked into the patient's chaotic life, but Elise spoke most candidly about her experience of losing the tenuous connection to her own sanity in the face of her patient's dissociation.

J: I think that's a great word: threatening. What is it that you think is so threatening?

E: **I think it's one sanity that gets threatened.** Like for me,

J: Like one's own?

E: **One's own sanity gets like yanked. And you know maybe there are many practitioners out there who are very sure of their sanity, I'm not one of them.**

Elise later began to make sense of how this particular fear of losing track of her own sanity manifested for her. She reflected on the way she felt left alone by the patient when the patient dissociated, leaving her questioning her own connection to reality. She clarified, ". . . I'm also sensitive to like, **"Oh my god, I'm talking to someone and they're not there, and then, where does that put me?"** I can also get like, **"Uh oh, we're in trouble."** According to Elise, there was something contagious about her patient's withdrawal from reality that made Elise question her connection to her own reality, too,

These four participants were the only ones to explicitly identify this fear of losing contact with one's own sanity. Though this theme was not consistent across all participant accounts, it was a salient and powerful one for the participants who endorsed it, promoting the urge to withdraw from the patient to protect oneself.

The participants' anxiety manifested differently depending upon the developmental stage of their career and the extent of familiarity with their patient, however in every instance, the participants referred to some level of fear or anxiety in response to their patient's dissociation, making this a ubiquitous part of contending with a patient's dissociation in session.

Therapist is Left Alone

The fear and anxiety that each participant felt in the face of their patient's dissociation appeared related to their experience of feeling left alone in the room. Nine participants reported a peculiar sensation of feeling alone while in the presence of their patient, her person gone while her body stayed in the room. Nancy, for instance, first noticed that in the long pause of the dissociation, her patient stared off and the room "went still." She reported in her written account, "It was as if I was alone." Darlene described a similar experience of feeling her patient "went away" quite abruptly. She used the following metaphor to describe her experience of feeling alone in the room:

J: And when was it that you first recognized that she had dissociated? What was the sign for you?

D: Well sort of like, you know when you're on the cell phone and the call has dropped, but you're still talking and you're like, "Are they still there? Wait a second are you still there? And a certain point you realized the call dropped. It was sort of like that because you know I was saying, "It must have been really hard" and you know like sharing it and I was just really saying validating things and I thought that was reassuring her and I was noticing that she wasn't moving or she wasn't...she physically looked a little bit frozen and was looking down and I realized that she didn't say anything back to me now and she wasn't indicating, you know some people don't say something back because they are crying, but at least they'll nod and you will know that they're hearing you, but I start to see a lack of responsiveness. I started seeing that.

Darlene's use of the cell phone metaphor provides a good example of this phenomenon. The therapist momentarily continues on while the patient is gone, only later becoming aware of the unusual lack of responsiveness in the conversation – either verbally or nonverbally.

Elise began to allude to this experience of being alone when she remarked, “They’re not there, and then, where does that put me?” She elaborated on how this experience generated a sense of “panic” for her:

There can be a feeling of panic. Uhhh, um, that could arise in the form of again it’s in the form of “We’re in trouble, what do I do? Oh my god, we’re in trouble what do we, what do I do?” So then I might feel to the other person, “Do something! Snap out of it! Do something. Help me!” Which may lead to some anger like, “Why are you leaving the room? We were just talking, we were just working. Where did you go?” . . . “We were just talking and then you went away.”

Jeff also noted a sense of being left alone. He described this as knowing that the patient was “not fully there.” He shared that he had an urge to wave his hands in front of his patient’s face, the way you do to grab a person’s attention when his mind is far off. Unlike Elise, he didn’t experience the aloneness as panic. Instead, he described an “eerie feeling” that likewise generated not-knowing and anxiety.

Darlene similarly explained how disconcerting it was to feel that her patient was completely gone while still sitting in front of her. She described feeling de-skilled in her patient’s absence. The helping skills she typically relied upon throughout her career were not available to her; it felt like there was no one in the room to help. She explained:

It’s not often that something happens that I feel that out of my element. That unsure. You know? So, I think maybe in the first five years of doing therapy, there were probably a lot more times that I felt like uh-oh, what do I do now? This is bad. Oh my god, like, I think um but even so if somebody’s present they are still in conversation. So even if somebody is saying, “Well, I want to kill myself,” There’s still a conversation. You can ask questions. You can say, well, you might want to do this about it. Like, something about the absence and me being solely responsible was a different feeling and I think when people are a little bit dissociative, I think with the intensity of this one and the length of it and the history there and the unexpectedness of it was. I can’t remember another time where I felt quite like that. I can’t remember a time that I felt like I needed to call 911 in session.

Darlene was able to unpack several components of her experience that left her particularly aware of being alone, and consequently, particularly anxious. She was no longer in conversation. This

left her feeling helpless. In her experience, there was nothing she could do to help and yet she felt wholly responsible for the patient's well being.

Catherine described another component of the experience of being left alone when her patient dissociated. She named this experience "disconnection," and described the patient's dissociation as holding an interpersonal meaning. Catherine experienced her patient's dissociation as the patient leaving her and leaving their conversation. According to Catherine, a feeling of disconnection pervaded the room when her patient dissociated. She elaborated:

I guess the disconnection and the lack of eye contact and the lack of processing and not the. (sic) There was nothing that was said as an indicator like "I don't know if I want to talk about this." Like she wasn't saying, "this feels kind of tough," or you know "that's kind of a bad topic for me," but instead it was a very overt like, "we're not, clearly we're not talking about it because I'm no longer here". . . . I guess it's a a feeling that . . . she was gone as opposed to, like a feeling of being in the room with someone, and then **there was a feeling of being in the room with no one.**

Nancy was able to more directly connect the eerie sense that she was alone with her subsequent fear that her patient would hurt himself or someone else. As she unpacked this, she identified her theory that this particular fear arose from her lack of contact with the patient – her feeling that he was a mystery. Here, she explained:

I think I have good intuitive sense, and that I can conceptualize someone and what is going on in a reasonable amount of time, and I was really stymied with him. So I you know. I don't know if my inability to really understand who he was or what was going on with him increased my fear, and so I started to think in terms of risk and that my countertransference was you know um fed by my fear.

She continued:

The fear he would hurt someone else was born out of my feeling that he was a mystery. That I couldn't figure out what was going on with him and maybe for me it was, he is intentionally not attaching or he is intentionally not offering parts of himself. In the beginning I wasn't sure if he was withholding, it that was his attachment style, if he was hearing voices. I just wasn't sure.

Later Nancy explained that she stopped feeling fearful during her patient's dissociative trances once he became more "available" in therapy. She continued, "These pieces of him that seemed to be connected to **relating** or **being joined** is how . . . my fear around his potential to hurt someone else, um, diminished." Nancy was the only participant to draw such a direct parallel between her feeling of being alone and her fear.

Being without this connection in the dyad, oftentimes when the therapist desired so desperately to be helpful to her patient, left the therapist feeling *left*, or as one participant said, *abandoned*. Catherine described her desire to create a safe place for her patient, and shared how it felt for her to watch her patient dissociate and learn that she did not, in fact, feel safe with Catherine.

Here I am and that's all I want to do, is know about her. Um and accept her and not only is she in a superficial way holding me at bay, but physiologically, cognitively saying absolutely not. And so then, that's when I become this bad person who is not safe and not trustworthy.

Jeff likewise described feeling "abandoned" by his patient when she dissociated. Just prior to the dissociation, he described a feeling of flow and oneness as he and his patient began to do important work that felt new and exciting to them both, and then suddenly his patient dissociated, leaving him feeling "abandoned" by her. He offered an interesting metaphor to describe this experience:

I tell her that I feel like I'm Charlie Brown and she's Lucy. And every time I stupidly hold the football thinking she's actually going to, or no, that she holds the football and I run up to the football (laughs) and she pulls the thing away and I, I feel abandoned. You you know, I feel like, like that's what I often accuse her of in those, that's my experience. It's like I get really engaged and really like I feel like **I'm in these kind of magical moments with her, something's opening up and then all of a sudden it's gone**, like Lucy pulling the football away.

For Jeff, it was not only the experience of being left; it was the suddenness and unexpectedness of his patient's departure. Like Darlene's example of a call dropping out, Jeff found himself

excitedly wanting to continue on in the conversation with his patient, but then suddenly their “magical moment” was over. His patient was gone. This took Jeff by surprise, contributing to the eeriness of this encounter for him.

Each of these participants reflected on their own experiential reaction to their patient’s dissociation, which often included a sense of confusion, anxiety and even panic that their patient abruptly left them alone in the midst of work that was and is typically so intimately mutual.

Therapist Retreat into her Own Subjectivity

Several participants were able to put words around how their experience of being “left” alone by the patient when he/she dissociated catapulted the therapist into his/her own subjectivity. Five participants identified self-focused thoughts and worries that emerged during the patient’s dissociation. It was as if the therapist had no one else to focus on when the patient left the room, leaving her with no option but to retreat into her own subjectivity.

Catherine was one of the participants best able to describe this process. She began by detailing her experience of the patient’s total withdrawal during the dissociation. She described it as a “shut down” and said it was “almost like a prison gate slamming closed. Like a prison gate (slaps hands) slam. . . . It was a very (slaps hands) like firm, solid, disconnection.” Catherine experienced herself as trapped outside of these prison gates. The following dialogue further elaborates on Catherine’s reported experience:

C: I’m on the outside. She’s in this torturous cell but that’s her environment and I’m basically, you’re not going to mess with it.

J: How did it feel for you to be placed on the outside?

C: Well hurtful, as I’d like to. It’s that same idea of I’m not a bad person. I’m not here to hurt you. Um and it’s sad. Sad especially now. In the moment I’m not sure how much I

had all of these ideas. But it's sort of sad that that's the safest place for you is somewhere really bleak and dark.

Catherine struggled with her experience of wanting to help her patient, but being trapped on the other side of these prison gates. As she felt increasingly disconnected from her patient during the dissociation, she began to retreat within herself. The retreat into her own subjectivity manifested as self-focused worry. She initially described the worry as about her patient's well being, but then refined her understanding of this as "worry about me." Her fears focused on her own competency and self-perception. Catherine believed that her self-focused worries were a direct result of the patient's total shut down. According to Catherine, her patient's subjectivity "was not available" and Catherine was left only with her own. The following extended dialogue illustrates the way Catherine conceptualized first the disconnection with her patient, and then her response to it.

J: Did you at all feel connected to her when she was behind the prison gates?

C: No.

J: What gave you that sense?

C: I think just a feeling that there was no, there was no affect. Certainly from her. **And any affect I had was really about myself.** I think I didn't feel too worried, **I mean in thinking back even now what I've shared about feeling worried but mostly, aside from worrying about whether it was medical, it seems like it was more worry about me.** Um and the ideas of compassion and empathy and feeling sad that this is her experience are happening much later but didn't happen in the moment. **My worries are about my performance and what I was going to do next and how this reflected on me and how I'm not a bad person.**

J: That's really interesting. A lot of people have talked about similar experiences almost using the same language you're talking about. People questioning their competency and what should I do? But no one has made that distinction that it's really a retreat into your subjectivity.

C: Hers was not available. I feel like I'm blaming her. But she was disengaged. I'd love to say I was feeling what she was feeling and maybe in a way, but this was all about me and what was going to happen to me.

J: So in a meta way?

C: It certainly wasn't empathy.

J: So it didn't feel like empathy. Is there a word for what it felt like?

C: It felt like abnegation. . . . I generally think of it as self-abnegation, that you just take your self out. She had taken herself out. **And I was just left with me.**

J: What sense do you make of that, that you were just left with you, either what that was like for you or how you thought about it at the time?

C: Well that's why I would wonder, what do I do? Or what about me? Or how do I maneuver through this? What do I do next?

J: What about the feeling you mentioned of being hurt?

C: A feeling of rejection. Like I didn't even have a chance. And in later circumstances. Now I think I'm less. There are other ways in which that same feeling comes up, where she says "No I'm not talking about it." Or "No I don't trust you." And so it's a lot more direct. Um. **But the hurt is being lumped into a pile of everybody in the world that might hurt her. And not being seen and not being given a chance.**

Catherine's experience of feeling on the outside of the prison gates led her into a self-involved reflective process and ultimately fueled her feelings of fear and anxiety.

Elise also described how she retreated into herself during her patient's dissociation.

Unlike Catherine, Elise retreated into her own childhood wounds and insecurities. She explained that when her patient dissociated, she too felt like she "left the room for a moment." I asked her where she went. She responded

I would guess, I go to my own place of incompetency. Like my own place of, umm, imposter and probably an earlier more primitive place in myself that says, "You don't know what you're doing." I would say I probably leave the person for a couple of seconds and go into my own insecurities or my, you know, my own childhood wounds. And uh confusion. Yeah.

Elise clarified that this retreat into herself was momentary. She was able to attend to her patient's more immediate needs while remaining curious about her own internal state and its meaning.

Both Catherine and Elise described how their feeling of being left alone in the room translated into their own self-focused fears and anxieties. Their descriptions can help to make sense of the salient fear that was present for all of the participants when their patient dissociated and “left” them alone in the room – fears that were often manically self-focused on one’s own competency and what intervention should be attempted next. As Catherine explained, when the patient’s subjectivity is not available, it leaves the therapist alone with only his/her own subjectivity in the midst of this frightening clinical encounter.

Therapist Hyperarousal in the Countertransference

There exists an interesting parallel between the nature of the patient’s trauma memory and the nature of the therapist’s experience in the midst of her patient’s dissociation. Just as the patient likely felt “left alone” in the traumatic encounter, so too, did the therapist feel left alone by the patient. Just as the patient likely felt terrified, incompetent and de-skilled, so too did the therapist in the midst of the patient’s dissociation. And just as the patient likely felt a sense of dread and doom, so too did the clinician experience a parallel, eerie feeling that something bad is happening or is about to happen. Interestingly, the participant’s physiological responses to the patient’s dissociation also mirror the human psychobiological response pattern to trauma – that of either hyperarousal or dissociation. Participants typically reported either feeling hyperaroused and hyper focused during the patient’s dissociation or reported a mutual dissociative process. Several participants even described a sequence of moving from initial hyperarousal into dissociation. I will detail here how the participants described these responses.

Several participants noted somatic signs of hyperarousal when their patient dissociated. Kaitlyn, for instance, described “just being like a little bit sweaty. . . .Maybe my heart was

pounding just a little bit once I saw that [the dissociation] happen. So maybe a little bit nervous.” Darlene reported similar signs during her patient’s dissociation. She said, “I bet my heart was racing, you know, I’m sure my palms were probably sweaty. I was scared.”

Participants also described a sharp focus on their patient and a state of hypervigilance. Stephanie described a surge of anxiety she felt in her body when her patient dissociated, but she also shifted to explain a level of hyper focused attention on her patient, reading her cues and watching her closely, that arose out of this hyperaroused state. She reported that she had to walk her patient out to the waiting room while she was still in a dissociated state. Stephanie said she was “watching her very closely.” She went on to explain this hyper-focused attention she had to her patient:

S: And then really focusing on any cues I was getting from her body and her expression and energy level and yeah. **So you sort of get that laser attention um to your client.** So at that point I don’t know what was going on with my body because I was very much focused on her.

S: . . . And so I was a little bit worried about her and getting her back and grounded before she had to leave the session. So I became very aware of how much time I had left. I was anxious. There was that little bit of adrenaline, like whoa okay. Gotta get her back and grounded. I was surprised that it had happened. And um, so yeah I was very present to how much time was left, to her cues, **watching her like a hawk, as to what’s happening in her body, what am I seeing, um, to gauge how much she was in the room versus not in the room. Um, so I was very focused on her and how much time was left.**

Nancy was another participant who identified this state of hypervigilance that included careful attention to her patient’s cues during his in-session dissociation. She was able to link this to her experience of being alone in the room, noting that when her patient “dropped out of us, I picked up.” I asked her about how “in the room” and “self-aware” she felt when her patient dissociated. She responded:

Paying attention to him, aware of the stillness in the room, aware of whether or not I was moving in my chair, aware of keeping my eye on him, aware of the silence. You know.

Aware of the kind of the length of time. Aware that when he spoke again, he might be tangential, it might not be connected to what he had started to offer. Very present. It was almost like when he dropped out of us, I picked up, which was interesting.

Darlene similarly described a level of intense hyper focus on her patient during the patient's dissociation. She called this being "hyper focused. Really intense." She was paying attention to "every little thing, her body language." Her focus was so intently directed towards her patient that she lost track of a sense of time. She explained, "I was just, that's why who knows how long it was? Maybe the two minutes was one minute but it just seemed like so long like every second was like ten seconds." A few moments later, Darlene clarified that her intense focus was laser-like, narrowed in on small details about the patient, but missing other sensory or perceptual cues. She explained:

I feel like I was hyper-present but not in a relaxed way. So, I don't know like, like I was very much there. I was nowhere but in that room. I wasn't thinking about anything else in the world other than what do I do right now. So I was very present but I wasn't like attending to anything else in the room. I wasn't like, like normally I'm here, I'm talking to you but I also see the couch, I can feel the air, like I can have these different levels of attention to different things that I would say, I wasn't attending to anything except for what was happening with her and what I could what I should be doing about it.

Darlene's experience of hyperarousal and hyper focus on her patient precluded her from perceptual or even cognitive awareness of other sensory perceptions or her own internal experience. Interestingly, this response represents a parallel experience to a typical response pattern to a major trauma, focusing in on narrow details but losing out on the larger perceptual picture. Elise described this experience of narrow focus as "**hyper focused to the point of dissociation.**" She described how she moved sequentially from a state of hyperarousal into a state of primary hypometabolic dissociation. She said, "I get so focused on what's happening that everything becomes so heightened to the point that it's overwhelming." Later she added:

The feeling is hyper focused like as if you just turned around and there was a fire or something. Like "Oh my god!" And so it's not hyper focused in a particularly

helpful way. It's more hyper focused like, "Oh my god. What's going on? What am I going to do?" And later, I'm not clear. I'm all feeling at that moment. All that (GASP). Something's happening, I have no idea what it is.

Elise reported panic and affective overload that accompanied her intense focus. Interestingly, this description of being "hyper focused to the point of dissociation" parallels the kind of hypervigilance associated with a traumatic response.

Both Catherine and Marcy were able to detail how it was that they moved from a state of hyper focused attention into a state of being frozen or dissociated. Catherine described a sequence first of being overwhelmed by her own thoughts, which then led to affective overload, and finally to a brief dissociative state. Catherine's experience of being overwhelmed by her own thoughts became manifest through the litany of questions she contemplating asking her patient. She explained, "All of the questions of like, what does that mean to you? Why do you think it's happening? How often is this happening? Do you notice something beforehand or afterwards, or how are you feeling?" Almost simultaneously though, Catherine felt frozen – unable to access all of these questions swarming in her mind. She said, "All of the questions that right now [during the interview] I can think to ask, **at the time I was sort of frozen in thinking I don't really know what to say about this.**" I asked Catherine to say more about how she labeled her thoughts as "frozen." The following dialogue describes her experience moving from being overwhelmed by thoughts to feeling devoid of thought when her patient dissociated.

C: I know I was sort of worried and my thoughts sort of, they weren't shut down. But I think there was a brief second of where things sort of did stop, of like, I see all these possibilities [of questions to ask] and I have no idea. And then moving from there. So there might have been a small moment of me having that same, there are all of these elements, so I'm frozen too.

J: Like an overwhelmed feeling? More overwhelmed than it was blank? It wasn't like there was an absence of thought?

C: It maybe was a little more blank. **There were a bunch of thoughts and then no clear direction towards a direction. There are a bunch of thoughts. Blank. And then move forward.**

This dialogue illustrates the sequence the participants described of moving from hyperarousal to dissociation in the midst of their patient's dissociation.

Marcy likewise spoke of this sequence of moving from hyperarousal to mutual dissociation. Unlike Catherine, Marcy identified anger rather than anxiety during her state of hyperarousal. She was able to describe how her angry, hyperaroused state alternated with a dissociative, or sleepy, state. She explained:

So when I'm feeling the anger, I'm not sleepy. Umm (pause) Although, it will often, a dissociative sequence would include probably you know, feeling the anger and then I might, you know, and she's still not talking, and then my mind will start wandering and I'll feel sleepy. So it might include all of those things, but the moments of when I'm angry, I'm not sleepy. I'm in the room. Umm, and then I'll often, I'll drift off from there.

Marcy alludes to, though does not explicitly state, the way her state of hyperarousal ultimately begets her sleepiness – what I am terming a state of mutual dissociation. It is possible that the therapist's experience of hyperarousal and resulting affective overload is a trigger for a dissociative defense mechanism, in the same way the participants described the sequence unfolding for the patient.

While all eleven of the participants commented on feeling either hyperaroused or dissociated in the midst of their patient's dissociation, Catherine and Marcy's responses regarding a sequence of hyperarousal to dissociation offer an interesting insight into how the clinician response pattern might change over time. Interestingly, this sequence continues to mirror the neurobiological response pattern to trauma: movement from initial states of hyperarousal and seeking to fight or flee, into dissociation as a way to escape when this effort to fight or flee fails.

Therapist Mutual Dissociation in the Countertransference

Those participants who did not report a state of hyperarousal in response to their patient's dissociation instead identified a state of mutual dissociation. Nine participants of the eleven reported some level of mild dissociation, from a state of momentary blankness, losing track of time or place, experiential feelings of foginess, to total blank-outs themselves. Marcy described a particularly powerful state of mutual dissociation in the most detail, comparing her own internal experience during the patient's dissociation to that of being put under a "spell." She explained:

I would feel really, the experience for me, was feeling really tired. **Almost like um, and not just tired, but almost like um uh this kind of heavy weight came over me and and it was, almost like, I mean I've used the word "spell."** (laughs). It almost had that feel to it, like it was just this heavy sort of cloud of fatigue, is how I experienced it, and and it was really hard to stay in the room. And my, it was, it was almost a physical feeling of not being present, but certainly I would either feel really like I could not keep my eyes open, or my mind would just go elsewhere. And and I wasn't at all present. And it was, it was a real, it was almost a physical sensation of like this fog of tiredness.

Later she explained:

So with this patient that I've been talking about, um, the hardest thing was, um, was staying awake, keeping my eyes open. I mean it was almost like someone was closing my eyelids, you know.

Marcy also reported this similar feeling of sleepiness in her follow up written account. She said that she experienced a "sensation of having someone almost forcing my eyes to close" while her patient dissociated. The consistency of her experience with this patient in the midst of the dissociative field suggests a distinct clinical phenomenon.

Elise also described an experience of mutual dissociation during the moments her patient dissociated. She commented on the contagion effect of dissociation:

I am also aware that when someone's dissociated, it can become a little bit contagious, like I might be also slightly dissociated and umm not very grounded myself. So, I think

there is also a contagion effect that I feel, like uh oh, where are we? And I get confused which is very uncomfortable for me.

Later she elaborated on what it feels like for her to be “slightly dissociated.” As she was admitting to her own counter-dissociative process, she also minimized her experience of dissociation, indicated below:

I think when I become confused in a session at someone’s response and I’m taken by surprise, it has the effect of, I could become overwhelmed, and I’m going to say **slightly dissociative** in that my brain isn’t really working. I’m just kind of in a “what’s going on?” Like, I’m disoriented. And in that moment, I guess I **can almost feel like “Where are we?” I can share in the feeling of disorientation, confusion, um, not being aware of time or space or place or soo.. yeah, I think it’s momentary**, but, I just know that sometimes even in a session where I’m sensing that there’s trauma or dissociation in the room, even if it’s a family, something happens to me that’s more visceral. I guess, I should say bodily or somatic, where I can feel a little removed, like “Oh I don’t know what I’m supposed to do” and “Where am I?” and “What’s my role?” and that maybe someone else should take over?

Elise’s comments highlight an important component of the theme of therapist dissociation; the participants understood this dissociation as resulting from contagion, not emerging as a result of vicarious traumatization or their own internal processes. Instead, the participants understood the dissociation as a projected or co-constructed experience with the patient.

Anna commented on a similar mild dissociation she experienced when her patient dissociated, and went even further to suggest that allowing herself to become mildly disoriented helped her patient.

. . . The brief moments when I’m imagining what happened [the trauma], I can feel a bit dissociated myself. And yet, it’s never to the degree where I don’t know that I’m here, but it’s kind of a fuzzy surreal feeling. Um, I felt it with other clients. Sometimes it’s like, hmm is that my allergies? What time of day is it? (laughs) You know what I mean? And yet over time I know what it is because it is so specific to the experience that either this particular client is having, or another one. Um, but mostly her. Because her her dissociation is so severe. And so um, experienced in such a deep, painful, way. That you know, her energy, I can’t just cut off her energy flow. I know I’m being affected by it. Um, and I know how to keep myself kind of here, but not so here that I can’t experience a little of it, because I think it helps her.

Anna placed importance on navigating this precarious line between being grounded enough to be helpful to her patient, but also being willing to enter into her patient's dissociation. Elise described a similar process of allowing herself to enter into her patient's dissociative state – to be, as Anna said, “here . . . but not so here.” Elise explained that she has learned to rely on her own dissociative process when her patient dissociates in session to manage what could become hyperarousal. She explained:

. . . Rather than like “(gasp) we have to do something” it's like it's time for me to step back and allow you the room you need to re-orient and I'll contact you calmly. . . it's just part of the work, like “Okay great, I asked you something, you dissociated” and then “Oh, you're back, you're ready to have a conversation again? Okay.” And I might take a break without becoming disoriented. Give them space and take my own break and maybe think, hmm what's going on, uhh do they look like they're ready to be contacted? So I think my leaving them and going into my own space, it improves as I, as we get to know each other and as I understand their process and they trust my process more. You know, it's almost like we are unconsciously saying, “You're dissociated. Maybe I'll dissociate a little, but we'll come back when we're ready. Like maybe we'll get a glass of water, instead of (gasp) Oh my gosh where did you go??”

Elise named this her “acceptance of first of all their need to go away and second of all maybe just a split-off part of themselves.” She described how important she felt it was to “just literally get comfortable with it [the split-off part of self]” rather than keep herself at a place of “horror or distance.” Elise did this by entering into a state of mutual but mild dissociation. She was the only participant to use the language of “getting comfortable” and “getting cozy” with the patient's dissociation, however these words reveal a common theme amongst participants of the importance of accepting both the patient's dissociation and *one's own counter-dissociative processes*. Elise explained that her willingness to enter into the dissociation, hers and her patient's, developed over time. She explained:

Yeah I think that a lot of therapists say, “I'm sane, you're not. You're sitting over there, I'm sitting here.” And I'm much more of the, we're just passing it back and forth all day, and I better hold onto my sanity as best, while allowing myself to go a little insane. And I believe that what I love about my work is that I can get yanked around, but even I have

my, sometimes I'm just like whoah. I had a few people years ago when I first started really seeing people who were dissociative, I think I, I think my anxiety about it pushed them away and I did get fired a couple of times for the first few people that I saw who were dissociative. And I think it was probably right that they fired me. I think I felt like "uh oh" they were pulling me into a place that I'm not going, and you better behave because I'm not going there. And now I'm a little more like, I wouldn't say I love it, but I'm more like, "Oh well. We'll find our way back."

Elise's words beautifully capture her acceptance of the utter normality of dissociation. She put herself on a continuum with her patients, humanizing them, by acknowledging and even welcoming her own dissociative process.

The pervasiveness of mutual dissociation in the therapy dyad, occurring for nine of the eleven participants, suggests that this process of dissociating in the face of dissociation is not merely an idiosyncratic defense mechanism, but instead a product of the contagion effect of dissociation and the co-constructed nature of the dissociation in the therapy dyad.

Summary

It is clear that all of the participants experienced strong personal and interpersonal reactions to their patient's dissociation. In many ways, the participants' reports of anxiety, abandonment, hyperarousal and dissociation in the session parallel the patients' experiences in the midst of the traumatic moment. Several participants commented on this parallel, and were able to make meaning of their patient's dissociation as an important intrapsychic and intersubjective phenomenon.

Elise's comment that her patient was "*communicating through the dissociation*" reveals an important contradiction and duality that continually arose in the data—a juxtaposition of intensity and blankness. Upon first glance, it appeared that nothing was happening in the midst of the patient's dissociation. The patient was blank, gone, and shut down, according to

participants. And yet, by their own accounts, the participants reported intense affective, somatic and cognitive experiences during their patient's absence. These reports represent a parallel of the patient's own experience of alternating between a hypometabolic dissociation and intense affective hyperarousal and overload, both during the session and hearkening back to the early traumatic moment(s). In this way, the patient can bring the therapist both to the scene of the crime in the traumatic moment and into their tortured internal world. The next section will elaborate on how the therapist's internal experience during the patient's dissociation can offer an entrée into the dissociative mind using the participant's own accounts and case examples.

CHAPTER VI

FINDINGS III: DISSOCIATIVE ATTUNEMENT

Findings I details how the participants made sense of their patients' dissociation, including the triggers for the dissociation in session and the function it served. These findings reveal that the patients' dissociation often held potential to convey important information about their affective state, trauma narrative or needs in the context of the therapy relationship. Findings II details the nature of the therapists' internal experiences when a patient dissociates in session. There was a predictable sequence to the participants' internal responses, suggesting a distinct clinical phenomenon. The participants' internal experiences in the midst of their patient's dissociation can be understood as a parallel experience of the patient's own state during the original traumatic moment – again highlighting the potential of the patient's dissociation to communicate important split-off memories or parts of self. Findings III integrates the content of Findings I and II. While Findings I focuses primarily on the *patient's* experience and Findings II focuses on the *therapist's* internal experience, Findings III details the way the therapist's internal experience reveals important information about the patient – unspoken aspects of her affective state, memories and needs. Findings III will present the construct of dissociative attunement – a relational experience of resonance in the midst of absence. This seemingly contradictory phenomenon involves the therapist listening and paying close attention to both self and other simultaneously, being present to the patient in the therapy relationship while still maintaining a safe distance. Chapter VI will detail the therapist's process of attunement to the patient in and through the patient's dissociation in-session – the process that allows the therapist to find the patient by looking within herself.

What is Dissociative Attunement?

What is dissociative attunement? The participants struggled to put language around this intersubjective experience that happened so rapidly and occurred seemingly outside of conscious awareness for therapist and patient alike. They used a series of theoretical constructs, such as “unconscious communication,” enactments and projective identification to describe this experience that they understood as wholly nonverbal. Ruth, for instance, struggled to articulate her belief that by sitting with her patient in the dissociation and through her own willingness to pay attention to what came up internally for her, that something happened between the two of them – something that Ruth understood loosely as progress. She explained:

So, and I think that maybe that would be my sitting with her in that and sharing it with her. It didn't happen alone. . . . I think it's co-conscious. That the whole experience is shared but that maybe we didn't even say a word about it. She didn't say it. She didn't say anything. I attempted to have a conversation with her afterwards, but I was experiencing all of that and perhaps even in my experiencing of it, something happened between the two of us and I don't know the mechanism by which that takes place, but we were sitting together.

I share Ruth's language to highlight a common theme amongst participants – that they knew something occurred in the therapist-patient relational matrix, but they often didn't know the mechanism by which that happened. The participants did not explicate a clearly conceptualized theory to make sense of how the dissociation held such power to communicate, yet like Ruth, they understood something about the power of “sitting together” in the dissociation and the experience of knowing something without “say[ing] anything.”

What I have learned from the participant accounts is that the work of listening and hearing through the patient's dissociation is both counter-intuitive and grueling. They consistently spoke about the urge to leave and withdraw from their patients in the midst of the dissociation, and yet acknowledged that their willingness to stay with their patient and to accept

and enter into their dissociative world was incredibly appreciated by their patient and enormously transformative for the treatment. Five participants noted that they received phone calls after the session to thank them, or letters even years after the treatment ended acknowledging how hard the work was for the therapist, and how meaningful it was that the therapist stayed with them through it. This willingness to stay present and be with the patient in the dissociative space is the essence of dissociative attunement. Tasha's patient, for instance, admitted that Tasha "got" something very important about her by staying with her through the dissociation and by responding after the dissociative episode in session by increasing the length of their sessions. Tasha explained:

T: She felt very much seen by it. She felt like I responded to a need she has.

J: And you think partly your internal experience was what shaped some of that?

T: I want to help her! (laughs) I mean you know in this case it worked out good. In other cases I'm all like, why is the patient? Who wants this more? You or them?

J: In this case she felt very seen, okay. How did you know that?

T: She said it. She said it. She said, she didn't say it then. She told me I think last week. She said I just can't tell you how helpful it is to not have to rush. She said, "**I feel like you really got something about me when you realized I needed more than just a regular session.**" So yeah. So that feedback didn't come until later but apparently it made a big difference to her.

Nonverbally, Tasha did get something very important about her patient – something her patient needed but never knew she needed and certainly didn't know how to say.

Ruth described a similar experience of tuning into something the patient needed her to know. She explained:

J: Do you feel like you made contact with what the client was experiencing during the dissociation?

R: My guess, yeah.

J: Why yeah?

R: Because my hope would be **that I was enough attuned to what it is that she had let me know about what her experience was, that what I'm saying is, I guess, is on track.**

J: When you're saying what she had let you know, you mean previously about her life history?

R: **Yeah and throughout the whole process I was attuned enough to her. Um, like that I got it. In that way. Like I got it. Like a parent, like a good parent. . . . Like a good parent, I got what the others didn't get about how hard this was for her [the upcoming termination of the treatment relationship which led to the dissociation in session] and about how painful and hurtful and disappointing and how she may have felt anger and that I was, I was okay with sitting with it.**

This experience of “getting it” in the midst of not speaking and not knowing is the process of dissociative attunement. When the therapist can be okay “*sitting with it*” for long enough to understand from the inside out, then she can “get” what it is that the patient knows but cannot tolerate knowing alone.

Through my analysis of the participant accounts, I have identified common themes and patterns in the data that reveal the components of this process of nonverbal and intersubjective communication that occurs between therapist and patient during and after the patient's dissociation in-session. There were clear themes that emerged across the accounts of all eleven participants that speak to this process of coming into contact with a split-off element of the patient's self, the impact of this contact on the dyad, and the strategies employed by the therapists to effectively manage their patients' intolerable and split-off memories and associated self-states. I will argue that the process of dissociative attunement is comprised of seven component parts, as identified by the participants in this study: Disjunction and Connection, Perception of Nonverbal Cues, Induced Feeling, Therapist as Placeholder, Asymmetry of Roles and Responsibility in the Dyad, Containment, and Therapist Imaginings. The following seven

sections will elaborate on these component parts of the process of dissociative attunement and provide illustrative examples from the participants to describe each theme.

1. An Apparent Contradiction: Disjunction and Connection

A large majority of the participants described feeling disconnected, in some cases “distressingly disconnected” from the patient during the dissociation, and yet many of the participants also described deep experiences of empathy and oneness with their patient either simultaneously or subsequent to the disconnect. The sequence of disconnection and then (re)connection ultimately set the stage for the process of attunement to proceed in the dyad. This section will unpack how the participants made sense of these seemingly contradictory experiences in the midst of their patient’s dissociation.

Disjunction

Ten participants spoke of some degree of disconnection from the patient when he/she dissociated in session. Marcy used the language of “very disconnected, very disconnected, just distressingly disconnected” to describe her experience during her patient’s dissociation. Anna, who also was aware of “being less connected to her when she’s out,” noted that this disjunction was a “felt sense.” Stephanie also described a “feeling” in the room that signified the disconnection. She clarified, “I can just feel them leave me. The energy is different. The energy is not present. This is the intuitive part of therapy (laughs) So I can feel it. The energy in the room changes.” As these examples illustrate, the therapists used both their perception of the patient and their internal experience and “intuition” to identify this disjunction.

The experience of disjunction in the dyad often led to a counter-withdrawal by the therapist. Several participants noted that their initial response to their patient’s dissociation was an immediate urge to withdraw. In many cases, the urge to withdraw was informed by the feeling

that the therapist couldn't meet the patient's needs. Marcy explained in her written account, "There was a feeling that she wants something or needs something that I may not be able to provide." In other cases, participants experienced the patient's dissociation as a personal affront and described feeling injured by the patient's rebuff of their attempts at connection. Catherine provided a good example of this. As noted previously, Catherine used the metaphor of a prison gate to describe the "firm, solid disconnection" between herself and the patient when her patient dissociated. In response, Catherine experience an urge to withdraw that manifested as frustration with her patient for projecting the victimizer role onto her and experiencing her efforts to connect as unsafe. She admitted:

But I think if I were really honest, there is a part of me that is a little like, that was like a little annoyed and a little like, um, hurt that, 'hey I'm not doing anything bad and I'm here to help you and that's not fair that I now created this response that creates a response in you that is more hurtful to you.' Like, that's not what I wanted and you know. Now our relationship is intruded on by all these other things and that **I am that much further from you**

Catherine even began to imagine the disconnection as persistent through the course of the treatment. She pondered:

Usually I think the you know, the issues of how safe am I here come up a lot later and that initially people might have a more superficial but um easier time kind of going through the beginning steps of getting to know a therapist. Where in the first session to dissociate, **is just like, oh I'm not even going to be able to do these first steps very comfortably and it's going to be a long ways uh for things that are seemingly um commonplace to be comfortable, and for me to trust you [the patient] with them and for me to trust my own experience and for her to feel like she could trust her own ability to have a feeling.**

Tasha experienced a similar disjunction in the dyad. She admitted to an urge to withdraw from her patient that occurred when the patient dissociated. The following dialogue illustrates her experience of this urge:

T: I can feel myself . . . sort of instead of relating, you know like, letting myself sort of out, even if I'm not saying anything, you can relate by not saying anything, so **I just sort of feel a closing up of it.**

J: Is it a somatic experience?

T: Yes, well it's an energetic experience. So yeah I can feel it but it's not like, you know, it's not, my muscles aren't tensing. That's not what I'm talking about. **I'm talking about a covering of myself.**

All of the participants who experienced this disjunction in the dyad noticed its arrival by way of their own internal experience and concomitant urge to withdraw. Tasha also understood her process of closing up as a “distancing mechanism” that represented a “parallel process” to the patient. Her state of withdrawal, according to Tasha, mirrored the patient's dissociation. She explained, “Because I'm working to overcome that distancing mechanism and she is working to overcome a distancing mechanism that she is using.” As such, Tasha used her internal experience not only to recognize the patient's disconnection, but also to understand it. Although they were disconnected, Tasha and her patient were working in synchrony.

According to Jeff, he did not experience himself withdraw from the patient during the dissociation, but he did describe a certain level of misattunement that promoted disconnection in the dyad. Jeff described in detail what he saw as the moment of disjunction between himself and his patient, where he and his patient were “off rhythmically.” As noted previously, his patient had begun to recognize her mother as a person with borderline personality disorder. Jeff felt empathically attuned to his patient as she was working on this realization and processing her feelings about her relationship with her mother. And then suddenly, his patient said “and animals” and her voice trailed off. Jeff imagined that his patient was remembering a particularly horrifying memory of her mother injuring the family dog. It is at this moment that the disjunction occurred. Jeff explained it as such:

It is as if there is a momentary, I can feel my own brain trying to make what she is saying make more sense. Um, like when she says, “And animals” and trails off. **I miss a beat or two, because I’m thinking she’s talking the way an ordinary person would be talking where there is a kind of continuity, but there isn’t.** And so to me, part of the eerie feeling is I realize I’m filling in the space for a second to make it make more sense. As if, first off, I mean, it doesn’t make sense (laughs). “And animals” didn’t make sense about anything she was saying, but it took me a while to kind of “get it.” And that’s part of the eeriness. And **eerie in the sense that she’s not there for, it’s not long. It’s definitely under ten seconds. It’s definitely not long. Um, and it’s as if I’ve sort of missed that ten seconds too,** because I think, I think because I’m sorting of giving it a continuous flow and it’s really more what I would call a shift in self-state that I have to strain to remember what just occurred. Like, do you know what I mean? Like there’s, that was bizarre. But I have to retrospectively, **so it’s like I’m off a beat interpersonally. You know there is the idea about contingent responsiveness with babies and mothers. It’s as if it’s not contingent for a little bit and I’m not contingent. It’s like there is something off rhythmically almost.**

Even subsequent to his patient’s dissociation, Jeff described a certain lingering dysregulation that took several minutes to repair. His patient shifted into a playful self-state. She began to needle Jeff, asking him what other patients talk about in session. Jeff recalled holding his hand up to try to stop the patient. He hoped to bring her back to the intense conversation about her mother, to the place where he felt in rhythm and attuned to her. In his efforts to bring her back to the work they were doing prior to her dissociation, there was a dysregulation in the dyad. He said, “and then I feel like there was this kind of dysregulation between us. She’s in a playful mood, I’m not feeling I can play with her in any way and it takes me a little bit of time to sort of come back, to wait a minute, what happened there.” Eventually, Jeff came to understand this dysregulation as a misattunement. Jeff reported that the misattunement began at the point where he anticipated and desired for his patient to continue the work, but essentially missed her need to slow down or shift gears. He explained:

I think it’s conceivable at a certain point where the misattunement begins is where I’m in effect wanting her to go on. I’m interested, excited and at that point it’s horrible for her and I don’t think I was attuned to that thing.

Later he continued:

This is a really good example of a kind of misattunement on a certain level. Like I really do think she's probably, in that there are multiple selves going on as she's telling me. There is a part of her that is pleased, that this is a kind of liberation that she can think about this and there is also a familiar part of her that is guilty, frightened, ashamed as she's telling me. **And I think at a certain point my attunement to her excitement loses the attunement to that other side. I lost the other and she blanks. That self isn't held . . . and then, she's all alone with it and she's really all alone with it as she dissociates.**

Jeff understood his patient's dissociation as arising out of his misattunement to the frightened, guilty and ashamed part of the patient's self. He also understood the dissociation as furthering the disconnection between them, leaving her "really all alone with it as she dissociates."

This extended example from Jeff illustrates several components of the disjunction the participants reported in the midst of the patient's dissociation. First, the disjunction was often the initial and automatic response to the patient's dissociation. The disjunction was also an interpersonal phenomenon, both experienced and contributed to by patient and therapist alike. The disjunction in the dyad then often exacerbated the patient's experience of being and feeling alone. And finally, the disjunction often looked like a misattunement – the therapist misses the part of the patient that is looking to connect despite the obvious signs of withdrawal.

Connection

In every example of disjunction that the participants reported, they also described a process of coming back into connection or attunement with their patient. Often this occurred during the same session as the dissociation, but occasionally the re-connection occurred several sessions or in one case, even years later. The connection was restored through the therapist's own efforts to find the patient. I will review how the therapists attempted to reconnect with the patients, and then address what enabled the therapists to make these efforts in the face of the pressing urge to withdraw.

Therapist effort to re-connect. Unlike most patients in psychotherapy, the connection between patient and therapist in the midst of a patient’s dissociative state is not a given. It is something that the therapists had to fight to maintain – battling against their own dissociative processes and distancing mechanisms, and engaging in the grueling work of reconnection. Marcy indicated that her efforts to re-connect with her patient were important in restoring their relationship. Her effort offered reassurance to the patient that she was willing to do the work and stay present, despite how hard it was. According to Marcy, this was what ultimately enabled the patient to “come back” and move out of her dissociated state. The following dialogue illustrates Marcy’s efforts at re-connecting with her patient during the dissociation:

M: . . . I keep asking her questions. Very carefully thought out. And the questions are you know, I’ll start with, “So what are you thinking?” Or I’ll start with, “Where are you?”, “Can you tell me what is in your mind right now?”, “Can you tell me what you’re feeling?”

J: Do you get a response?

M: Yeah after a couple of minutes she can start to come back.

J: What do you think pulls her back?

M: That’s a really good question. It’s a really good question. Is it, umm, that she, it may be that she wants, she doesn’t want to be in that space of not being able to talk? **Maybe my working so hard to reconnect with her is reassuring to her? I think that’s probably it. That I make so much effort and that it’s actually, it’s about the hardest work I’ve ever had to do in those moments of trying to get her to reconnect. I think she needs me to make that effort so that she can feel safe enough to come back. And that I really do want to know what’s going on. It’s really hard.**

Marcy shared that her efforts to find her patient were authentic; she really did want to know what was going on. Other participants described a similar experience using different language. Ruth, for instance, indicated that while the patient dissociated, “I was by her side there. Literally. I mean.” Tasha likewise described her attempts to stay by her patient’s side, even as the patient was fragmented and unable to communicate. Tasha said, “I’m still listening, I’m still inquiring.”

Elise also made efforts to re-connect with her patient, but understood these efforts as mostly nonverbal. Elise described an instance in which her patient asked to take her hand, offering the pair a beacon of connection in the midst of the dissociation.

Well, I learned over time, a long period of time, that I would have to very very gently contact her my contacting her would almost be that I would have to sense that she was almost ready to be contacted. A lot of it was nonverbal. . . . I asked her if it would help if I sat near her if it would help or bother her, and she said I believe that it would help. And there were times she asked me to take her hand, but from more afar, not sit next to her and take her hand. But sit across from her and take her hand.

The image of Elise taking her patient's hand during the dissociation is an evocative one. It illustrates the extent of the therapist's willingness to find and hold the patient, and the power that this effort alone holds to bring the patient back from the dissociation.

Despite the disjunction, or perhaps because of the disjunction, the participants were able to re-connect with the patient. Jeff described the disjunction both as an example of misattunement, but also as providing an opportunity for repair and deeper connection.

I mean, it's a little difficult to say whether that will make it, you know I think it's sort of umm, I think there's the possibility that uhh it makes it more difficult for her to return if she senses um I'm less in touch with the part of her that is feeling overwhelmed. On the other hand, given our history, and given the what feels and felt like a repair a few minutes later, might it made other things like this, I mean I don't know, but I can kind of see both. One being not a good thing for the future and the other, sort of, meaning we, you know, we do the best we can, and we seem to get over it and move on in a way that feels um productive, uh you know. I don't think it was accidental she called after sort of thanking me. . .

The disjunction in these encounters offered the therapist an opportunity for "repair" as Jeff says. According to the participants, the patient's withdrawal and the therapist's urge to withdraw in response is what provided this opportunity for the therapist to resist the temptation to withdraw, or to make efforts to re-connect after the withdrawal.

Enabling the re-connection. What then is it that enables the therapist to engage in this “grueling” work of re-connection in the face of the urge to withdraw? Several themes emerged to explain what the therapists drew upon to enable the re-connection.

The first theme was deep empathy for the patient’s pain and a desire to protect and help the patient. Four participants identified states of empathy that emerged while the patient dissociated in session. Kaitlyn identified that her empathy emerged simultaneously with the urge to withdraw. She explained that she “would have had those conflicting feelings, like disconnected but also that pull to like, sad for her, that pull that I wanted to help. I think that those two things kind of come up pretty strongly for me.” Tasha identified empathy that emerged subsequent to her feeling of pulling back from her patient. She explained this as such:

I feel concerned about you know doing a good job of her, taking care of her as best I can. I mean she’s in so much pain. I don’t want to make that worse. And I don’t want to make it not better either. I don’t want to make it worse and I don’t want to let it be the same.

Tasha’s desire to take good care of her patient is reflective of a state of deep empathy, feeling the patient’s pain, and acknowledging a responsibility to ameliorate this pain. For Tasha, this emerged only after an initial disjunction in the dyad. Ruth, on the other hand, never experienced a disconnection in the therapy relationship. Instead, Ruth described feeling deep empathy for what she imagined her patient was experiencing while she was dissociating. In response to a question I asked, Ruth affirmed that the experience of the dissociation did not cause her to feel at a distance from her patient. Instead, she said:

If anything, based on the process that I had going through it with her, **I felt a great deal of empathy for her. Not only in the moment but afterwards.** I really I mean for someone, when someone is in that state and it’s I mean, I felt a great deal of empathy for her. I did. Because it, that’s so difficult, that that was an indication to me about how difficult this must be for her. . . .My guess was that this whole process must have been incredibly difficult for her, like the most difficult thing we’ve ever done together even though it wasn’t together.

Later Ruth explained that her ability to maintain connection to her patient during the three to five minute dissociation in session grew from her empathy. She explained that during the dissociation “I really felt empathetic towards her. . . . In some ways maybe what we shared was that I was experiencing the pain that most likely I’m assuming she was experiencing about the whole situation. So maybe that was a shared experience.” Ruth spoke to the true meaning of empathy – feeling the other’s pain within oneself. Perhaps because Ruth was the only participant to take in the experience of the other, she was also the only participant who experienced connection without a concomitant initial disjunction during the dissociation.

Four participants identified that the process of labeling the patient’s withdrawal as dissociation was the step that enabled them to attempt to re-connect with their patient. Instead of experiencing the patient’s withdrawal as an intentional relational maneuver to distance or as a manifestation of resistance, the act of labeling the withdrawal dissociation enabled the participants to accept the patient’s need to dissociate and then resist the urge to withdraw in response. Marcy described how helpful it was for her to finally recognize that her patient’s experience was dissociation and to name it as such:

I think my first advice would be to pay attention to your somatic experience and so that you then know when the person is dissociating. And instead of doing what I did before I understood this, which was to feel guilty and ashamed for being sleepy, which will make you want to withdraw from the client. I mean whenever you feel ashamed or like you failed your tendency is to withdraw rather than engage, **so if you understand it as dissociation, then you are grounded theoretically.**

Later, Marcy identified that naming the dissociation also helped her feel less frustrated with her patient. Instead of viewing the patient’s withdrawal as resistance, she was able to see it more empathically as a necessary survival strategy. She explained how she first came to identify the patient’s experience as dissociative:

And then I came to think that it was, it was some kind of dissociative experience for her. Because of the feeling of tiredness and floating that I would feel And so once I started to think about those moments not as her purposely withholding information from me but that I would ask about a feeling and then she would dissociate away from the feeling. Um and that in a way it's all that she can do when she has that feeling, it's not like she's purposely pushing me away.

Marcy's understanding of her patient's need to dissociate promoted her empathy for the patient, kept her feelings of shame at bay, and ultimately enabled her to maintain connection.

Participants also noted that identifying and naming the patient's dissociation enabled them to tolerate the fear of the unknown that accompanied the patient's dissociation. Elise explained how important it was for her to "show an acceptance of first of all their need to go away and second of all maybe just a split-off part of themselves that I can just literally get comfortable with." Doing so, Elise explained, helped her "go from a state of maybe horror or distance" to a feeling of "coziness" with the dissociation.

Nancy likewise explained that naming the dissociation enabled her to tolerate her fear. Nancy specifically identified fear about her patient's unknown symptom picture. Once she understood her patient's symptoms as dissociative, she felt better able to control her fear of the unknown. The following dialogue depicts the way that naming the dissociation altered Nancy's experience of her patient.

N: I think there was kind of a suspension of wondering whether we'd be connected when he'd return. It was kind of, it was kind of like I appreciate the um the value and function of dissociation, so it didn't feel like he was um deliberately trying to disconnect and I felt able to tolerate um wherever he was even though I felt you know at different times curious and frightened of what was happening in front of me. **Once I named it as dissociation, that was easier for me.**

J: How did things change when you named it?

N: Well I wasn't frightened anymore. I didn't think he was hearing voices I didn't think he was psychotic I didn't think he was you know um having some kind of delusions or hallucinations. It felt that he had just disconnected. He talks a lot about, he describes a lot

of the experience of derealization and depersonalization. He can see himself seeing himself, which is different than when he suddenly is quiet and he goes off somewhere.

In all four cases, acknowledging that the clinical presentation was a dissociative episode and naming it enabled the participant to relax and remain present, resisting the urge to run.

One participant also identified a patient-factor that enabled re-connection in the dyad. Jeff explained that he was able to come back into focus and feel more present to his patient only when she became more present, too. In this case, both the disjunction and the re-connection were wholly mutual and co-constructed. Jeff explained that after what he called the “misattunement,” “for the next several minutes there was a kind of coming back into focus. And I think I relaxed, I felt present when she was present.” He clarified that as the patient came out of the dissociation, she was able to remember what they had been talking about prior. This was a new experience in their relationship, and Jeff believed it was what enabled him to more quickly re-connect with her. He explained:

During the talking about what happened, because she remembered it, I felt like, like I could kind of get back to where she was. I mean she helped, she helped me attune to her affect because um she more quickly could stand in the spaces. That’s the way I would describe it.

Jeff described an experience of comfort and unison when his patient returned and was able to “stand” in the gap between what happened before and after the dissociation. He said, “I mean, you feel like you’re on the same planet. And it was process-able, even if she wasn’t willing to go back there, it was, we could at least process she’s had enough and it felt comfortable moving the session along.” The patient’s ability to remember the content of the session just before she dissociated restored continuity. Jeff felt “on the same planet” with her, indicating that the rhythm and resonance in the dyad returned.

These experiences of disjunction and re-connection set the stage for the participant's experiences of attunement – the process of reciprocal recognition in the therapy dyad which included a congruence of inner experience and yet an asymmetry of how these experiences were shared. In some cases, the participants' experiences of disjunction and the urge to withdraw can be understood as a synchronous state to the patient's dissociation, representing a component of attunement to the patient. Further, the dialectical process of disjunction and connection in the midst of the patient's dissociative encounter mirror the process of attunement to the patient's internal experience – providing enough mutuality in order for the therapist to become aware of the patient's experiences, but enough distance for the therapist to safely tolerate, mentalize and contain these experiences.

2. Perception of Nonverbal Signals

The relational experience of disjunction and then connection provides the context in which attunement can occur during the patient's dissociation. A second crucial step in the process of dissociative attunement rests in the therapist's ability to recognize the patient's internal state. This recognition often occurs rapidly and exists outside of language. The participants were largely unable to describe how they came to know or understand something about their patient's internal experience during the dissociation – outside of using words such as “empathy” and “care” and “listening.” However, ten of the eleven participants did describe a very nuanced and focused attention to the patient – particularly the patient's nonverbal facial and bodily cues during the dissociation that they believed gave them important information about the patient's state. The participants' attention to the nonverbal signals displayed by the patient provided insight into the patient's unspoken affective states and needs.

Several participants commented on their observation of *bodily cues* displayed by the patient. Tasha first noticed her patient's "slack" facial expression, and understood this as reflective of the patient's scattered and unintegrated state. She explained:

Her face was kind of slack. I wouldn't say her facial expression was flat, that's not what I mean. But she was like, she just couldn't pull it together. Like when a person, I don't know if you ever notice this, but sometimes some people when they get really tired, their face just stops. They might laugh or something but then they kind of (laughs) (makes slack facial expression). That's how her face was. Slack.

Several other participants commented on the patient's *lack of eye contact* as an important cue that he/she was no longer present, as illustrated in the examples below:

There were a number of times that were very brief . . . where she like looked, turned her head to the side, looked off, and seemed glazed over. (Catherine)

Shutting her eyes. And eye contact is gone. She cannot look me in the eye when this stuff is going on. (Anna)

He would begin to answer a question and then just pause and look down. No eye contact. (Nancy)

She would stare. She would look different. (Elise)

Participants also reported being tuned in to the *cadence of the patient's speech*, rather than just the content. This, too, provided a way for the therapist to tune into the patient's state. Ruth and Darlene described witnessing their patient fall silent.

I saw her get very quiet. And um, I saw, she obviously stopped talking. And she looked like she was staring into space or deep in thought. And it happened for about... probably anywhere from 3 – 5 minutes. (Ruth)

And then I guess she started to get a little quieter and maybe more space between the sentences Like just kind of talking a little more slowly and a having a little less to say, going within herself a little bit. (Darlene)

Tasha witnessed a slowing of speech:

And um, she is, she is very slow. She's very slow to speak. She's very slow to process cognitively, which probably has to do with the ECT. Um, and she um so there is sort of that a sense of being of retarding. And I don't mean. She's smart. She doesn't have a

mental incapacity. But um uh that slowness was very present, but it is present all the time. And I already knew that about her.(Tasha)

Jeff and Anna noticed a similar trailing off that occurred. Their patient's verbalizations became fragmented and no longer made narrative sense.

So she said something that first off wasn't a finished sentence and she trailed off and looked off. . . so it didn't even really narratively make sense. . . . And then looked off. She was quiet. (Jeff)

Well, her, the conversational flow was interrupted. So if I'm speaking of her and she's pretty grounded and she's herself, her host self, it flows pretty naturally back and forth, back and forth. Um, when she switches, it's like mid sentence, she just stops. And what she's saying are not complete sentences that make sense. They are bits and pieces. She'll say a word. She'll say, something like "a van." (Anna)

Other participants paid attention to *changes in the patient's body positioning or posture*:

She would go to the fetal position, yeah. So I couldn't see her eyes. (Kaitlyn)

So physically what will happen is her posture will change. Umm, she'll kind of withdraw in . . . and she'll kind of curl within herself. She'll hold, this time, she was holding her ears. . . .(Anna)

And her posture would become very, very rigid. (Elise)

No affect. Very still. (Nancy)

The participants were tuned in to a host of nonverbal cues displayed by the patient through body and patterns of speech. Often this tuning in consisted of a catlike perception, being hyper focused to any changes in the patient's bodily state or facial expressions. Stephanie referred to this experience as "watching the patient like a hawk." This hyper focused level of attention was especially salient for those participants who did not experience a dissociative countertransference during the patient's dissociation. Stephanie explained that while her patient was dissociated, she was "very present to how much time was left, to **her cues, watching her like a hawk, as to what's happening in her body.**" Darlene also commented on a state of hyper focused attention, feeling attentive to "every little thing" that the patient's nonverbal cues might

tell her. She described being “hyper focused. Really intense.” She recounted the following internal dialogue during the dissociation:

I was just like Okay. Calling her name. You know. Call her name again. Is she breathing? Look at her. What is she doing? She is breathing. What could possibly be happening. You know, like, like. **Every little thing, her body language.**

Interestingly, while both Stephanie and Darlene denied feeling dissociated themselves during the patient’s dissociation, both participants admitted to mild out-of-body experiences without labeling them as dissociative. Instead they described these experiences as feeling unable to focus on themselves while attending so closely to their patient. The examples below illustrate their difficulty maintaining awareness of their own states while being hyper focused on the patient.

And then really focusing on any cues I was getting from her body and her expression and energy level and yeah. So you sort of get that laser attention um to your client. So at that point I don’t know what was going on with my body because I was very much focused on her. (Stephanie)

I don’t know, my heart might be racing, but I’m not going to sit here and self-regulate (starts laughing). Right? I got an emergency here and I need to help this person. You know, too bad if I’m uncomfortable. You know if not an emergency and feeling nervous or something, I could probably also attend to myself a little bit and be present. . . . Yeah, if it’s kind of more of normal experience or daily experience, whenever I can have the dual-attention of what’s happening to me and the other. But here it was all about testing out what to do for her and to help her. (Darlene)

Kaitlyn was more able to shift back and forth between attending to her own internal state while maintaining sharp attention to her patient’s nonverbal cues. She explained:

I kind of always felt like I was having an inner dialogue with myself. Wondering am I doing the right thing? Oh crap, what’s going on? But, as far as like, uh, I was consistently in the room with her and I was like, my eyes were always on her. I was watching her but I couldn’t shut off my inner, my inner self-talk. But I also was like really engaged with her.

The participants who were able to maintain this dual focus both on the patient and on themselves often described using their intuition in order to get a sense of where the patient was and what was

happening for her. Attention to one's intuitive sense of the patient represented another type of nonverbal cue the participants learned to pay attention to. Like other nonverbal cues, the participants' use of self to gain insight into the patient's state occurred rapidly and often outside of conscious detection. Participants described having a "gut sense", "a feeling" or "intuition", or even "acting before thinking" on something that later turned out to be an accurate perception.

Catherine explained:

J: One of the things you mentioned was that there was something distinctive about it. It wasn't just that she was thinking or uncomfortable, so what was it that led you to the conclusion that really she was dissociating?

C: I'd say it was the feeling in the room, the feeling that she wasn't there. . . . That she just wasn't there, that there wasn't a sense of tension where she might have been defending, you know being like, trying to disregard what I was asking or that she was sort of ruminating on something, that I guess maybe yeah, there was no tension and there was no connection.

Anna also described how she used her self and her own clinical intuition to sense when the dissociative field was present in the room. She began by saying that she first knew when dissociation entered the dyad by awareness of a different feeling in the room. She elaborated:

Now that I can pinpoint pretty well what someone who is dissociating is, and sometimes it's a gut thing. It's like I'm sure I had the thought, but it's been so split second that I don't even remember. I don't realize I've had the thought. I'll just say "Are you here?" Or... **Sometimes I'm almost surprised that I've just said something and it's like, then I think of it . . . and how often it's accurate.**

This level of perception indeed occurs outside of conscious detection, and too rapidly for human comprehension or narrative. Still, it represents a crucial component of the process of attunement to the patient in the midst of the dissociation. When the therapist is able and willing to tune in to the patient both on the level of perceiving nonverbal, bodily cues, as well as perceiving internally generated information that likely arises out of the nonconscious perception of somatosensory cues, this enables a rhythmic connection and congruence between patient and

therapist to emerge and develop – even in the midst of the patient’s (and at times the therapist’s) dissociated state.

3. Induced Feeling

The next step in the process of dissociative attunement follows from the perception of nonverbal signals. As the participants paid close attention to the nonverbal cues displayed by their patient, they were impressed by a powerful feeling that came over them, often identified as not entirely their own. Tasha introduced the language of “induced feeling” to describe the process of coming into contact with and then experiencing within oneself a mild piece of the patient’s split-off emotional experience. Six participants reported having an induced feeling from the patient. The following dialogue introduces the language of induced feeling used by Tasha and her understanding of this feeling as distinct from a parallel process.

J: And do you feel you made contact with what the patient was experiencing during the dissociation?

T: Okay now what do you mean made contact?

J: Um had any connection with, um, I think of it as I almost have a visual image, like touched it, made contact with it, got some information about it.

T: **I got an induced feeling of it.**

J: Okay what do you mean by that?

T: I can feel that um, so I was experiencing a feeling of um being separated from myself. You know.

J: That was the parallel process you were mentioning before?

T: No, parallel process is a little different. **An induced feeling is something that I pick up from my patient. I get, it’s information that I’m getting, just like that image. I get a feeling of oh okay that’s what it is. To me, that’s making contact.** Parallel process, that’s me, that’s my process, which is paralleling the patient’s. That’s not making contact with the patient, that’s my stuff.

J: And what was the part you were getting from her, the induced feeling?

T: That feeling of being separated. Um, being, um, I'm trying to put it into words. I can think of what it is. Um, scattered. That's a good word. **Feeling of being sort of scattered. Not being um that's what sort of gives me that word organized. Like not being organized. Being fragmented. Being scattered. Being pulled apart. Trying to rake up all the leaves.**

Tasha understood her own feeling of being separated and scattered to be induced by the patient – reflective of the patient's current emotional state. This synchronicity of states represents an important part of the process of attunement to the patient. Marcy also understood her emotions during her patient's dissociation to be induced by the patient's otherwise unshareable affective experience. She described a combination of feeling both floaty and disconnected but also angry during her patient's dissociation in session. She understood this as *feeling the patient's feelings*. She explained, "She'll sort of look down and she'll go completely silent. . . . The feeling is so conflictual for her and I think it's her rage that is so hard for her to stay with and so that I feel the anger, umm . . . **I feel her anger at those times.**" Marcy then took pains to differentiate this induced feeling from that of projective identification. She said that it feels similar to projective identification, but indicated that the difference with the induced feeling is that the entire process occurs outside of language. "The difference is it's nonverbal," she explained. "There is no, you know, you're, you know, 'You're always angry at me.' There's no talking. (laughing). **But I feel really angry and then I realize that it's probably her anger that I'm feeling.**" Both Tasha and Marcy understood their internal experience as reflective of and induced by the patient's split-off and unacknowledged feeling state.

Ruth noted that she experienced great empathy for her patient while her patient was dissociating. She believed she came into contact with the depth of pain that the patient was feeling but was not able to verbalize. Unlike Tasha and Marcy, Ruth described this pain as a shared experience. She elaborated, "In some ways maybe what we shared was that I was

experiencing the pain that most likely I'm assuming she was experiencing about the whole situation. So maybe that was a shared experience." She went on to say she felt her patient's "hurt, sadness, frustration and anger." She understood these feeling states as both hers and the patients, co-constructed in the therapy relationship. She said:

Well in the moment I was allowing myself to experience it as is in my own being. To be able to be thoughtful about it, to be able to experience it. Yeah I mean I got to, I allowed myself the opportunity to experience it because that's informative for me. I like to think of that as being informative, who the person is sitting across from you but also about the work that we've done together and that we are doing it together in the moment.

Ruth differentiated this shared feeling as distinct from that which is wholly projected onto her by the patient. Instead, she said that in the course of our conversation during the interview, the feelings reappeared for her. "Yeah, even talking about it you can, even as we are talking about it and I'm remembering it, I can experience it." The fact that Ruth was able to experience these feelings outside of the presence of her patient suggests that the feeling states exist within her – perhaps induced by but not entirely projected by her patient.

Jeff also described experiencing a portion of his patient's affect during the dissociation in session, but was careful to clarify that his experience was not identical to his patient's; it was a mild and modified version of her experience. He explained, "There is certainly a **little bit** of a kind of queer fear in that eerie moment that's **probably a piece** of her own experience, that **probably her own experience could map onto that, that split off affect.**" While Jeff spoke of the experience of an induced feeling, he was much more cautious in labeling his own internal state a direct reflection of his patient's.

Like Jeff, Catherine got an induced feeling from the patient, but believed this was only a "mild" version of her patient's experience. Unlike the other participants, Catherine did not understand her internal experience to reflect anything about her patient's state until she began to

think through it in the context of our interview conversation. Only with this reflection did she begin to see parallels between the internal state she described and the one she imagined her patient was experiencing. Catherine identified feeling alone, de-skilled and uncertain about herself in the context of the dissociation. She then understood these feeling states and her related actions to be a mirror of her patient's split-off affective experience. The following dialogue illustrates her understanding of the feeling induced by the patient.

J: Do you feel you made contact at all with what she was experiencing during the dissociation?

C: I think mildly. Mildly in considering it now. I'm really putting a lot of words to it. Very mildly.

J: What did you make contact with?

C: The sense of what does this say about me? I'm all alone in this. I don't know which way to go. Don't know what's right to do. I feel judged.

J: How are those things contact with her experience?

C: I imagine that might be some of what she's experiencing. That something harsh and hurtful and critical is going to come my way and I'm all alone and I need to protect myself. And my sense of what's the right thing to do is my way of protecting myself. That I can in some way protect against failure or criticism if I can figure out the right thing to do.

J: So is there a way that you understand or label this, that your internal experience in some ways perhaps mirrors hers?

C: I mean my tendency is to think yes. Though I feel like it's very light. I didn't feel that there was a real danger and there was no threat to my core self. It was, you know, similar in the way that I've said, as in 'Oh I might be rejected or judged and I need to figure out how to maintain my self safely,' but to no degree with what she was feeling. It was like a little confusion, wonder, frustration, anxiety, but very mild.

Catherine even considered her momentary experience of mild dissociation to represent a possible mirroring of her patient's experience of withdrawal. She explained:

J: I'm interested by the phrase you used that you felt frozen, because clearly now you can think of a million things you could have processed with her, but at the time, what was that, that feeling of being frozen?

C: Well I'd love to be as rich and say, "Well Oh I'm sure it was just a mirroring of her experience." (laughs) Which it could well be, that she sort of froze and I to some degree sort of froze and didn't know, I didn't know where her experience came from in a way that she also might have not known where her experience came from.

Catherine's understanding of the induced feeling is more akin to an enactment. Her realization about the way her internal state mirrored her patient's came only after these states manifested by way of action. She made sense of these parallels between her behavior and her patient's original traumatic experience only through processing it in our conversation.

The participants were thoughtfully aware of not imposing their own experience or their construction of meaning of their experience onto their patients. They were scrupulous not to assume that their internal experience represented a direct, one to one correlation with what their patient was experiencing. They used the qualifier "maybe" quite frequently as they explored with me how their affective states might represent a distillation of their patient's. Still, the participants considered their own affective experiences to be salient information to cautiously consider as they thought through what was happening for their patient. The "mild" synchronicity between what the participants experienced during the patient's dissociation and what they imagined the patient's dissociated internal experience was, again represents a way that the therapists came to know and understand their patient's experience, but in an altered intensity or form. These alterations represent a crucially important part of the process of attunement. Both patient and therapist were able to share in an experience while feeling the separateness of this experience. The patient can know that the therapist indeed understands while also not worrying that she has infected the therapist with her toxic feeling. The therapist can understand something about the

patient without likewise needing to fall into a prolonged dissociated state. The therapist instead is able to know but also to contain and tolerate in a way that the patient is and has not been able to.

4. Therapist as Placeholder

The fourth component of dissociative attunement concerns what the participants did with the induced feeling they got from the patient in the midst of the dissociative state. Often the feelings induced by the patient were intense and overwhelming. Despite this, participants described being willing to “hold” the patient’s feelings while the patient couldn’t. Catherine used the language of “placeholder” to describe her willingness to step in and take on the patient’s subjectivity in the midst of her absence. Six participants reported feeling called to step into the patient’s experience during the dissociation – to be, as Ruth said, “the keeper” of the patient’s experience during the moments the patient could not hold in mind her own historical and affective experiences. Nancy explained, “It was almost like when he dropped out of us, I picked up, which was interesting.” When the patient “dropped out,” the therapist felt called in to feel the patient’s feelings and hold onto the patient’s memories. Nancy, in her written account, even felt the responsibility of observing the “passage of time” while this was “momentarily lost to the client.” The therapist’s willingness to hold the time, space and experience of the patient while she was dissociating provided a crucial sense of continuity that eventually enabled re-engagement and connection to occur.

Ruth noted that she tried to provide continuity in her patient’s absence by holding in mind her patient’s history while being with the patient. She explained:

Um so in those moments where she is checked out. . . . She’s dissociating, she’s checked out. **In a way I’m the one who is holding all of the stuff.** You know it’s like I am holding the history of our work together. And there is so much going on in those moments and it was longer than it had been, so I really had a chance to sit and be active

and thoughtful in that process . . . it's like, because that's all there for me, and because I'm being thoughtful and aware of what it is that we had been talking about, and how that might be impacting her . . . **Um I'm the keeper of that. And I'm experiencing it in a way for her.** And being really respectful of it. I like to think of myself as being really respectful of that and her history was difficult in many ways . . . It's like this was so unbelievably painful for her . . . So I was able to experience it for her in a way.

Ruth described well the phenomenon of being the placeholder for the patient's experience. The therapist can hold onto the painful parts of the patient's history when the patient can't. This provides a much-needed continuity in the dissociative gap.

Catherine introduced the term "placeholder." She used this language to describe being the keeper of the patient's feelings, as opposed to the keeper of the patient's memories as Ruth indicated. Catherine elaborated on this:

I feel like I'm the placeholder for the feelings, and that's when I'm less having a picture of things, and more feeling horrible or like confused or like confused or I don't know where to go or what to say or what could possibly make anything better. . . **Um so, sometimes it's just me trying to, well not just, but trying to reconnect and trying to be present as well and hopefully be understanding and validating and in some way lighten.**

Catherine understood her willingness to step in and feel the feelings for her patient temporarily as a way to understand, be present and reconnect with her patient.

Jeff described feeling called in to provide continuity to the patient's thought process, using what he knew about the patient's narrative to make cognitive sense of her words. Jeff shared that when his patient was dissociated and using nonsensical fragmented speech, "I can feel my own brain trying to make what she is saying make more sense." He attempted to make sense of her words that were inherently nonsensical. He explained, "I realize I'm filling in the space for a second to make it make more sense." He attempted to give her experience a "continuous flow." He acted as the placeholder for the patient by lending his cognitive mind to provide a framework around the patient's affectively loaded and fragmented experiences.

Kaitlyn, too, commented on her sense of urgency to “hold” her patient’s experiences during the patient’s dissociation. She identified her responsibility for the patient’s well being and her guilt for having triggered the dissociation as promoting her obligation to be the placeholder.

She explained:

The responsibility. The “Oh no I brought this back up for her.” Some of the guilt around that. Like the okay, like I need to support her **now I have to hold this for her. Like, taking on a lot of her in that moment.**

Unlike the other participants, Kaitlyn described the way she needed to abort her own internal experiences, leaving her subjectivity entirely in order to make room for her patient’s. She explained:

K: I think I just, I think that’s where I wasn’t quite as aware of them [her own thoughts and feelings]. Like they came up and then I would just push them aside. **Like I wasn’t like living in those in the moment because I didn’t feel like there was space enough for me to have those feelings in that moment. Like in that time it wasn’t really about me. Or it couldn’t be.**

J: Mmm hmm. So did you feel like you could be in the room?

K: (pause) Not when she was dissociating. No, I felt like it had to be a little more, like I needed to.... Yeah.

J: You needed to..?

K: You’re going to make me finish that sentence aren’t you? (laughing) **I feel like I needed to step aside for her in those moments.**

Kaitlyn offered an extreme example of acting as the placeholder for the patient’s feelings, memory and mind; Kaitlyn needed to empty herself entirely in order to “hold” the patient’s experience.

These participants described an interesting process of tuning into the patient’s presumed experience by way of their own internal experience. As Bromberg (1998) would say, the therapist was “standing in the spaces” – in this case the space left by the patient when she left the

therapist ostensibly alone in the room. The participants also understood their ability or willingness to do so as promoting re-connection and enabling their patient to return authentically and re-engage in the therapy relationship. While this is an asymmetrical connection between patient and therapist, it still represents a very close degree of connection and attunement – where the therapist comes to know about and understand the patient’s experience from within it.

5. Asymmetry of Roles and Responsibility in the Dyad

While the participants were able to engage intimately and in some cases even merge with their patients’ interior experiences, there always remained an asymmetry in the dyads in which the roles and responsibilities of each member of the pair were starkly different. All eleven of the participants identified a feeling of responsibility for their patient. For some participants, this emerged as a paternal or maternal feeling. For others it manifested as an urgent pressure to act in the service of protecting the patient. In either case, the differentiation of roles and responsibility in the dyad was crucially important in forestalling a merger of experience and enabling the therapist to know the patient’s experience from the inside out, while also ensuring that he/she ended up safely on the outside of the patient’s experience. This differentiation of roles and responsibility in the dyad provided the therapist with enough distance to moderate the intensity of the shared experience, enabling him/her to feel something different and ultimately do something differently than the patient could, ultimately (and hopefully) offering the patient the opportunity to do the same.

Ruth clearly asserted that it was the recognition of her role that helped her resist falling into a counter-dissociated state in the midst of her patient’s dissociation. She began by describing the way she felt her patient’s hurt, sadness and frustration in her own being. I then asked her if

she had any experiences of a dissociative countertransference in the face of her patient's dissociation. She responded:

So maybe at moments I would have like, started to go there [to dissociate], but I bring myself back. That's the responsibility piece. That's how we are different. That's why I'm in this seat and you're over there. I'm bringing myself back. What's going on? What was I just thinking about?

Ruth's awareness of the difference of roles in the dyad enabled her to contain her patient's experience effectively and not succumb to the temptation to dissociate away from the feelings, too.

Several participants commented on the asymmetry of roles in the therapy relationship by referring to an encompassing feeling of responsibility they had for the patient's well being that became particularly salient during the patient's dissociation. Ruth described it as such:

J: The other thing you said that I wanted to come back to was that you said it's a lot of responsibility. Can you say more about that?

R: Totally, **because the person is not able to connect with that so you're the holder of it, I mean. That is that's yeah. That's a ton of responsibility.** Yeah.

J: So what was it that you felt responsible for?

R: For holding that information. For being respectful for where she is at and that she is not able to be in touch with it. And for what I did with it next. Because that's important too. She's already overwhelmed, so being thoughtful of how I'm going to proceed, I mean, that's important too. But also you know kind of it's a fine line to walk. You don't want to continue to overwhelm the person but you also know that um, this is an important part of her process as well, understanding herself, that's what she came in to do, so, being patient, being responsible for helping her to be patient.

In this segment of dialogue, Ruth connected her experience as the placeholder for her patient's feelings and her ensuing feeling of responsibility for the patient. When the patient was blanked out, the therapist was the only one left protecting the patient and ensuring her safety.

Kaitlyn also described her feeling of responsibility for the patient that separated her role from the patient's role and implied an urge for her to "act and fix it" for the patient. She explained:

J: I'm wondering about how in the moments when she dissociated, how you think that impacted the therapy relationship, in terms of your feeling of connection or even not, with her?

K: **I think I felt even more responsible.** For me, it just um uh intensified those feelings a lot. Like I just felt like Oh my goodness, she's like, she seems incapacitated to me again and again and again. So I felt like I needed to give her more and more tools to take care of that.

J: So there was this pressure you felt?

K: Yeah more pressure.

J: It almost sounds like an urge to ...

K: (interrupts) Act. **An urge to act. Yeah an urge to do something.** . . . ;So like um you have this pull to act and like fix it but then I also realize that this is intense trauma and she's going to have um, it's going to be a long road for her with recovery from that.

As Kaitlyn described here, the therapist's feeling of responsibility for the patient often led to an urgent need to rescue the patient. She described this responsibility both in the interview and in her follow up written account, where she described her experience with a different client. She said, "I feel it's a very vulnerable experience for my client, and that felt like a lot of responsibility for me to handle it and help her through it. It caused me to feel somewhat protective of her in that moment." Darlene also spoke of this urgent need to act and help the patient that was informed by her responsibility for the patient. She explained:

I think I was feeling hyper-alert on trying to figure out what to do. . . . I was trying to make decisions about what would be the best thing to do to assess if I could bring her back. Is this dissociation? Could I bring her back? So I was pretty much, very actively, problem solving. What steps can I take right now to figure out what is going on? . . . I think I was it was like **I have to save this person**

Some of the participants noticed this urge to save the patient and opted not to act on it, whereas other participants identified becoming increasingly solutions-focused and active in the session.

Stephanie experienced a similar responsibility to make things better for her patient. She took this on as her sole responsibility, not a shared one in the dyad. In the example she shared, she and her patient used an image that the patient came up with in order to represent her fear of being overwhelmed. Here, Stephanie described this image, and also revealed her feeling of responsibility to ensure that her patient did not become overwhelmed.

[She] had this wonderful image for herself of, she talked about feeling overwhelmed. Her fear was that if she really worked on the memories, really remembered them and worked on them, that she would be overwhelmed and wouldn't be able to function. And so her image was that she would have a sweater with buttons, and she wouldn't be able to work, she wouldn't be able to function and she would just be in this sweater with the buttons. Like a cardigan I guess is what she was. And so that become our symbol of my pacing what was happening and I would say, **“I won't let you end up in the sweater with the buttons.”**

Like Ruth and Kaitlyn, Stephanie differentiated her role from the patient's role. Stephanie took responsibility for titrating her patient's affective states; it was Stephanie's job to make sure her patient didn't end up in the sweater with the buttons. She explained that her patient's friend came to pick her up after the session, but noted that she still felt like the person who was responsible for the patient. She said:

I would not let her be incapacitated. If I would have had to cancel my next client, I would have done that. I would not have let her go with her friend because I felt responsible. I wouldn't have said, “you need to take care of the woman with the sweater on right now. She's your responsibility.” **She was my responsibility, I felt at that moment.**

This statement illuminates another aspect of the therapist's feeling of responsibility.

Several participants identified the experience of feeling alone with their patient's care. Stephanie couldn't pawn her patient off on her friend – she was Stephanie's responsibility and Stephanie's alone. Tasha provided a clear example of feeling alone as her patient's mental health support

system. She contrasted this with her prior experiences of working in the context of a residential treatment setting where many others helped to take responsibility for her patients' well being.

She explained:

When I was in the rehab and working with women that had this experience . . . I just felt very relaxed with it, and I wasn't worried about was I doing the right thing or not? Because I knew that whatever I was going to do for them was the best thing they had available to them. . . . PLUS I saw them every single day. So, if something was not good tomorrow because something happened today, you deal with that tomorrow. And during the night, there are people there. They check on them every hour. They're not alone. . . . So, I guess I feel I have a greater, I was going to say I have a greater feeling of responsibility, but that's not really it. It's that I have more anxiety because . . . **I am their mental health support. I'm it.**

Tasha was able to identify the origin of her feeling of responsibility for the patient. Tasha felt the burden of her patient's mental health care and basic safety resting upon her shoulders.

The participants described an urgent need to protect and care for the patient that became particularly strong in the midst of the patient's dissociative state. Several participants even used the language of feeling like a "parent" as the patient regressed to a non-communicative, dissociated state. Elise explained that when her patient was dissociated, she felt the urge to take on the role of the "commanding mother figure" or a "stern mom." Kaitlyn explained that when her patient was dissociating, she felt "in some sense responsible for her person." She continued, "It basically was like she was a kid, and I was like, a parent. So that's kind of how it felt. So like holding that for her, was like, I was, taking care of her in those moments." Ruth had a difficult time putting words around her intuitive sense that there was something inherently parental about her way of being with the patient. Here, she attempted to describe how she understood this.

It's kind of like being a parent. It's kind of like a parent in the sense that like . . . you're merging, so not like with an infant, although in some ways it kind of is because it's like a nonverbal situation. I don't know how to describe this. Um, so you're like the holder of it, like a parent but not really a parent. That's my experience of it. . . .

Ruth described feeling like the “holder” of the patient’s feelings and memories, including her trauma memories. Her experience was a unique combination of merging with her patient’s state, but also remaining aware of her role and responsibility for the patient, as she noted above “That’s how we are different.” This combination of *feeling with* but *taking care of* the patient felt inherently parental to Ruth.

Part of the parental stance the participants described was the development of maternal and loving feelings towards their patients. Kaitlyn, for instance, understood her feeling of responsibility for her patient and her willingness to serve as the placeholder for her patient’s experience as growing from a deep level of empathy and care for her patient. She explained:

Well I cried afterwards [after the session]. I couldn’t cry right there, I felt like I wanted to but I couldn’t. . . . I know with her, I leaned in a lot. Like I would, my body would just trying to communicate that to her. Umm and I don’t think I would have felt so responsible for her and had all of those other emotions like that I was saying, like even the “oh shit” and all of that stuff, **if I wasn’t so sad for her. Like I don’t think that I would have felt. Like if I didn’t care about her or if I didn’t feel, like if she didn’t pull at my heart in that sense, I could have easily removed myself more.** . . . But because um because um knowing her background and knowing how difficult it was for her in those moments, and how she it almost felt like she was just up against so much that was coming at her. Um that like it made me so sad for her so that then I felt I think all of the other feelings flowed from that feeling.

Kaitlyn alluded to the connection between her willingness to feel with her patient and her concomitant urge to take responsibility for her patient’s well being which left her sufficiently outside of her patient’s experience. These connected processes represent an important part of the process of dissociative attunement. The therapist must be both simultaneously with the patient and with herself. She must feel a congruence with the patient’s state but not share the *identical* state. The therapist’s parental role and responsibility, then, protects him/her from falling into a mutual state of helplessness and terror. Anna summed up her perception of her role by describing her feeling of responsibility for her patient as simply ordinary. She said:

To me, I think it's um, I think it's a rather typical response, just from any person hearing that information in therapy. **It speaks to how connected I am to her. It speaks to how willing I am to go there. And to my confidence that it isn't going to negatively impact on me.**

Here, Anna described both her connection to her patient, but also the necessary separation of roles that enabled her to “go there.” Her words allude to the confidence that those in a “parental” role must necessarily have – that they can recognize and *bear* the other's painful states, knowing they will not crumble. When the therapist can experience herself as necessarily different from the patient, as well as responsible for the patient in some way, it enriches her ability to contain the patient's experience such that what was once toxic and unspeakable becomes bearable.

6. Containment

A sixth primary component of the process of dissociative attunement is the therapist's ability to contain her own emotional responses to the patient's dissociation, the induced feeling provoked by the patient, and the patient's affective state during the dissociation. Eight participants identified some level of containment during or subsequent to their patients' dissociation in session. This emerged alternately as containment of the patient's affective state or fragmented thoughts, or containment of one's own response to the patient's dissociation.

Several participants noted the importance of containing or “tolerating” the patient's painful affective state during the dissociative gap. This included both a containment of the patient's blankness as well as containment of the affective state that triggered the dissociation, and developed in response to the original trauma. Ruth used the language of “tolerating” to describe how she came to understand important aspects of the patient's experience. I asked how it was that she was able to maintain attunement to her patient through the dissociation. She replied:

By listening to her. By tolerating the bad stuff. Um, meaning the stuff that other people wouldn't tolerate. And my willingness to be with her in that. And talk to her about it. Even if, and to sit with her when she couldn't.

Ruth's description of containment includes containment of the "bad stuff" – the painful affective states, the gruesome memories, the difficult relational encounters. An important part of this containment is the willingness to stay with the patient, to bear witness and not turn away or abandon, despite how painful it is. Elise argued that the therapist's willingness to provide this containment promotes the development of trust. She explained:

I think that as time goes on that what develops is a sense of trust that I can hold their stuff and that umm, and I do believe that some of that communication is probably not conscious. Like I can hold your stuff, it's okay. Umm, and I can hold onto my own, enough, not fully, but I won't terribly lose it.

Elise walked a narrow path between losing herself enough in her patient's experience to become mildly disoriented, and yet still holding onto her role and responsibility for the patient's well being such that she could engage in this process of containment.

A second component of containment that the participants described was the containment of one's own feeling states that emerged while the patient dissociated. As noted in Chapter V, the therapist's feeling states in the midst of the dissociation were often a mirror of the patient's split-off affective states. As such, containment of one's one state indirectly offered the patient an important model for how to tolerate the parts of self that have been, for them, unbearable. Jeff offered an excellent description of his ability to contain his own feeling states and resist the urge to "likewise dissociate" in the face of his patient's dissociation. He elaborated:

To the extent that you can contain the moment, meaning you can feel what's going on without having to likewise dissociate. In other words likewise just sort of have the thing go on unacknowledged. Which I'm suggesting I did with her for many years where she would dissociate, I wouldn't even know it. You could say that's also partly my own dissociation at that moment. **To the extent that you can contain that kind of eerie feeling, contain the guilt that you've overwhelmed someone, because I did. To the extent that those feelings can be, you can tolerate, that's what I mean by contain,**

I'm probably not using the word technically right, **you can tolerate it so that you can can try to share what had just been unshareable.**

Anna, too, spoke about her ability to “tolerate” the emotional reactions that she experienced in the wake of her patient’s dissociation. She admitted that while her patient was dissociated, she entertained graphic and horrifying images of the patient’s trauma involving human trafficking. She described feeling “sickened and sad” and “angry at the evildoers.” In the next breath, Anna clarified “To qualify that, I’m kind of so used to having the experience that **I’m able to tolerate it** and it typically abates.” When I asked her how she is able to tolerate these images of horror and her feelings of sadness and anger, she replied: “**You get used to kind of taking that information and containing it or um, kind of getting my own reactivity leveled down and making it kind of putting it aside while I’m watching what’s going on with her.**” According to the participants, a crucial component of tuning in to one’s own internal experience and using it as information about the patient’s state was the ability to contain one’s own internal experience – the feelings and images that got aroused – and then tune back in to what is going on for the patient.

Ruth explained how she engaged in this more cognitive process of containment while her patient was dissociated. She said, “I would say that as I sat with what I was experiencing, I felt what came up. . . . **I was allowing myself to think about it but also experience it.** Sadness, disappointment. Anger. Frustration.” It was in the feeling, but also thinking about this feeling, that Ruth enabled her experience of sadness, disappointment, anger and frustration to be different from her patient’s. Kaitlyn also used the language of “contain” to describe her urge to “make sense of this” for the patient, to make the experience process-able and shareable, as Jeff has said.

Tasha was able to put words around how this process of making sense of things for the patient, including thinking through the experience, holding it in mind, and putting words around it, can be transformative for the patient. She explained:

And the other thing was that, um, the only tool I used with her was talking. I wasn't EMDR trained then. And um talking and you know the relationship and um it helped her. It helped her. And I think that she she's very high functioning normally. She's a very high functioning woman. **And um I think that the experience of repeatedly being able to contain by verbalizing, and actually having words be the container, um, and that being able to just talk about all the different ramifications of the feelings,** the intense intense paranoia.

This third component of containment was not primarily an affective process. Instead, the participants relied upon their ability to think through a feeling and hold it in mind in order to tolerate it.

These varied methods of containment were an important part of the process of dissociative attunement. Elise shared that her willingness to tolerate her patient's dissociation – her endless repetition of fragmented and nonsensical statements, and the confusion and terror it evoked – “is where the healing is.” She elaborated:

E: Almost feel like, with dissociation, my feeling right now is more that, you know, it's okay, it won't threaten my id, I'm okay, my identity will stay intact. Umm as opposed to “You're really threatening my sanity and my identity here.” Which I've I've felt . . .

J: Right. And do you think that your clients get something from your ability to do that?

E: **Oh I think it's where the healing is. Yeah. I think that even as, I think, my ability to accept my client, even her rumination, which is very hard to accept, which I make it clear I'm frustrated with, it's almost like it's helped her to function better and better and better all the time. Um and I think probably kept her out of the hospital.**

This ability to contain – to intuitively know, tolerate and bear witness to the patient's state during the dissociation without leaving – and then to help the patient make this experience think-able, represents an important part of what makes the process of attunement so compelling. As Elise suggested, it's where the healing is.

7. Therapist Imaginings

Many of the participants described a process of communication that occurred between themselves and their patients in the midst of the dissociative field that existed outside of time and language. They struggled to put words around these experiences, often apologetically scratching their heads and stating, “This is the best I can do.” As Ruth explained, “. . . I also think that there are certain things that happen that, um, in the room that you can’t put words to.” Jeff also described a process of nonverbal communication in the dyad, noting that the patient’s dissociated parts of self “get communicated through channels other than the explicit verbal channel.” Anna had a similar conceptualization. She felt that through the dissociating, her patient was communicating with her “in some way. Not verbally.” Elise described her understanding of this nonverbal communication as “our unconscious speaking to one another very powerfully.” She said that this process is “immediate. It’s not something that we have time to process well. It’s the immediate unconscious’ ‘Where are we?’ and that that triggers my own, I’ve lost my compass. That’s my thinking.” Seven participants described some of the communication that occurred in the midst of the patient’s dissociation as nonverbal. How, then, did they imagine this communication occurred?

The participants in this study reported fascinating musings, thoughts, images and fantasies that occurred in their internal experience during the patient’s dissociation. These imaginings manifested in various sensory modalities but not in verbal language. Eight of the eleven participants reported at least one, and in several cases two, mental images or imaginings that emerged for them in the midst of their patient’s dissociative state. These mental images were powerful in distinct ways. In some cases, the mental image transported the therapist to the scene of the patient’s original trauma, helping the therapist to understand something about the

traumatic moment and enabling the patient to no longer feel alone in this scary memory. In other cases, the mental image offered the therapist insight into the nature of the patient's unspoken affective experience, and then enabled the therapist to provide a form to the patient's emotions that could later be translated into words. Finally, several mental images experienced by participants were purely self-soothing. These images enabled the therapist to tolerate her own intense reactions and thus facilitated the re-connection between patient and therapist from their respective dissociative states. These varying imaginings allowed for parts of the patient's experience to be communicated in the only way they are stored – sensory perceptions and fragmented images that exist wholly outside of language. In what follows, I will provide extended examples of these therapist imaginings described by eight of the participants.

Fragments of the Patient's Trauma

Four participants described images that came to mind during the patient's dissociation that were fragments or distorted perceptions of the patient's trauma. These participants were able to provide a sense of continuity to their patient's narrative through their own willingness to entertain in mind a constructed image of their patient's trauma. These were not one-to-one exact replica of each patient's trauma memory. Instead, they were constructed images internally generated by the therapist reflective of some component of the original trauma. I will describe each of these four examples in turn.

Anna. Anna was working with a patient who was victim of human trafficking and child pornography. Anna admitted that she entertained very graphic images of scenes of the patient's trauma when her patient dissociated in session. She explained that when her patient was not able to communicate with her verbally in any comprehensible way, her mind "makes leaps" about what might be happening for her patient. She said:

I started to imagine you know these people. And like where, you know, where do they go to like, do they pull these kids out of their beds? Do they get them off the street? Do they come from another country? You know? The the the global nature of it was having an emotional, I was having an emotional reaction to that piece of it. Like this is some big awful sixty minutes episode. You know what I mean? Um, So I I I recall being affected that way briefly. **What usually happens with this client is I get that kind of an imagery um, because she isn't communicating it clearly. My mind just kind of makes leaps about what must be happening, what could be happening in.** And I'm very careful about throwing that back in because that's just where my mind is going. Um, so yeah. And and of course I'm just feeling sickened and sad for me. For the situation that she was in. Um, angry at the evildoers. . . . Yeah this is just so so awful.

She shared further detail about the nature of the imagery that came to her mind and how this impacted her:

What I was seeing was the terror of these children. And you know imagining them being, like I said, either taken from some far away place and on a boat or probably a boat ship tier. Or from you know the ghetto around the city. Or maybe not you know? Maybe just picked up off the street. Because I think she used that word. "Picked up off the street." Um, and then I kind of imagined them all kind of huddled into this little van. You know? Um and even right now as I talk to you about it, I'm feeling sick in my chest. Just thinking about it. It's like a tightness. You know? That kind of um, it's just that disturbing level of it.

Anna's willingness to entertain such horrifying imagery – like that from a sixty minutes episode as she said – provoked a strong affective response. She felt sick and sad and disturbed. This language depicts Anna's empathic entry into her patient's internal feeling world. The imagery she held also provided a missing continuity for the dyad. When her patient stepped out of herself and into a dissociative trance, she couldn't keep a continuous recollection of her own history and instead fell into what Anna understood as an inchoate, senseless affective world. Anna's ability to hold in mind the patient's trauma for her enabled her to maintain continuity for the patient, filling in the gaps.

Anna also shared that the imaginings that came to mind for her when her patient was dissociated also gave her a new understanding of her patient that she didn't have access to before. In this case, Anna was able to see a broader picture of the intergenerational component of

the patient's trauma history – that she was born into a human trafficking ring in which her biological mother was also a young victim. She said:

A: I've always imagined what she probably looked like as a little girl. . . . And then, you know, I see this little girl she probably has braids in her hair, she's she's she appears to be African American . . . Um, and then the idea also the imagery I was getting was once she shared that word trafficking, then I started to get a sense of okay this is where this came in for you. . . . She probably over the years had an adolescent mother who is part of this whole thing. Prostitution, the whole thing. Who, in her memory, was killed in front of her. And you know really starting to see... I started to have that image of how this came to be for her. Did they pick her mother up off the street and how did that work? And then she had, you know she was born in this scenario. From what she understands, from the memory that she has and some of it is very early, there was no living anywhere else. There was no being picked up off the street. There was no, you know, so, then it it gave me an image that I didn't always have of that part of her history.

J: Even generations before her?

A: Yes. Which was new for me. And it doesn't mean it's factual. It just means it's where my head went.

Whether or not this information was factually correct, Anna reported that having this imagery in mind offered her an empathic view into the patient's internal world. It allowed her to see her patient as a vulnerable young child, victim to the violence she was born into. Anna explained that this new understanding came by way of her internally generated imagining during the patient's dissociation; she held in mind a mental image of her patient as a young child with braids in her hair. In the following dialogue, she explained how she made sense of this image:

J: What are the feelings that accompany, when you see her as an eight year old with braids in her hair? What kinds of feeling come over you?

A: I get sad. It's just plain old sad. You know?

J: Her vulnerability?

A: Mmm hmm. And what she had to learn to do, and um, the the types of things that the distorted beliefs she had about herself. You know? Because there's no purity there. You know, there's no innocence.

While Anna knew that her patient had suffered a horrible trauma, she didn't know all of the details about this trauma. She said that the images she entertained of kids being picked up off the street and the global and intergenerational nature of the patient's trauma came to her mind prior to the patient disclosing that she was a victim of human trafficking. She explained:

So that my mind went there and then some of the things I was imagining she was validating without me telling her. So it [my imaginings] helped me kind of get like, okay so this is trafficking thing going on, and then before, this is before I asked her what would the charge be if this woman were on trial now? And she said 'trafficking.' That was after my mind went there. In a way I feel like it opens up clarity for her and I don't know how that's transmitted sometimes.

Anna alluded to an uncanny transmission of information from one subjectivity to the other in the therapy dyad that was totally nonverbal and occurred outside of conscious awareness. Her internal images sensitized her to an area of the patient's trauma that was yet to be spoken about. While Anna was careful to say that she didn't presume her mental images were an exact replica of her patient's experiences, they still offered her an important entre into the part of the patient's self and history that couldn't, yet, be uttered aloud.

Jeff. Like Anna, Jeff recounted an experience of holding a portion of the patient's trauma memory in mind while the patient dissociated. During the session, his patient had been describing a realization that her mother likely suffered from borderline personality disorder. The act of doing this represented a huge disloyalty that provoked anxiety for the patient. In the midst of this work, which Jeff experienced as important and engaging, the patient said "and animals" and trailed off, entering a dissociative state. Jeff imagined that his patient was recalling, and perhaps revisiting, a particularly traumatic memory of her mother hurling the family dog at a well. Jeff explained that when his patient abruptly said "and animals" and then entered into a dissociative trance, his mind stepped in to provide continuity to this otherwise senseless fragment of speech. He recalled this particularly disturbing memory the patient had "kind of" told him but

“never fully told” him about her mother injuring the family dog and then he held this memory in his own mind while the patient was dissociated. He explained:

The dissociative moment happened here. She talked about the rage and the issue around separating and then she said, and then she said, “And animals.” And she didn’t finish the thought. (pause) And she blanked out. So so she got quiet. Now I had a hunch I knew what she meant, that it didn’t have anything to do with borderline personality actually (laughs) but it did have to do with a particularly upsetting memory that she’s never fully told me, but she’s kind of told me. Uhh, in which I think the mother, uh, well I know the mother, at least what the patient reports is that the mother had picked up their dog, barking dog, and smashed it against a well in their backyard. And I think this was a particularly horrifying uh thing. So she said, “and animals.” And she went blank.

Like Anna, Jeff was able to provide continuity to the patient’s fragmented speech by filling in the gaps. He relied on his own memory of what the patient had previously told him about this incident in order to make sense of her nonsensical words. In so doing, Jeff also provided a continuity of self for the patient, holding together her fragmented pieces by holding her and her history in mind when she couldn’t.

Kaitlyn. Kaitlyn also found that while her patient was dissociating, her own mind gravitated to the nature of the patient’s trauma. Unlike Anna, she resisted the development of a mental image of her patient’s trauma. She thought about the fact of her patient’s trauma, but did not visually see it occurring. Kaitlyn admitted that in the moments that her patient was dissociating, she began to wonder if the patient was imagining her father sexually abusing her.

This process of wondering introduced this memory into Kaitlyn’s mind too.

K: An image that I can remember reflecting on or thinking about is like, what is she thinking? Like, where is she at? Like what’s going on, where is she like? Where is she emotionally at. And almost trying to picture that. Like is she going, what what what in her mind would her father be doing to her right now or where would she be detaching to or dissociating to mentally, like if that’s where she was going.

J: Did something specific come to mind in terms of what was in her mind? Did it formulate as a picture or was it more a thought?

K: No I think it was more a thought. I don't think I would want to, I think I was fighting having a picture, particularly because of the trauma that she suffered was really horrific, that I wouldn't want go there. Yeah.

Interestingly, Kaitlyn admitted that she resisted the development of a visual image of the trauma scene. Her words suggest that the development of a visual image was pressing, and that she had to “fight” the development of the picture in her mind. Her words also suggest that the experience of this picture could communicate some of the horror that the patient experienced in the traumatic moment, explaining why Kaitlyn “wouldn't want to go there.”

Marcy. Marcy, too, admitted to entertaining disturbing mental images of “rape type imagery” while her patient dissociated. She said:

There were a lot of times with her that I would have um I mean she actually did some drawings that were really disturbing drawings of umm, male and female genitals and umm which inferred aggression and umm rape type imagery. Umm and I think that it maybe that some of those images, some of the memories of her drawing would come to mind during those times.

Marcy was able to hold onto the memory of her patient's drawing, which suggested the memory of the patient's trauma, while the patient needed to retreat to the safety of a dissociative state.

In these four examples, the therapists' willingness to mentally accompany their patient to the “scene of the crime” enabled the patient to feel less alone in the trauma. Now, the therapist's mind held onto the image or minimally the fact of the trauma, too. In some cases, the therapist took the patient's place in the trauma momentarily. The therapist was then plagued by the horrible images or recollections, while the patient remained safely blanked out. This exchange ultimately introduced empathy and offered safety to the patient.

Ominous Fantasies

While these four participants entertained mental images specifically related to the nature of their patient's trauma history, other participants entertained more generalized ominous

fantasies of something bad happening while their patient was dissociating in session. These imaginings did not represent any factual information about the patient. Instead, the participants made sense of these imaginings as communicating an underlying affective experience the patient was defending against.

Kaitlyn. Kaitlyn shared that during her patient's dissociation, she envisioned her supervisor coming into the room, first as a symbol of support and solace, but then quickly making things worse for both her and the patient. The following dialogue illustrates what Kaitlyn imagined during her patient's dissociation.

K: I almost went and got my supervisor Anyways, that's also another time when I questioned myself. That's I feel like that's a breach of trust to bring somebody else into that moment and I didn't want to leave her, but like, were my skills enough to do this right now? To bring her back? It was really scary.

J: That sounds like another interesting thought that came up though. This fantasy of getting your supervisor.

K: Yeah like I need help. Yeah yeah exactly.

J: Did you imagine your supervisor in the room?

K: Yeah yeah I did. I forgot about that. I guess that's one picture that I had. . . . My supervisor was not great. Like she. Like, I was like, what is she going to do? She's not trained in trauma work. Like she, I didn't. I didn't respect her at all. So. . . . maybe I didn't feel like I had the support.

K: I envisioned her walking in and then I actually envisioned her not handling it well. How bout that? That's really interesting. Like her being like "Come on!" (snaps) "Let's go! What are you thinking? What are you thinking? Come on! (claps)" Just a little bit more, just like. Because that's somewhat of her personality, just like, "I don't take anything from anybody." Like, "Come on, get up, you can do this."

J: So that she would be kind of pushy?

K: Yeah pushy with it. Yeah, so. I think that that's a good way of describing it, like how she would handle it. . . .Or I envisioned losing the patient more if I brought a third person into the room. Like okay. It actually will like, it will get worse not better if I bring somebody else into the room.

Initially Kaitlyn was searching for help. This emerged in the fantasy of her supervisor entering the session and bailing her out. Then Kaitlyn envisioned her supervisor failing her and ultimately failing the patient. This mental image, while not a direct representation of the patient's history, transmitted the felt-experience of feeling alone, wanting help, and ultimately being let down.

Nancy. Nancy also admitted to having an image of something ominous happening during the time that her patient was dissociating in session. She explained that she entertained images of a mass shooting occurring on the college campus where she works, alluding to a recent mass homicide at Virginia Tech University. The following dialogue illuminates Nancy's imaginings and the meaning she made of them.

N: This is really a weird thing. **I had images of Virginia Tech** when I couldn't figure out what was going on with him, who he was. Would he hurt himself? Would he hurt someone else? Because his energy was hostile.

J: That must have been terrifying.

N: It was very withholding. It was very hostile and then there were these dissociative moments. It wasn't terrifying because I didn't want to catastrophize and I didn't want to over-assume. **But in the spirit of full disclosure there were moments when I wondered who was in the room with me.**

J: If it's okay to talk about, and tell me if it's not, what particular kinds of images?

N: Things I've seen in the media.

J: Were you also imagining it happening at locations here (on campus)?

N: Yeah yeah. I had information about him from his previous therapist that at one time he had plans of using chemicals in the lab to hurt himself because he is so isolated and doesn't have a social life, doesn't have a good relationship with his family and spends so much time in his head and can just dissociate in the way that he can. All of that added up to me as a recipe for risk.

J: And what do you make of the fact that that's what came to mind particularly in those moments he was dissociating?

N: That I couldn't figure out what was going on with him. That there were unknown parts of him.

Nancy understood these images of horror as related to her utter lack of contact with her patient – not knowing who it was that was in the room with her. It is also possible that Nancy was intuitively in touch with a fear of danger, aggressive and violent urges, and total helplessness that existed in the traumatic moment. In this way, Nancy accompanied her patient to the “scene of the crime”, too, though the crime was a wholly imagined one, generated out of the therapist’s own imaginings.

Images Reflective of Patient’s Feelings

Two participants reported imaginings that were seemingly unrelated to the patient’s trauma memory. Instead, they described mental images that were reflective of the patient’s affective state. Two participants, Catherine and Stephanie, described a mental image that they said helped them to transform the patient’s unspoken affective state into sensible words.

Catherine. Catherine described images that came up for her while her patient was dissociating in session that, to her, evoked split-off aspects of her patient’s emotional experience. Catherine became aware of a visual image that she understood as a metaphor for her patient’s split-affect affective experience. She imagined a little island with one palm tree in the middle. She said, “and that’s him. He’s steadfastly there and he’s completely isolated from everyone.” Catherine used this image to understand the way her patient is “grappling with, do I stay connected to people who I find very hurtful and in this whirlwind of having no self in relation to them? Or do I have a self and completely isolate myself on this little, like, desert island with the one palm tree in the middle?” Catherine understood this image as a visual representation of the patient’s core dilemma. It enabled her to understand her patient from within the context of this metaphor.

Catherine also described a time in which her patient was speaking in session and stopped abruptly in the middle of a sentence. He “grasped the chair and held on tight.” In this moment, Catherine imagined both a roller coaster and a runaway train. In the images, Catherine said, there is “this sense of trying to grasp something as he’s drowning.” I asked Catherine how she made sense of these images. She explained, “I assume that’s what he is feeling. That I’m having some experience or I guess fantasy of what’s inside of him.” In this case, Catherine was able to transform a senseless feeling into a visual image and then into words, offering form to the patient’s experience such that she was able to communicate it back to him in a way he could digest.

Stephanie. Stephanie also recounted her experience of a mental image during her patient’s dissociation that gave her information about her patient’s feelings. She entertained two mental images, one that reflected her patient’s view of herself and another that represented Stephanie’s altered view of the patient. Stephanie shared that her patient had a terrible fear of becoming overwhelmed in the work of therapy. The patient illustrated this fear by describing a mental image of herself wearing a “sweater with buttons.” The patient’s image of this sweater was drab and confining. It represented, for the patient, the fear of ending up in a psychiatric hospital and shuffling the halls while wearing a drab, lifeless cardigan sweater. Through the course of the therapy, she asked that Stephanie not let her “be in the sweater with the buttons.” When Stephanie’s patient dissociated in session for the first time, she admitted that she immediately envisioned her patient wearing “the sweater with the buttons.” She went on to describe the sweater:

J: Do you have a mental image of it, like maybe what color it was?

S: Um gray. With big buttons. For some reason I see big buttons. Not the little cardigan buttons. I see these big buttons. Almost [she makes a circle with her fingers].

J: Like the size of a silver dollar?

S: I don't know why, but yeah.

Stephanie held this image in mind while simultaneously entertaining another image – the image the patient had described for herself – wearing a drab cardigan sweater in “state hospital.”

Stephanie said, “She would be one of those shuffling, overmedicated people, not in a straight

jacket but with this sweater on that she would wear everyday.” For Stephanie, this image

represented the loss of her patient's vitality. In contrast to this image, Stephanie “saw the sweater

as a little more funky.” “It was kind of a hand-knitted with big buttons, funky sweater,” she said.

When I asked her what this image meant to her, she replied: “Because I think that was my

representation that I liked her. It was kind of this funky, gray sweater. . . . The sweater was her, I

think. You know what I mean? You know, this hand-knit funky sweater was her personality that

was.” She continued, “ I could see her sitting in my office but there would be no life in her,

sitting in this sweater.” Stephanie's patient saw herself in a sad sweater shuffling around in a

state hospital, whereas Stephanie saw her patient in her office sitting in a funky sweater. In both

images, the sweater represented lifelessness and a loss of vitality, except in Stephanie's image,

her patient was able to retain a small piece of her former self by wearing this “funky sweater.”

Stephanie explained how these two images emerged for her and what meaning she made of

them:

I sort of developed this image about what she thought was going to happen to her or what the worst case scenario for her was. But I never saw her going that, being that unable to function. Um, I saw her more moderately unable to function. You know, not herself but more able.

Stephanie was able to visually imagine the patient's image of herself in a cardigan in state

hospital, and then she was able to generate an altered image that offered a different, more

moderate possibility for her patient. Moments later, Stephanie clarified why it was that her image of her patient was so different from the patient's image of herself. She said:

Um yeah I think that the reason why I see the sweater maybe differently is because I saw her differently than she saw herself. . . . She saw herself as having the capability of ending up in the state hospital. Not being able to function. And I didn't think that was going to happen. So that was not my image, that it was going to get that bad. I believed, I believed she was a very capable woman. . . . She was she was a very able woman. Very able woman.

In Stephanie's example, the images that emerged for her not only depicted her patient's feelings and fears, the second image that emerged offered a way to modulate these feelings and fears.

Self-Soothing Imaginings

The final type of imagining that emerged for participants were self-soothing thoughts and imagery that enabled the participant to tolerate something difficult in the patient's narrative or in the dyad. Three participants identified self-soothing imaginings. These participants initially expressed some embarrassment about retreating to self-involved thoughts, but ultimately described them as comforting and soothing. These self-soothing imaginings enabled the participants to tolerate either the patient's dissociation or something difficult occurring in the dyad that contributed to the dissociation.

Marcy. Marcy described having fantasies of shopping or cooking while her patient dissociating in session. She initially described these as unrelated to the content of the session, but ultimately determined that these "pleasant" thoughts were a way to help her tolerate her own uncomfortable feelings in the face of her patient's dissociation. She explained:

I mean I think my mind will go to what I'm going to make for dinner (laughs) you know? What shoes do I want to buy at Benjamin Lovell (laughs). It will go anywhere. Yeah and then I'm like all of a sudden I realize that I'm just thinking about all these random things and that I'm not present with her. . . . I think that the thoughts are probably quite soothing to me. You know, thinking about cooking or shopping, those are pleasant things (laughs). So it may be some kind of way of containing myself, my own feelings.

Elise. Elise entertained a similar “daydream” of her grocery list and her dinner plans when her patient dissociated in session.

I might even daydream. I might just be like “You’re in your mind, I’ll go into my mind. I wonder when you’re going to be ready to talk again.” I’d like to say I’m wondering what set them off, but probably I know. So I probably go into “Alright. I need to go to the store. What do I want to make for dinner tonight?” And that might sound terrible but I think I just feel comfortable. I just have a little time to think and not worry and just know that we’ll come back.

Elise expressed some embarrassment upon admitting that she retreated into self-involved thoughts while her patient was dissociating, but ultimately understood these thoughts as reflective of her willingness to accept her patient’s dissociation.

Tasha. Finally, in Tasha’s written account, she reported a soothing thought that emerged for her when her patient was dissociating. She said, “I thought of my supervisor and his kindness to me when I am struggling. That helped me relax and meet this very troubled patient where she was in those moments.” This imagining of her supervisor enabled Tasha to gather up and then provide the kindness and support her patient needed from her.

These three examples illustrate the power of mental images and imaginings to help the therapist tolerate a scary clinical situation or the intensity of the patient’s fears and feelings. In all three of the cases, the imagining helped the therapist to offer the patient something he/she needed. In Marcy’s case, she was able to stay present and tolerate her own intense feelings. For Stephanie, she was able to retain and offer to the patient a modulated version of her fear, and for Tasha, she was able to gather up the energy to provide kindness and presence to her patient in her struggles.

Summary

This chapter detailed the components of the process of dissociative attunement: Disjunction and Connection, Perception of Nonverbal Signals, Induced Feeling, Therapist as Placeholder, Asymmetry of Roles and Responsibility in the Dyad, Containment and Therapist Imaginings. These components characterize the relational experience that can occur in the midst of a patient's dissociation. This experience includes connection and disconnection, a merger of internal states with the simultaneous maintenance of distinct roles, and attention to both the nonverbal cues of the patient and the internal experiences of the therapist.

The process of dissociative attunement engages contradictory experiences and holds them in dialectical tension. Dissociative attunement is an experience of resonance, connection and communion between therapist and patient in the midst of the withdrawal of one or both parties. It is an experience of understanding and "getting it" in the midst of mental confusion. It is the resonance of internal experience such that the therapist holds onto a feeling induced by the patient or acts as the placeholder for her thoughts and experiences, while also maintaining the inherent separateness of the two and the distinctness of roles in the dyad. Finally, the process of dissociative attunement involves listening. It is a special kind of listening that requires catlike perception of nonverbal cues while also maintaining a simultaneous awareness of one's internal experience. This listening requires that the therapist be both here and there, inside and outside, all at the same time. It is a kind of knowing while feeling like you don't know anything at all.

The following chapter will compare these seven parts of dissociative attunement to the construct of dissociative attunement as it is constructed by Karen Hopenwasser (2008) and will also explore the implications of this expanded definition of dissociative attunement for social work practice and research.

CHAPTER VII

DISCUSSION

The purpose of this study was to further develop the theoretical construct of dissociative attunement put forth by Karen Hopenwasser (2008). The construct of dissociative attunement aims to capture the nonverbal and psychobiological process of attunement between patient and therapist that allows for the therapist to tune in to dissociated aspects of the patient's self by way of her own subjectivity. This construct builds upon neurobiological research, clinical wisdom and theoretical accounts from the fields of trauma and dissociation and relational psychoanalysis. The construct as defined by Hopenwasser is in the earliest stages of its formulation. There is little theoretical elaboration of the component parts of this process and no empirical study of the process of dissociative attunement as it unfolds in the clinical dyad. It was hoped that this study would both test the theory of dissociative attunement through empirical study as well as further develop the construct by identification of the steps and component parts of the process of dissociative attunement.

Summary of Findings

The primary research question of this inquiry emphasized the reported internal experience of the therapist when a patient with an early life trauma history dissociates in session. Despite the primary focus on the nature of the therapist's internal experience, findings also emerged regarding the common nature of patients who dissociate in session and the function this dissociation served. These findings set an important contextual framework to understand the nature of the therapist's internal experience. The patients referred to in the forgoing accounts are

people who have been traumatized in unimaginable ways, usually by a caretaker quite early in life. According to the participants, the effects of such trauma were long lasting. The patients presented with dissociative symptoms that entered into the treatment and inevitably impacted the therapy dyad. These patients used dissociation as a way to manage affective overload in the session or to communicate a need for their therapist to down-regulate the affective intensity they felt in response to their trauma memories. These patients also used dissociation as a way to expose vulnerable, broken and child-like parts of themselves in the therapy dyad, allowing their therapist to see, perhaps for the first time, the full extent of their fragility and pain.

A patient's need to dissociate then set off a predictable sequence of responses in the clinician. These internal responses reported by the clinicians and then catalogued by me answered the primary research question of this study. The therapists' internal responses were initially marked by intense fear and anxiety, concern about their ability to be helpful to their patient, and even fears about losing contact with their own sometimes tenuous connection to reality. These self-focused fears arose from the clinicians' experience of being abruptly left alone in the room by a patient when he/she dissociated. With their patient's dissociation rendering them absent, the clinicians quickly felt de-skilled and in some cases panicked. Often, this led to a retreat by the clinicians into their own subjectivity. This retreat manifested in self-involved or self-reflective thoughts and worries only tangentially, and in some cases not at all, related to the patient. Unintentionally, this left a patient even more alone in the dissociation as the clinician retreated, too. Participants also reported a predictable range of somatic responses in the face of their patients' dissociation. These responses mirrored the psychobiological response pattern to trauma – that of hyperarousal and dissociation. Participants experienced a hyper-focused attention as well as increased heart rate and hypervigilance. For some participants this eventually

led to a counter dissociative process in the face of the patients' dissociation. The full spectrum of the participants' responses –from initial fear and aloneness to self-involved thoughts, and finally hyperarousal and dissociation – reflect a parallel of their patients' presumed experience in the original traumatic moment. Findings regarding the nature of the therapists' internal experiences in the face of the dissociation reflect that the patients were able to bring their therapists to the scene of the crime and into their internal world by way of the dissociation.

This parallel experience reveals the possibility of understanding a patient's dissociation not simply as a defense mechanism to be rid of, but instead as an interpersonal phenomenon that holds the potential to communicate crucial information about the patient and the treatment. Exploration of this possibility addressed the four sub-questions guiding this inquiry. Findings revealed that the clinicians' willingness to tune in closely to their patients' nonverbal cues and pay attention to the internally generated information by way of their own countertransference experiences allowed them to decode meaning from their patients' dissociation. As a result, the clinician can offer an ability to bear witness and to tolerate their patient's formerly intolerable experiences. The patient can feel heard, known or understood. This process of tuning in during a patient's dissociation can be understood as *dissociative attunement*. This interpersonal process is made up of seven component parts, as identified by the participants and constructed through my knowledge of the literature on dissociative attunement and my own unique construction of meaning of these participant accounts.

The findings of this study provide support for many of the theoretical constructs discussed in the review of relevant literature. The participants reported experiencing their patients' dissociative experiences as existing outside of time and language and triggered most often by remnants of traumatic memories or associated affective experiences. This supports the

prevailing wisdom in the field of trauma and dissociation regarding the nature of the dissociative process and its manifestation in clinical presentations (Howell, 2005). The participants' accounts also offered support for the use of therapist countertransference as a pathway to know and understand what is in the mind – particularly stored in the right brain – of the patient (Bromberg, 1998; Davies & Frawley, 1994; Ogden, 1994; 1997; Reik, 1948; Schore, 2001; Stern, 2003, 2010). The accounts of the participants also lend support for Karen Hopenwasser's (2008) construct of dissociative attunement, while adding depth and nuance to this construct.

The findings will be discussed in further detail as they relate to the available literature. First, I will discuss the unexpected findings that emerged through the course of data collection that were not anticipated by review of the literature. I will review the main findings of the phenomenon in question. I will explore the constructs of vicarious traumatization and secondary traumatic stress and discuss the relationship between these constructs and my findings. I will then turn to a discussion of the potential for traditional talk therapies to promote affective overload amongst highly traumatized patients, including the participants' first-hand experiences of this affective overload and their ideas about what might promote containment in the therapy dyad. I will discuss the findings regarding the function of the patients' dissociation and review how they fit with available literature on in-session moments of disengagement. I will then review the claims of relational analytic trauma theorists that dissociative experience can be accessed only by way of the therapist's internal experience and discuss the fit between these claims and the findings of this inquiry. I will then discuss how the findings fit with and depart from the construct of empathic attunement. I will turn to a discussion of Hopenwasser's construct of dissociative attunement and review the ways in which dissociative attunement differs from empathic attunement and highlight how the findings of this inquiry build upon Hopenwasser's

construct of dissociative attunement. I will then consider my positionality in the construction of these findings as well as the transferability of these findings to other settings and populations. I will review the implications of these findings for clinical practice and social work education. I will conclude with a discussion of the limitations of this study and suggest directions for future research in this area.

Unexpected Findings

In addition to answering the research questions I set out to address, the participants' accounts offered several areas of unanticipated insight. The first is the profound isolation that the therapist-participants reported in this work. Almost all of the participants remarked that they had not had the opportunity to discuss or process their own personal and internal responses to working with such a highly disturbed patient, even in the midst of good supervision. A theme emerged revealing the largely *unspoken* nature of the therapist's internal experience when a patient dissociated in session. Many of the participants expressed appreciation at the conclusion of the interview, noting some surprise that they found it so helpful to unpack their internal experiences and think through what was happening for them. Catherine, for example, shared: "This was actually really helpful for me in actually giving this good attention in a way that I didn't initially really take the time to think about and process." She went on to explain that part of what she found helpful about processing her own experience was the in-depth attention we were able to provide to such a seemingly minute clinical interaction. She elaborated:

Well I think beyond, I feel benefited by having been able to discuss it rather than reading about someone else . . . It's not the same as having an hour to really process it in a way that doesn't happen in supervision . . . It's not like, let's spend sixty minutes and talk about moment by moment, you know, overlapping questions about this seven second experience. It's great.

Catherine's statement reveals the preference often given to the gestalt of a therapy session, both in clinical supervision sessions and in clinical writing. This tendency to reflect on big-picture themes and recollections leaves the clinician alone with the moment-to-moment encounters in a clinical hour and the intense affect they often evoke. Several participants admitted that they never thought to reflect on these minute experiences in such detail. For instance, Darlene hadn't had the space to consider her experiences in this way and was grateful for the opportunity to do so. She explained:

I'm fascinated by what you're, the questions you're asking. No one has ever asked any questions like that of me. You know I never even talked about that dissociation, that experience. Maybe with my consult group just to relay it to them, but you know, that level of depth, it's very interesting.

The participants were grateful for the opportunity to "dissect" such an overwhelming clinical experience that became both personally and interpersonally charged. The gratitude, surprise and curiosity the participants reported in response to simply talking about their internal experiences led me to conclude that the internal responses of these therapist-participants had been wholly un-verbalized, representing an interesting parallel to the nature of what is dissociated in the patient's experience. The process of putting words around their experiences was enlightening and enlivening for the participants, leaving them with questions as well as a curiosity to understand more about how their own internal responses informed their work. Still, many participants reported a concomitant feeling of being overwhelmed by this process of reflecting on the distress and sometimes horror they experienced in the midst of their patient's dissociation. Kaitlyn, for instance, commented on how our conversation about her response to her patient's dissociation brought her into fuller contact with just how overwhelming this experience was for her. When I asked her if there was anything else she'd like to add to our conversation as we were concluding the interview, she responded:

I don't know. I think it's really interesting for me. I haven't really thought about it and I haven't actually ever said that was an hour and a half [regarding her experience of her client dissociating in session for an hour and a half.] Even when I was with my colleagues I didn't really outline exactly how long the dissociation like really lasted for but then like, Oh my gosh. That was an hour and a half!

Kaitlyn's statement that she hadn't shared her experience with her colleagues or even "outlined" the nature of her experience in her mind was a consistent theme across many participant accounts. This finding, though unexpected, supports the argument made in the literature review that there is scant attention to the in-session experience of the clinician in clinical writing or empirical research. As such, the participants' in-session experiences were often discarded both in supervision consultations as well as in the inner dialogue of the clinicians themselves. As a result, the participants were profoundly isolated in their work with these highly disturbed and highly disturbing patients. This, at times, contributed to the participants' tendency to question themselves and their clinical skills and led to what Elise called "feel[ing] like a freak." At the end of the interview, she asked me, "Do I sound like other people you've interviewed?" Elise seemed hungry for camaraderie and resonance of experience with fellow clinicians – an antidote to the isolation of this lonely and grueling work. When I affirmed that there were some consistencies across participant accounts, she responded, "Wow that's fascinating. Because of course I feel like a freak!" Seven participants, including Elise, asked to see the results of my study once it was completed. While the participants all have a clinical interest in the topic, I also suspected that many were searching for a resonance of experience with the other clinicians interviewed for this study. Like Elise, they were searching to not "feel like a freak!"

These unexpected findings suggest that clinicians who work with such a highly traumatized population are particularly vulnerable to isolation and ensuing self-doubt in this

work. It also suggests that clinicians who work with patients who dissociate in session may be uniquely helped by being able to process their own internal experiences and responses to patients that occur in-session. Elise confirmed this suspicion when she admitted,

Sometimes I like being interviewed for something like this just because I kind of, I have my selfish need to understand all that about. Yes, I am working with people who dissociated. **What is happening to me?** What does happen? So it's also been helpful for me to be asked this, and also validating to hear yeah this is what happens to people when their clients are dissociating and not that I'm bad at it, or I don't know what I'm doing, but that that's part of the whole thing

As the findings suggest, the clinician is called to leave her own subjectivity and be a stand-in for the patient during the patient's dissociation. When this happens, it becomes even more important for the clinician to have the space to reflect on her own experiences and understand what has happened to her, as Elise's comment suggests. The findings also imply that this self-reflection must not only attend to the larger clinical picture or even the gestalt of the therapeutic relationship, but to the moment-to-moment clinical interactions within a session. Attention to the clinician's internal experience with an intentional focus on such a brief clinical interaction in-session might serve as an antidote to the isolation and also provide a parallel framework for the patient of the work of verbalizing an experience that is most often left unformulated.

My experience in conducting interviews with the participants highlighted another area of unexpected findings. There was often a parallel process that occurred during the course of the interviews that mirrored the patient's dissociative process. For instance, participants' speech patterns were often fragmented and they frequently veered off topic, leaving sentences unfinished. The following is an example from an interview with a very intelligent and very eloquent participant. She began by describing her surprise that her patient dissociated when she did. She said, "I was surprised by the fact that. This was probably the. Like I had said it had

happened before but not to the. I mean she really, yeah.” Such phraseology was not an uncommon occurrence. I often was not aware of this pattern until I began to transcribe each interview and found many missing words and frequent incomplete thoughts, evidencing perhaps my own mildly dissociative process as I was interviewing the participants. Additionally, I had the common experience of witnessing participants lose their train of thought throughout the course of the interview or forget the question I had just asked them. Frequently participants asked me to repeat myself or remind them what we had just been speaking about. The following dialogue provides a brief example:

J: And is this a person with DID?

Participant: No. I’ve been seeing her a long time, several years and have yet to really umm, talk in detail about her trauma. So, um, I know the kind of outline of her childhood um, but, um, the actual um, events or relational um, relational circumstances of her trauma she hasn’t really talked about. So, um, um, I forgot your question. (laughs).

This example illustrates the difficulty participants often had holding thoughts in mind and maintaining their train of thought, especially as we were discussing their patients’ trauma memories in detail. These occurrences reveal a parallel dissociative process that occurred for the participants during the experience of the interview as they were speaking about highly traumatized patients and their dissociative episodes in session. While it remains unclear *how* this parallel experience permeated the interview, it highlights the contagious nature of a patient’s dissociation as well as the overwhelming, and perhaps normative, need to distance oneself from such horrific and unspeakable traumas.

The Phenomenon in Question

Across participant accounts, the findings revealed a consistency of therapist internal experience in the face of a patient’s dissociation. Such consistency suggests that the internal

experience of the therapist in the midst of a patient's dissociation and the ensuing process of dissociative attunement represent a distinct clinical phenomenon. Chapter V details the components of this phenomenon: anxiety, feeling alone, retreating into one's own subjectivity, hyperarousal and mutual dissociation. At the inception of this study, there was no available research examining the internal experience of the therapist when a patient dissociates in session. Subsequently, a theoretical article including a case example was published detailing a dissociative experience within the treatment hour (Rankin, 2013, p. 63). Interestingly, the author's description of her own internal experience in the midst of her patient's dissociative shifts echoes components of the findings of this study, further validating this phenomenon as distinct. Rankin names this phenomenon "dissociative numbing." She argues that the clinician is "vulnerable to falling into self-states that emerged in treatment as a biphasic process consisting of re-traumatization, followed by immobilization of the therapeutic process by the therapist's traumatized state" (Rankin, 2013, p.63). During her patient's dissociative shifts, she herself experienced a "mind-numbing paralysis", reflective of the mutual dissociation described in this study. She describes the experience as both disorganizing and hard to tolerate, paralleling the therapist anxiety and hyperarousal noted in this study. Finally, she reveals that during a patient's dissociative shifts, the clinician is challenged to hold onto a "coherent sense of herself in the face of unbearable internal risk that the patient's experience evokes" (Rankin, 2013, p. 63). This statement captures the terror evoked by engaging with the patient's dissociation and the threat of losing one's own sanity that has been described in my findings. What each participant initially experienced as a peculiar self-experience that occurred in isolation can be seen in aggregate form to represent a quite ordinary response to the peril of a patient's dissociation.

Vicarious Traumatization

The findings suggest that engaging in an intense empathic connection with a survivor of grave trauma holds a powerful impact on the therapist. The concepts of vicarious traumatization and secondary traumatic stress likewise explore the impact of trauma work on the helper.

Vicarious traumatization refers to the harmful changes that occur in a professional's view of self, others and the world as a result of exposure to patients' traumatic material (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). This construct refers primarily to shifts in a helper's cognitive schema, and suggests that these changes result from the cumulative effect of engagement in trauma work over a sustained period of time. The findings of this study, in contrast, suggest that therapists are impacted by acute moment-to-moment clinical encounters with a patient's trauma memory and associated symptoms. Additionally, the findings of this study do not imply long-term shifts in a therapist's cognitive schema. Instead, the findings of this study extrapolate on the therapists' in-session and often fleeting thoughts and feelings that do not necessarily alter or impede their functioning outside of the therapy session.

Secondary traumatic stress is a related concept. This term refers to a wider cluster of symptoms that mirror the symptoms of posttraumatic stress disorder (Bride, Radey & Figley, 2007). This cluster of symptoms in the helper can result from short-term or acute exposure to a secondary trauma. Again, the findings of this study differ from the concept of secondary traumatic stress. The participants in this study reported symptoms of hyperarousal and mutual dissociation that lasted for the duration of the patient's dissociation, and in some cases, for the duration of the psychotherapy session in question, but these experiences were acute and fleeting. They did not extend past the therapy hour and did not intensify to rise to the diagnostic criteria of posttraumatic stress disorder.

The findings of this study are also distinct from the constructs of vicarious traumatization and secondary traumatic stress in that these constructs refer to only the deleterious effect of engagement in relationship with trauma survivors. The findings of this study, in contrast, imply that the effect of empathic immersion into the heart and mind of a highly traumatized patient holds the potential for vicarious traumatization, but also affords the opportunity for increased engagement and empathic attunement in the dyad. For instance, the disjunction that is created in the therapy relationship immediately subsequent to a patient's dissociation in almost every case gave way to a re-connection and increased capacity for empathy. The participants reported being able to see their patients' vulnerability and respond more closely to their patients' needs as a result of their willingness to engage their patients in the pain and terror that accompanied the dissociative moment. There were various strategies that the participants employed in order to bear this horror, including an awareness of their distinct role and responsibility that left them sufficiently outside of the traumatic memory as well as a capacity for containment and mentalization that enabled the participants to tolerate the intense affect generated from engagement in the patients' trauma narrative and dissociative gaps. Finally, the therapists' ability to entertain "imaginings" likewise offered a strategy to promote self-soothing and improve their capacity to safely maintain empathic connection with a highly traumatized patient. These findings offer a complementary understanding of constructs such as vicarious traumatization and secondary traumatic stress – namely, that deep engagement with highly traumatized patients holds the potential for rich and valuable therapeutic encounters.

Traditional Talk Therapy and Affective Overload

As noted in the literature review, prevailing wisdom in the study of trauma treatment suggests that verbally processing a traumatic experience during a psychotherapy session has the potential to activate implicit memory systems and leave a patient both hyperaroused and unable to regulate this hyperarousal (van der Kolk, 2009). The findings of this study support this prevailing notion. Participants frequently described being witness to their patients becoming hyperaroused and affectively overwhelmed subsequent to speaking about a traumatic memory or engaging in a relational encounter which re-enacted some aspect of the original trauma. In each case, the trigger for the dissociative experience in session was the patient's affective overload. Participants described this as the patient being "overloaded," "emotionally ripped open," "totally overwhelmed," and experiencing "complete overload." This finding supports the current stance in the trauma field that a titrated process of entering into the trauma is needed (Courtois et al., 2009; Ford et al., 2005; Herman, 1992) while also suggesting that clinicians need to remain vigilant for the emergence of this affective overload in session. Additionally, this finding supports the notion that a new theoretical understanding is needed to comprehend how traumatic and dissociated memories can be communicated safely in the context of treatment.

Function of In-Session Dissociation

Findings of this study suggest that there are two primary functions of a patient's dissociation. The first is to manage the affective overload elicited by engagement with the trauma narrative. The second is an interpersonal function, intended to communicate some need to the therapist. While no empirical research to date has examined the nature of in-session dissociative experiences, there is a small body of research that examines in-session experiences

of silence and disengagement (Frankel & Levitt, 2009; Levitt, 2001; Stringer, Levitt, Berman & Matthews, 2010). Levitt (2001) found that “obstructive silences” – moments that patients described therapeutic engagement and exploration as halted – could be categorized into two types: disengaged pauses and interactional pauses. Disengaged pauses were utilized by a patient to shut oneself down emotionally. This often occurred automatically and without conscious awareness. The researcher even described these pauses as containing “a feeling of blank-ness” (Levitt, 2001, p. 234). These so-called disengaged pauses mirror the way the patients described in this study non-consciously used dissociation to shut down affectively. Interactional pauses, according to Levitt (2001), focused on the process of communication between patient and therapist and often included a patient’s more conscious strategies to elicit a particular response from the therapist. These interactional pauses mirror the second function of dissociation found in this study, often serving as an interpersonal communication to the therapist to slow down. Though Levitt’s research did not specifically study dissociative pauses, her findings correspond to the two primary functions of dissociation found in this study.

A later study by Frankel & Levitt (2009) investigated moments of “disengagement” in session. This research likewise found that patients used disengagement to protect themselves from pain, modulate overwhelming emotional experience and maintain the therapy relationship. While Frankel & Levitt’s study investigated disengagement as opposed to moments of dissociation, their findings parallel the findings of this study – namely that patient motivations for moments of either disengagement or dissociation are to modulate affective overload or to communicate an interpersonal need in the therapy relationship.

Taken together, these findings about the function of dissociation as well as the literature regarding in-session silences and moments of disengagement reinforce the notion that

dissociative episodes in session can in fact hold varied and nuanced meanings. These moments of disengagement during session can be understood not merely as symptoms to rid the patient of or resistance to work through, but instead as processes to investigate and understand. Further, the findings of this study suggest that moments of silence, disengagement and dissociation can hold opportunities for repair, (re)engagement and communication in the therapy dyad.

Dialectical Tension

This seeming contradiction between disconnection and re-engagement illuminates a duality that existed in the data. In several areas, data emerged that initially suggested a contradiction, but which I ultimately came to understand as processes existing in dialectical tension with one another. For instance, the disconnection that occurred initially in the face of the patient's dissociation in almost every instance gave way to a re-connection and increased attunement in the dyad. In fact, in one of the memos I retained, I noted, "I'm having an interesting experience of not knowing how to code certain statements as either a disjunction or closeness/empathy. I had conceptualized the two initially as opposing constructs, but it seems to be more of a continuum where one bleeds into the other." My struggle to differentiate the disjunction from the re-connection in the raw data highlights the related nature of these two processes. It appears that these processes are not opposing ones, but instead stand in dialectical tension with one maintaining the other. The initial disjunction that occurs in the face of the patient's dissociation begets the therapist's attempts to reconnect. Perhaps the therapist's grueling efforts to reconnect emerge from guilt or shame about her initial urge to withdraw. Without the disjunction, it is not clear if the increased connection or attunement would occur.

Likewise, without the increased connection, it is unclear if ensuing disjunctions would occur. The processes appear inextricably bound.

A second seeming contradiction in the data can be seen in the participant accounts of feeling either hyperaroused or dissociated in the face of their patient's dissociation in session. I initially understood these processes as divergent ones, but ultimately came to see them, too, as alternating components of a larger process – the natural response pattern to a traumatic event. These experiences likewise stand in dialectical tension with one another. It is the therapist's total willingness to immerse herself in the patient's trauma narrative that evokes a state of hyper focused attention and hyperarousal. She entertains vivid and graphic imaginings, comes in contact with induced feelings and even, in some cases, acts as the placeholder for the patient's experience. The intensity of this experience begets the mild mutual dissociative state, leading to a lack of focus and ultimately a feeling of being out of the room. Immersion in the patient's self begets total withdrawal. Elise alluded to the relationship between these processes when she described her experience during her patient's dissociation as being "hyper focused to the point of dissociation." Again, what on the surface appear to be contradictory processes, in fact, maintain one another.

The examples of these dualities in the data reflect the nature of the dissociative process. The function of dissociation is, to paraphrase Putnam (1992), to enable an escape when there is no escape, to offer a dreamy adaptation to a frightening trauma, and to provide a way to remember the trauma and to forget it all at the same time. These processes, like those found in the data, are dialectically related to one another. These findings suggest that the dialectical nature of dissociation as a phenomenon becomes manifest in the therapist's internal experiences in the midst of a patient's dissociation in session.

Parallel Experiences

The dualities present in the internal experience of the therapist mirror the dualities in the nature of a patient's experience in the midst of a traumatic moment. Accordingly, findings revealed a parallel process between the internal experience of the therapist during the dissociation and the presumed experience of the patient during the original trauma. During a patient's dissociation in session, the participants reported experiencing dread, fear about something bad happening, guilt, feelings of being ineffectual, and feelings of rejection and abandonment. These experiences parallel the accounts of survivors of trauma commonly reported in clinical practice. The participants then identified self-involved thoughts and worries and experiences of hyperarousal and mutual dissociation in response to their fears. These behavioral responses, too, can be understood as synchronous to a patient's typical response to a traumatic experience. These parallels between participant and patient internal experiences and behaviors suggest that the therapists' internal experiences offer an entry into the interior world of the patient in the dissociative space.

Therapist's Countertransference as Knowledge

Relational analytic trauma theorists hold that dissociated aspects of a patient's self can become known only by way of interpersonal engagement with the patient, relational enactments, and investigation of the therapist's countertransference experience in the context of the therapy dyad (Aron, 2003; Bromberg, 1998; 2011; Davies & Frawley, 1991; 1994; Howell, 2005; Stern, 2003; 2010). The findings of this study both support and elaborate on this notion. In making sense of the function of their patients' dissociation, the participants described the in-session dissociation as an interpersonal process and even a strategy to communicate needs in a preverbal

way. The participant accounts supported the theoretical wisdom that dissociated aspects of self get communicated interpersonally and intersubjectively in the context of the therapy dyad. The findings departed from the stance of relational analysts such as Aron (1996) and Bromberg (1998) in that the participants largely did not see this intersubjective communication as an enactment. Only one participant used the language of enactments to understand this communication and one other participant used the language of projective identification. The eleven participants struggled to put words to what they understood as a process of nonverbal communication in the pair. They did not always know how it was that they came to understand something about their patients in and through the mutual experience of the dissociation, but they knew it non-verbally and perhaps even non-consciously. In fact, there was a certain *je ne sais quoi* the participants reported about the way they came to know information about a patient through the dissociation. This *je ne sais quoi* is revealed in participant statements such as: “Sometimes her dissociated part will express that somehow nonverbally. And it’s kind of hard for me. I don’t know how to really define that to you,” and through another participant’s attempt to describe this “unconscious communication.” She continued:

Unconscious communication. The co-consciousness, the whole, weird kind of like, that thing that goes on somehow. You know what I’m talking about? So like, there’s a little something-something between us that maybe neither one of us could put words to but that really even when you don’t think there may have been something that’s gone down, that really maybe, for both of us, something has.

Although the participants struggled to define how they came to understand something about their patients through the dissociative episode in session, themes emerged across participant accounts to help make sense of phenomenon. In particular, two components of the process of dissociative attunement, *Induced Feeling* and *Therapist Imaginings*, detail how the therapists’ attention to their internal experience gave them information about a feeling state, memory or need thought to

be reflective of their patients' states. These findings support the belief that the internal experience of the therapist represents a crucial means to access, know and contain otherwise inaccessible and unknowable parts of the patient's self. By describing the seven component parts of dissociative attunement, the findings also fill in the gap in available literature regarding *how* this process of implicit, non-conscious attunement to the dissociated aspects of the patient's self unfolds moment-to-moment in therapy dyad.

Enactments and Projective Identification

Prevailing wisdom in the field of psychoanalysis suggests that dissociated content can become manifest in the therapy dyad only by way of action – the unconscious repetition of relational patterns known as enactments (Aron, 1996). One participant in this study labeled his experience with his patient during the dissociation as an enactment. A second participant described part of her experience during her patient's dissociation as projective identification. Two other participants described an encounter that I interpreted as an enactment although they did not label it as such (They were not trained psychodynamically and thus “enactment” was not the language they used to describe their experience). I did not report on these experiences in the findings, as they were not relevant to my research question. Instead, I was seeking to determine if dissociated content could become communicated in the therapy dyad by ways *other than* enactment. I mention these examples of enactment now to confirm that my findings partially support the contention held by relational analysts that dissociated material gets communicated by way of enactment. My findings support this belief, while also adding that enactments are not the only way that dissociated material gets conveyed in the therapy dyad. Instead, the findings here suggest that there is a more mutual and co-constructed process of communication that can occur

in the midst of the patient's dissociation when the therapist is willing to listen to internally derived knowledge and remain present with the patient throughout her dissociative gap. Further, these findings suggest that *Therapist Imaginings* including thoughts, fantasies and images, hold power to communicate relevant affective states, needs, or fragments of a traumatic memory that are split-off from a patient's experience of self during the dissociation. These imaginings do not necessarily inform action. In many cases for the participants, they acknowledged these imaginings and reflected on them, but did not enact them in the therapy relationship. The findings of this study suggest that the process of dissociative attunement described here can aid in the communication of dissociated content in the therapy dyad, existing alongside enactments and projective identification as a way that aspects of a patient's self get conveyed in the therapy matrix.

Attunement

The concept of attunement can help shed light on this process of nonverbal communication that was so difficult for the participants in this study to articulate – the *je ne sais quoi* of how these therapists came to understand something about their patients through the dissociation in session. As noted in Chapter II, attunement is defined as the state of reciprocal recognition between two people which includes a congruence of inner experience (Benjamin, 1995; Siegel, 2010). Newton (2008) clarifies that attunement consists of both resonance – being completely in tune with the other such that there is a feeling of *getting it* – and synchrony – the experience of two people acting together as if they are one. The process of attunement requires the ability of both partners to move into the nonverbal and body world, the world of the right hemisphere of the brain (Newton, 2008; Schore, 2008). Both the process of becoming attuned

and the experience of being attuned exist outside of language. The partners rely on perception of nonverbal signals such as facial expression, tone, posture and other gestures that communicate nonverbal and often highly affectively loaded information (Newton, 2008; Siegel, 2010). There is also a subjective component to attunement, understood as the experience of profound connection, seeing and knowing the other deeply (Siegel, 2010).

The findings of this study map neatly onto the construct of attunement. One of the components of dissociative attunement identified in the course of this study is the *Perception of Nonverbal Signals*. The participants reported a nuanced and very focused attention to the patient, especially their facial expressions, body language, and the cadence, tone, volume and rhythm of speech (or lack thereof) during the dissociation. Often this attention was described as sharply focused, in some cases to the point of drowning out awareness of one's own subjectivity or the surrounding space. The kind of focus and attention that the participants reported can be understood as being in a state of *right-brain receptivity* – the right brain of the therapist is tuned to the nonverbal and right brain communications of the patient. This function is what enables the therapist to hear and know the dissociated parts of a patient's self, stored in the patient's right brain. The sharp and pointed perception of nonverbal signals identified by the participants in this study parallels the focused attention and clear perception that are viewed as prerequisites of attunement.

The findings of this study also reflect the subjective component of attunement – the state of resonance, the experience of “getting it” from the inside out, and the felt sense of knowing the other deeply (Newton, 2008; Siegel, 2010). Specifically, the component of dissociative attunement labeled here *Induced Feeling* describes the resonance component of attunement. Participants experienced within themselves a mild or modulated version of their patients' split-

off affective experience. One participant, Tasha, labeled this an “induced feeling” she was “picking up from my patient.” She went on to explain, “It’s information that I’m getting . . . I get a feeling of ‘Oh okay that’s what it is.’” Tasha here was describing the way she came to know, instinctively, “what it is” for the patient through her ability to be in resonance with the patient’s feeling state. Tasha had a momentary experience of being with her patient in the feeling, leaving her with the sense that she “got it.” Another participant, Ruth, used this same language of “getting it.” She explained that by containing the induced feeling from the patient, she “got it.” She explained:

Yeah and throughout the whole process I was attuned enough to her. Um, like that I got it. In that way. Like I got it. Like a parent, like a good parent . . . Like a good parent, I got what the others didn’t get about how hard this was for her and about how painful and hurtful and disappointing and how she may have felt anger and that I was, I was okay with sitting with it.

Like Tasha, Ruth described the experience of being attuned to her patient, which began with affective resonance but ultimately led to a more cognitive left-brained understanding of the patient.

Participants also described a sense of connection to their patients through or subsequent to the dissociation, identified in the *Disjunction and Connection* component of dissociative attunement, that likewise reflects the resonance component of attunement. Participants identified a sequence of first feeling distressingly disconnected from their patients during the dissociation, and then ultimately entering into a state of deep empathy. Participants described an urge to take care of their patients, to help them, and most essentially to stay with them, continuing to listen and be with them in the dissociative space. The level of connection that participants were able to maintain through the dissociation is at odds with the primary function of dissociation – to

distance and disconnect. This surprising finding reflects the ability of the participants to maintain attunement to their patients, even in the midst of the dissociative space.

Finally, the findings of this study parallel the synchrony component of attunement. As a result of their resonance to the patients' dissociated parts of self, the participants reported experiencing both hyperarousal and mutual dissociation in the face of their patients' dissociation. Interestingly, these processes reflect the psychobiological response pattern to a major trauma – and likely reflect the therapists being brought into synchrony with the state of their patients during the dissociation.

These findings taken together suggest that the process of attunement was at play between the patient-therapist pairs in the midst of the patient's dissociation. While these findings can map onto the construct of attunement, there are also components of the findings that either diverge from or expand upon the construct of attunement. The construct of attunement helps to make sense of the participants' experience of being in rhythm with their patients – the reports of affective resonance, synchronous behavior, induced or contagious feelings, and deep connection. The construct of attunement falls short, however, in helping us to understand the participants' accounts of retreating into their own subjectivity and alternately feeling distressingly disconnected from their patients in the midst of the dissociation. The construct of attunement also fails to explain the participants' tendency, and I would argue need, to act from within a different role than the patient, ultimately moving out of synchronous behavior. The therapists in this study were able to stand in for their dissociated patients (*Therapist as Placeholder*) and contain for the patient what had been, for them, unbearable (*Containment*). The therapists' ability to first attune to their patients' split-off affect was a crucially important part of the process of dissociative attunement, however it was the therapists' ability to then feel or do something

different with it that enabled the process of dissociative attunement described here to be restorative for their patients and mutative for the treatment.

Dissociative Attunement

Building on Hopenwasser's Model

The construct of dissociative attunement as described by Hopenwasser (2008) was the first of its kind to merge the fields of psychoanalysis and trauma theory to describe how those with an early and horrific trauma history communicate states of unbearable pain in the therapy dyad. She provides a beautiful description of attunement, including the way it has been defined across theoreticians over time. She privileges processes of attunement, entrainment and resonance in her description of this construct. She comments on how the process of attunement emerges uniquely with a person with a dissociative disorder (the state changes are quite rapid and the therapist is unable to track or process these changes as they occur) (Hopenwasser, 2008, p. 358). She then alludes to the way that dissociative attunement can proceed even when there is a momentary lapse of empathic attunement during these rapid state shifts. She offers two compelling case examples, and yet, it remains unclear how dissociative attunement can proceed without empathic attunement or how dissociative attunement as a construct differs from attunement, except in that it occurs with a person with a dissociative mind.

The findings from my study build upon Hopenwasser's early formulation of dissociative attunement by identifying seven discrete components of the process of dissociative attunement. I have expanded upon her initial framework which emphasized empathic attunement and affective resonance to include components that describe how the therapist becomes attuned (*Perception of Nonverbal Signals*), how the attunement manifests in the therapist's subjectivity (*Induced*

Feeling and Therapist Imaginings) and what the therapists do with this attunement to help themselves and their patients (*Containment and Asymmetry of Roles and Responsibility in the Dyad*).

The findings of this study depart from Hopenwasser's construct of dissociative attunement by paying closer attention to the therapist's minute-to-minute internal experience during a patient's dissociation. As such, these findings emphasize processes of dissociative countertransference as opposed to dissociative transference identified by Hopenwasser. These findings also provide further insight into components of the therapist's cognitive process and the therapeutic relationship that promote attunement through the dissociation.

The findings of this study also help clarify the relationship between attunement and dissociative attunement. Findings suggest there is a disjunction between patient and therapist that often looks and feels like a misattunement. This manifests first through the therapist's initial urge to withdraw and is maintained by the therapist taking an asymmetrical role from the patient. While there still remains some resonance, synchronicity and connection, these exist alongside a disconnection and uniqueness in the experience of patient and therapist that allows the therapist to both *know* and *not fully know* the patient's experience at the same time. This disjunction and distance lies at the heart of dissociative attunement. In Hopenwasser's theoretical construction of dissociative attunement, she emphasizes processes of attunement over disjunction. However, in her case example, she details a therapeutic rupture which occurs when she continually finds herself being "mean" to her patient, a self-experience that she at times, but not always, identifies as her own. She distinguishes this repeated interaction from projective identification or enactment, explaining that this is a "process beyond countertransference" (p. 356). Instead, "it felt like a jointly dissociated awareness that was actually a function of attunement." Here,

Hopenwasser alludes to a disconnection in the dyad that begets attunement, but she does not elaborate on it or describe how the disconnect translates into a closer attunement between the two. In fact, she later describes the repeated meanness as the attunement, and explains, “This attunement held us like gravity to each another” (Hopenwasser, 2008, p. 357). It is clear that she emphasizes descriptions of synchrony and connection over those of rupture. The findings of my study illuminate the relationship between synchrony and disjunction in the dyad, and offer an explanation for how these two processes relate to one another and to the construct of dissociative attunement.

Attunement versus Dissociative Attunement

The construct of dissociative attunement as defined by Karen Hopenwasser (2008) entails *empathic attunement*, *dissociative transference* and *affective resonance* as the three primary components. Relying only on these three component parts to define the construct of dissociative attunement does not adequately differentiate this process from that of primary attunement. Empathic attunement and affective resonance are both essential ingredients of the process of attunement. Dissociative transference merely provides the context within which the attunement occurs but does not further differentiate how dissociative attunement differs from attunement as a distinct phenomenon.

The findings of this study identify seven component parts of this process. Several of these components mirror the crucial steps in the process of attunement – especially the *Connection* component of *Disjunction and Connection*, *Induced Feeling*, and *Perception of Nonverbal Signals*. However, four components of the construct of dissociative attunement represent ways the construct presented here diverge from empathic attunement alone: the *Disjunction* part of *Disjunction and Connection*, *Therapist as Placeholder*, *Asymmetry of Roles and Responsibility*

in the Dyad, and *Containment*. These components distinguish dissociative attunement as a wholly different process, not merely attunement occurring in the midst of the dissociative field. I will review each of the four components that distinguish dissociative attunement from attunement, including the functions that dissociative attunement requires from the therapist.

The *Disjunction* subcomponent of *Disjunction and Connection* speaks to the distressing level of disconnection that the participants experienced when a patient dissociated in session. Usually this was the participants' initial response to their patients' withdrawal. Participants described feeling annoyed, angry, bewildered, or left alone and often admitted to withdrawing from their patients in response. This was not always a conscious choice. One participant likened this to non-contingent responsiveness between a mother and baby, describing it as "something off rhythmically," and being "off a beat interpersonally." Later he framed this disjunction as a "misattunement." He explained that while he was attuned to one part of his patient, he lost attunement to the part of her that needed him to slow down, resulting in her ultimate disconnection from him, herself and reality for the moment. Eventually in this case, there was a "repair" and reconnection. During our conversation, this therapist wondered if the "misattunement" was what offered the opportunity for repair. This account raises an important question about the necessity of the disjunction in the process of dissociative attunement. Does the clinician need to experience a withdrawal or disjunction in order for the repair and reconnection to proceed? The findings of this study do not offer a detailed answer to this question. It is possible that the disjunction is merely the initial response to a patient's dissociation, which ultimately gives way to empathy, attunement and reconnection. It is also possible that this disjunction is necessary in order for the therapist and patient pair to recalibrate – a certain proof for the patient that the therapist will return when she goes away and make

amends when there has been a misattunement. A final possibility is that the “misattunement” was really only a misattunement to one (perhaps more conscious) part of the self, while in fact the therapist was very closely attuned to a dissociated aspect of the patient’s self. In this case, the therapist’s own feelings of annoyance, anger, blankness and loneliness represent resonance with the patient’s split-off affective state. The urge to withdraw represents a synchronous behavior with the patient’s total withdrawal through the dissociation. It is as if the therapist, unknowingly, meets the patient through very close attunement to the part of self that neither patient nor therapist has linguistic access to. Hopenwasser (2008) comments on this possibility in her case example, noting, “what might have appeared to others as misattunements were in actuality syncopated, synchronized shifts through multiple self-states” (p. 360). This hypothesis requires further research to determine the precise relationship between the disjunction and ultimate connection and its association to the process of dissociative attunement.

Therapist as Placeholder is a second component of the construct of dissociative attunement that diverges from attunement alone. The construct of attunement describes resonance of feeling between two people but does not denote a transfer of feeling from one to another. The findings of this study suggest that there is a transfer of feeling states from patient to therapist, wherein the therapist momentarily takes on the states of the patient while the patient remains safely blanked out. When the therapist acts as the placeholder, there is no direct and simultaneous resonance between feeling states of patient and therapist. This may help explain why there is a felt disjunction in the dyad during this exchange, differentiating this process from attunement.

According to the findings of this study, the therapist’s experience of being the “placeholder” for the patient’s feeling states and memories almost always led to an

overwhelming feeling of responsibility for the patient. This emerged in the subsection *Asymmetry of Roles and Responsibility in the Dyad*. Here the findings suggest that the therapists were able to come into contact with a split-off part of their patients and engage that part with deep empathy, while also remaining at a safe distance. The therapists in this study described feeling wholly responsible for their patients – at times even using language “parental” or “paternal” to describe their experience of responsibility for their dissociated patient’s well-being. The therapists’ parental role and responsibility protected them from falling into a mutual state of helplessness and terror with their patients. Instead, they moved out of resonance and synchrony with the patients’ traumatized state and were able to offer a level of containment of the traumatic state that the patients could not obtain.

Containment is a final component of the construct of dissociative attunement that differentiates it from attunement alone. Participants described both being able to tolerate the emotional state of their patients and also to *think about* their patients’ experience, engaging the left hemisphere of the brain with what had primarily been a right-brain affective and nonverbal state. This ability to think about one’s own mental state from a distance is an aspect of mentalization (Allen, 2003; Bateman & Fonagy, 2004). The findings suggest that the participants were able to tolerate and then hold in mind, mentalizing what was aroused for them during a patient’s dissociation. The addition of this left-brained process of thinking and verbalizing is not implied in a traditional construction of attunement, and yet according to participants, it was this process of containment (both affective and verbal) that enabled them to be helpful to their patients in the midst of the dissociation.

These four components of dissociative attunement distinguish this construct as a distinct process of connection and communication that occurs with a dissociating patient. The therapist

can be brought to the scene of the original trauma momentarily through her own reverie, but then quickly rely on her ability to mentalize and contain these experiences. She can feel the traumatic affect, again momentarily, and then regulate this affect. While this process begins with attunement, including connection, resonance, and perception of nonverbal signals, it is the therapist's ability to disconnect and distinguish herself as other than the patient that enables her to utilize her own mental and emotional abilities to contain and mentalize – and ultimately to help the patient.

Bucci and Images as the Pivot Point

Chapter II reviews Bucci's (2001) theory of the multiple code system and the referential process as a way the therapist can understand clinical content through nonverbal and subsymbolic means. The referential process is particularly relevant to the findings of this study. According to Bucci (2001) the referential process enables the translation of subsymbolic experience into nonverbal symbols and then into words. Participants reported experiences that parallel the three stages of the referential process as described by Bucci (2001): arousal of their own affective or sensory experience; use of metaphoric objects such as memories, images or songs that can become a symbol for the affect aroused in the subsymbolic mode of communication; and a process of reflecting on the meaning of this internally generated metaphoric object and its relationship to the patient. The participants' strong affective responses are manifest in their experiences of anxiety and somatic signs of hyperarousal. Participants described feeling overwhelmingly sad, terrified or angry – all representing the transmission of subsymbolic affective content indicated in stage one of the referential process. Participants also reported experiencing unusual images or what I have termed "imaginings," either of their patients' trauma memories or some self-soothing image of their own. These images were

internally generated by the participants and appeared to reflect the important affective content generated in the first stage of the referential process as described by Bucci (2001). Despite this similarity in the use of metaphoric objects, the findings of this study do not wholly support Bucci's contention that the translation of subsymbolic content to symbols nearly always occurs by way of images. Eight participants reported use of some kind of metaphoric object; however only two described this definitively as a *visual* image. More often, they used words like "I pictured" or "I imagined," denoting a metaphoric object that included images but also involved other sensory perceptions. The therapists' imaginings were more often a combination of visual, somatic, affective and cognitive components that merged simultaneously. Still, the experience of these internally generated imaginings served the same function Bucci describes in stage two, that is, the translation of subsymbolic into symbolic content in the mind of the therapist. The findings of this study suggest that the therapist then can contain the subsymbolic content largely because she has such internally generated imaginings to guide and anchor her. These imaginings allow the therapist to rely on left-brain cognitive processes to frame, understand and ultimately contain what initially was transferred as wholly affective, sensory and somatic information. This final step of containment and mentalization reflects the third stage of the referential process as described by Bucci. As such, the findings support Bucci's theory of the referential process, with the caveat that images did not hold the same power as metaphoric objects that Bucci has theorized.

Relevance of Findings

The findings of this study are unique in that they are derived from the direct clinical experience and retrospective accounts of clinicians. This study aimed to uncover the therapist's

interior thought process and somatic and affective experiences in the moment-to-moment clinical encounter when a patient dissociates in session. As such, the findings of this study offer an experience-near account of the process of attunement to dissociated aspects of a patient's self. There is relatively little information available on the intersubjective nature of dissociation or how it manifests in the therapeutic dyad outside of abstract theory. The accounts detailed by this diverse group of clinicians provide rich empirical data to build a preliminary theoretical account of the process of dissociative attunement. The steps and component parts identified in the findings of this study were informed by the available theoretical literature but were driven principally by the rich and detailed first-person accounts of the eleven participants. The findings presented above represent an important infusion of empiricism into the construct of dissociative attunement, which has thus far been wholly construed on the basis of anecdotal clinical experience or abstract interpretations of available theoretical accounts.

Construction of Findings

I have taken care to remain open to surprise and grounded in the data as I coded and analyzed participant accounts. Still, within the context of this constructivist grounded theory, I have utilized my own life experiences and positionality to interpret and make meaning of the data. The patterns that I observed and the themes I chose to highlight have been influenced by my training in psychodynamic theory and my immersion in the literature of relational psychoanalysis. These fields emphasize unconscious processes of communication and relational interactions, and privilege process over content. As such, the findings highlight the interpersonal and affective processes that emerged in the data and perhaps give less attention to more cognitive or behavioral explanations of the phenomenon in question. While the findings reflect the raw

data reported by participants, the organization of the data and the weaving together of themes, patterns and observations are uniquely my own.

Transferability

In the description of these findings, I have attempted to present sufficient detail about the context of this study in order to allow comparison of these findings to other populations and settings. The therapists I interviewed subscribed to diverse theoretical orientations and reported varying professional degrees, practice locations and experience levels. As such, it is likely that their experiences may translate to the experiences of a broad range of clinicians. Additionally, the participants in this study described their internal experiences in depth and detail, offering the reader much information in order to determine if the findings translate to their own settings and personal experiences. Finally, it is possible that non-clinicians who are in relationship with such highly traumatized people may resonate with the feeling states of the participants described here.

Implications for Clinical Intervention

The findings of this study detail the seven component parts of the process of dissociative attunement. These findings suggest that the effort the therapist makes to re-connect with the patient subsequent to a dissociative gap and an experience of disconnection in the dyad is crucially important. Participants indicated that it was their effort to re-engage with each patient that enabled the patient to return from his/her respective dissociative state. This finding implies that clinicians should engage in efforts to stay present to both self and other in the midst of a patient's dissociation in session, and when these efforts fail, then engage in the "grueling" effort to find the patient and re-connect with her. This re-connection can be furthered through the use

of eye contact and body language that suggest openness, by asking gentle questions to make contact with the patient, and occasionally, through the careful use of appropriate touch when the patient explicitly requests it.

Findings of this study also suggest that an important early component of the process of dissociative attunement is the perception of nonverbal signals. This finding implies that clinicians working with patients who dissociate in session should remain vigilant to the patient's body language, posture, cadence and rhythm of speech in order to tune into what is being communicated and not spoken about. Further, the findings suggest that the therapist's internal experience also holds potential to communicate information about the patient's affective states, memories and needs in the context of the therapy relationship. It follows from this finding that clinicians working with patients who dissociate in session should pay special attention to their own internal states, including emotions, thoughts, reverie and other imaginings that arise in the context of their patient's dissociation in session. It is also important that clinicians be careful not to impose their own experience onto their patients or assume that there is a direct one-to-one correlation between their internal state and their patients'. Instead, it is suggested that clinicians utilize their internal experience to better tolerate the discomfort and confusion of their patients' dissociation and to generate curiosity about their patients' state and needs.

Finally, the findings regarding the process of dissociative attunement suggest that these experiences of connection and communication can only safely occur when the therapist maintains a constant awareness of his distinct role and responsibility to and for the patient. The awareness of one's role as a caretaker enabled the therapists to keep themselves empathically connected to but sufficiently outside of their patients' experience in order to remain in safe connection to their patients. This finding implies that a therapist treating a survivor of early life

trauma who presents with dissociative symptomology needs to maintain a vigilant awareness of his role as a caretaker for the patient in order to forestall merger of internal experiences. I think of this as allowing oneself to touch down upon a patient's experience without falling completely into it. This ability to both connect while maintaining a safe distance from the patient's emotional state promotes attunement in the dyad and also prevents the development of secondary traumatic stress symptoms in the therapist.

In addition to implications for working with patients who dissociate in session, the findings of this study also have broader implications for therapists working with a highly traumatized patient population. One of the unexpected findings of this study revealed the profound isolation that the participants experienced in the midst of this grueling therapeutic work to the edge of a patient's trauma and back. One major benefit of this research, in my purview, is its potential to remove the sense of isolation that therapists who work with such profoundly traumatized patients routinely experience. It is my hope that the publication of these therapists' accounts will help to normalize the experiences of other clinicians who are trudging through their patients' dissociative episodes in isolation. The ability to understand one's own response to patients as part of a phenomenon, rather than as a failure of containment or a function of incompetence, can move the clinician out of the shame-based urge to withdraw and towards a willingness to stay and listen in connection and communion with the most damaged parts of a patient's self. It is also possible that the publication of these accounts will enable fellow clinicians to reflect more intentionally on their own experiences in session, thus opening up a window for empathy, repair and recognition of nonverbal communication in the treatment.

The findings of this study also call on us as a field to expand the current formulation of dissociation as merely a symptom to rid patients of. The findings suggest that dissociative

processes in general, and dissociative attunement in particular, can be painful and problematic but also therapeutic. The findings call us to consider dissociative defenses not only as a symptom to eradicate, but also as a process to get comfortable with and make interpretive sense of. It follows from the findings of this study that mutual dissociative processes, including processes of dissociative attunement, should likewise be respected and carefully used in the treatment to understand a patient's shifting states and re-engage with a patient after a dissociative withdrawal.

Finally, the findings of this study reinforce the importance of the simple and yet incredibly difficult task of listening and sitting with another human being in her or his pain. With the rising pressure to perform only evidence-based interventions in treatment, the social work field is in danger of losing its emphasis on relational healing. We are moving steadily towards a preference for action over the simple and powerful act of bearing witness to a person's pain and resisting the temptation to withdraw or to enact problematic relational patterns. This movement in the field makes me reflect on an admonishment frequently offered by one of my earliest supervisors: "Don't just do something, sit there!" This simple advice is increasingly hard to justify to third party payers and the call to have quantitative empirical evidence for each intervention. The findings of this study suggest that the power of listening to and being with another person, attempting to understand him, *is* an empirically based intervention. Hopenwasser (2008) agrees. She concludes her article by noting: "When we sit with our patients in a state of mutual grief and disappointment, we are utilizing dissociative attunement in its most therapeutic form" (p. 362). The construct of dissociative attunement as defined here holds the potential to support this age-old clinical wisdom with empirical research and encourage clinicians to rely on relational healing even and perhaps especially, with our most traumatized patients.

Implications for Social Work Education

Historically in the study of trauma, the discussion of dissociation has been marked by what is absent and missing from the patient or her narrative, not by what can be generated and made newly available to her through the dissociation. Further, the study of dissociation has been consumed by a one-person psychology. Dissociation is seen as a symptom that exists within the person, not as a process that can be contagious between two people or as an interplay of dissociated self-states in the therapy context. This inquiry opens up the conceptual space for re-examination of these suppositions. The findings of this study imply that social work education would benefit from expansion of the current way we conceptualize dissociation as a symptom to include attention to the interpersonal experience of dissociation in the therapy context.

The findings of this study also reveal the isolation inherent in working with a highly traumatized patient as well as the powerful affective experience this work evokes for the clinician. These findings imply that a clinician entering into this work will need an extensive support network in order to tolerate the intense emotions evoked and to stay attentive to the patient's needs. Clinicians would benefit from the routine incorporation of clinical support or consultation groups into educational institutes as well as training sites. Social work education might also better prime beginning social workers to consider the importance of building in a clinical support network prior to embarking on their professional careers, especially in cases where a student plans to work with a highly traumatized patient population. Finally, social work education would benefit from the publication of accounts of clinicians' internal experiences in working with such a highly traumatized population in the scholarly literature. Such accounts would help to foster a sense of community and offer normalization of these experiences.

The findings of this study emphasize the importance of the clinical construct long taught in the field of clinical social work of “use of self.” They suggest that the construct “use of self” can be more narrowly defined as the use of self-reflection on one’s own countertransference responses in order to understand implicitly derived knowledge and nonverbal affective communication in the therapy dyad. Social work education would benefit from an incorporation of this more narrowly defined construct into student training. This content would be relevant to include in curricula for the Human Behavior in the Social Environment sequence for first year students, as well as Advanced Clinical Practice classes for advanced students.

Schools of social work have become increasingly burdened by the pressure to teach only evidenced-based practices, narrowly defined as those treatments supported by only a particular type of research – the golden standard of the quantitative randomized controlled trial. As schools of social work have increasingly submitted to this pressure, they have begun to divorce themselves from developing the self of the clinician, including the intuition, self-reflection and interpersonal skills needed to build a solid working alliance. Social work education would benefit from the development of small supervision groups in order to provide the format needed for developing clinicians to feel safe enough to explore and reveal their own interior processes as they engage in clinical work.

Interestingly, my findings reveal that those clinicians who identified their theoretical orientation as either psychodynamic, interpersonal or relational were better able to reflect on and name their own internal processes during the session described, as well as reflect in an organized way on the meaning this held for the therapy relationship and what it might communicate about a patient’s state. Participants who were trained psychodynamically were able to resist the temptation to “do something” to make the patient’s dissociation go away and instead were able

to sit quietly, both self-reflecting and paying close attention to the patient's shifting states. For instance, Ruth described her decision to "be quiet" and just wait while her patient dissociated. She explained that she was thinking, "Let's see what she does with it. To be quiet, to see what she does. Those were the first, the initial, like. (sic) Be patient!" I asked her about what she imagined would happen if she stayed silent. She replied:

I don't know. Meaning, literally, I don't know what's going to happen if I'm quiet. . . I wanted . . . to see what she, what would happen. Again, because I think of it as being respectful. And I don't know if that's the best word, but allowing there to be the lack of words. . . .Allowing the experience to happen and by not doing an intervention or intervening, it gave me the opportunity to do what I did, and to be aware of what I was experiencing. What I was thinking, what I was feeling, and again, I can say I think of that as being informative about what she is not able to access. . . Also about the intersubjective experience and the work and then also potentially what we can do with it afterwards.

Ruth described her directive to "be quiet" and wait to see what happens as not intervening. I would argue that this was in fact a powerful intervention, and perhaps harder to execute than using grounding strategies, breathing techniques or another intervention that preferences doing over being. When I asked Ruth where she learned this directive to be quiet, she quickly ascertained that it came from her advanced psychodynamic training. This finding suggests that schools of social work – particularly those designed to train future clinicians for engagement in trauma work – might benefit from incorporation of more psychodynamic theory and practice into their curriculum.

Limitations and Future Research

I approached this inquiry with an awareness of several major limitations. The primary limitation, in my purview, is the difficulty ascertaining the accurate nature of a clinician's internal experience. For the purposes of this inquiry, I obtained each participant's *verbalized*

recollection of her experience, but not her *actual* internal experience. I asked each participant to recount a past experience retrospectively, and as such, the account that each participant offered represented a re-constructed recollection of his/her internal experience only as he/she remembered it. It is likely that participants forgot or reconstructed aspects of their experience on the basis of how they interpreted what happened in the session or what happened in the therapeutic relationship subsequent to this session. In an effort to account for this limitation, I asked each participant to complete a written account of an experience in which the same or a different patient dissociated in session within one month of the interview and I requested that they complete this written account immediately after the session if such an experience occurred. In this way, I was able to obtain a more experience-near account of the clinician's inner experience when a patient dissociates in session. The data from the written accounts did not differ in any substantial way from the data from the intensive interviews and did not yield additional concepts, suggesting that the therapist reports of their internal experience did not change over time. Additionally, there is an accepted standard of researchers utilizing intensive interviews to understand either a patient's or clinician's retrospective recall of the events of a therapy session (McLeod, 2003). Despite this, future research might rely on an interview procedure used in psychotherapy process research called Interpersonal Process Recall (IPR) in order to obtain a clearer picture of what happens moment to moment in a therapy session. The IPR method begins by either audiotaping or videotaping an actual therapy session. Then, either the patient or clinician is invited to view or listen to the tape with the researcher present. The participant is asked to stop the tape whenever he/she decides that something significant occurred, and then he/she is asked to discuss his/her interpretations of the therapeutic event with the researcher. The IPR process seems uniquely able to tap into the participant's perceptions of the

moment-to-moment events or interactions of a therapy session (McLeod, 2003). Future research might incorporate the IPR process in the study of dissociative attunement for a more in-depth analysis of this research question.

Another major limitation of this inquiry is that I did not video record the interviews and therefore I was unable to capture the participants' nonverbal communications in the context of the interview dialogue. In order to account for this limitation, I took scrupulous notes on the nonverbal processes that I was able to witness and retained these notes in the interview transcripts where relevant. This allowed my observations of bodily expressions to be preserved and enabled me to catalogue the participants' nonverbal communications alongside their verbalizations. Future research might include the video recording of each of intensive interview to capture nonverbal communication and to code and analyze parallel processes of nonverbal communication that manifest in the interviewing dyad.

A third major limitation of this inquiry is the relatively small sample size. Rigorous grounded theory projects aim to collect upwards of twenty participants. While this was my goal, recruitment was much longer and much more arduous than anticipated. Many potential respondents did not report having the experience of a patient dissociating in session. Expert clinicians who have worked with severely traumatized patients frequently reported being overextended in terms of their work commitments and unable to devote the time necessary to participate in my study. This limitation was accounted for by collecting data from participants in two formats – the intensive interview and the follow-up written account. Furthermore, coding and analyzing of the data occurred as the interviews continued to progress, allowing me to ensure that my codes were saturated before ceasing my recruitment efforts. Future research in this area

should include a larger and more diverse sample in order to determine if results from this study can be generalized to a larger population of clinicians.

A final limitation of this inquiry is that I interviewed only clinicians about the intersubjective and mutual process of communication of dissociated content in the therapy dyad and neglected attention to the recounted experiences of each patient. Future research might include exploration of patient perceptions and experiences of this process as well, including how patients experienced their respective therapist's reactions to their dissociation in session and what they found helpful before, during and after their dissociation in session. Investigation of patients' accounts of their experiences alongside therapists' accounts would strengthen the understanding of how dissociation is experienced and understood intersubjectively in each therapy pair.

Concluding Remarks

Findings of this study suggest that entering into a therapy relationship with a person who has been injured in unimaginable ways is a grueling process. It engages one's own emotional, physical, and I would argue, spiritual self. It requires that the therapist journey with the patient to the horror of the original trauma and to the edge of sanity and back. In the course of the last two decades, the mental health field has begun to consider the impact of this grueling work on the clinician. Constructs such as vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995) and secondary traumatic stress (Bride, Radey & Figley, 2007) have evolved to name the deleterious impact of engaging in relationship with a severely traumatized person – impacts that rise to the diagnostic criteria of posttraumatic stress disorder. These effects are seen as cumulative. Less attention has been given to the minute-to-minute clinical experience of

engaging with a traumatized patient in their trauma narrative and associated symptoms in the context of a single psychotherapy session. Findings from my study suggest that the ability to stay present to a patient who has entered into trauma time and the willingness to listen to implicitly derived knowledge in the midst of a patient's dissociation in session has the potential to promote attunement, strengthening the working alliance rather than leading to burnout and withdrawal. The construct of dissociative attunement stands in stark contrast to those of vicarious traumatization and secondary traumatic stress. It suggests that something rich and rewarding can emerge from engagement with a highly traumatized patient in both their narrative and their symptoms. The construct of dissociative attunement suggests that the dissociative space should not be merely managed or avoided, but instead entered into. Doing so can promote a powerful experience of connection and communication through the therapist's oscillating and careful attention to self and other.

As a final thought, I will return to the story of Clara. Through my repeated and arduous commitment to staying present to her, even and especially in her dissociative gaps, she moved towards an integration of self and closer relationships with others. Towards the end of her treatment, she presented a second art display, no longer empty and cavernous. This time it was filled with images and artifacts that held tremendous meaning to her. She grouped them together with other items that were somehow related, suggesting the fragmented parts of her narrative and her self were moving towards integration. She titled this artwork: *Connections*.

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Appendix A
Interview Guide 1

Date of Interview:

Time of Interview:

Location of Interview:

Name of Interviewee:

Gender:

Age:

Degree(s) obtained:

Specialized training:

Years in Practice:

Type of practice location:

Previous practice experience:

Trauma training and experience:

Theoretical orientation:

Contact Information for Interviewee:

1. The experience of the patient when he/she dissociates in session

A. Can you describe an experience in which a patient you were seeing dissociated in session?

*What happened?

*What did the patient do or say?

*What happened next?

B. How did you know he/she was dissociating? What were the signs?

C. What triggered the dissociation?

*What led up to it?

*When did it start?

2. The inner experience of the therapist when patient dissociates in session

A. What internal response did you have immediately after you became aware that the patient was dissociating? (Think back to your internal response...)

*What did you feel?

*What was your first thought?

*What did you feel in your body?

*What images came to mind? How long did they last?

* Was that a new feeling/thought/sensation in your body?

PROBE: Can you say more about that? Can you help me understand that?

B. What was your level of focus like?

*How self-aware or not self-aware did you feel at the time?

*How “in the room” did you feel?

C. To what extent did you feel connected to the patient in this moment?

*What gave you this sense?

* How did you know?

3. The impact of the therapist's inner experiences

A. What did you do with your internal responses?

B. How did your internal responses impact how you responded to your patient, if at all?

C. What meaning did you make of these internal responses?

D. What do you think triggered this response from you?

4. The impact on the therapeutic alliance and the treatment

A. Do you think that your patient was aware of your response to his/her dissociation?

*How did you know?/What makes you think that?

PROBE: Can you say more?

B. How did your internal responses change or impact the therapeutic relationship, if at all?

C. How did your internal responses change or alter the progress of treatment, if at all?

D. How might things have gone differently if you might have had a different internal response?

E. How did you choose to intervene?

*What did you do?

*How did the patient respond to that?

*What happened next?

5. Dissociative communication

A. What ideas do you have about what was happening for the patient when she dissociated?

*What do you imagine she/he was thinking?

*What do you imagine he/she was feeling?

*What made him/her not able to articulate this?

B. Are there other ways that this patient has communicated dissociated content in session? If so, can you describe this?

C. More generally speaking, what is your belief or understanding about how other patients communicate to you in therapy the information, affect or parts of self that are dissociated?

6. Debriefing

A. Is there anything we spoke about today that you'd like to clarify?

B. Is there anything else you were hoping to share about this topic today that we didn't get a chance to?

C. Do you have any advice for practitioners who work with patients who dissociate in session?

Appendix B

Updated Interview Guide

Date of Interview:

Time of Interview:

Location of Interview:

Name of Interviewee:

Gender:

Age:

Degree(s) obtained:

Specialized training:

Years in Practice:

Type of practice location:

Previous practice experience:

Trauma training and experience:

Theoretical orientation:

Contact Information for Interviewee:

1. Context of the experience when a patient dissociated in session

A. I'd like for you to bring to mind one significant or salient experience in which a client you were working with dissociated in session. Before we talk more about it, take a minute or so to recall the experience, and let me know when you're ready.

*Can you tell me about what happened?

*What did the patient do or say?

*What happened next?

B. How did you know he/she was dissociating? What were the signs?

C. What triggered the dissociation?

*What led up to it?

*When did it start?

* How did it start?

2. Making Meaning of the Patient's Experience

- A. At the time, how did you make sense of what was happening for the patient?
- B. What thought do you have about why the dissociation occurred at that moment in session?
- C. What do you imagine the patient was experiencing during the dissociation?
- *What do you imagine he/she was feeling affectively?
 - *What do you imagine he/she was thinking?
 - *What do you imagine he/she was experiencing somatically in the body?
- D. How did you come to these conclusions about his/her experience during the dissociation?
- E. What he/she able to articulate this (verbally, at the time or later?)
- F. What function did the dissociation serve, in your opinion (intrapsychically and interpersonally?)

3. The inner experience of the therapist when patient dissociated in session

A. Now I'd like to focus our discussion on your inner experience when the client dissociated in session.

What internal response did you have immediately after you became aware that the patient was dissociating? (Think back to your internal response...)

*What did you **feel?** (affective response)

*What was your first **thought?**

*What did you feel **somatically in your body?**

*What **images** came to mind? How long did they last?

* Was that a new feeling/thought/sensation in your body?

PROBE: Can you say more about that?

How do you feel about that?

Can you help me understand more about what was going on for you in that moment?

How did you interpret that?

What did you make of that?

What you think about that image/internal experience now, what feelings does it evoke for you?

B. What was your level of focus like during the patient's dissociation?

*How self-aware or not self-aware did you feel at the time?

*How "in the room" did you feel?

C. To what extent did you feel connected to the patient in this moment?

*What gave you this sense?

* How did you know?

D. To what extent do you imagine there was either resonance or dissonance between your affective experience and your patient's affective experience?

*Did you feel you made contact with what the patient was experiencing? If yes, how so?

4. The therapist's construction of meaning of his/her inner experiences

A. What did you make of your internal responses? (have already asked this)

*What meaning did you make of them?

B. What do you think triggered this response from you?

C. How did your internal responses impact how you responded to your patient, if at all?

D. What did you do with your internal responses?

E. How do you think it changed how you proceeded in that session, if at all?

5. The impact on the therapeutic alliance and the treatment

A. Do you think that your patient was aware of your response to his/her dissociation?

*How did you know?/What makes you think that?

PROBE: Can you say more?

B. How did your internal responses change or impact the therapeutic relationship, if at all?

C. How did your internal responses change or alter the progress of treatment, if at all?

D. How might things have gone differently if you might have had a different internal response?

E. How did you choose to intervene?

*What did you do?

*How did the patient respond to that?

*What happened next?

6. Dissociative communication

A. In your mind, was there anything significant you learned about the patient as a result of this experience in session?

* Did anything come from it?

*Did you learn anything new about the patient?

B. Was there anything the patient was able to communicate to you as a result of this dissociative experience in session?

C. Has the patient dissociated in session before? If so, has your internal experience or response changed over time? If so, how?

D. Are there other ways that this patient has communicated dissociated content in session? If so, can you describe this?

E. More generally speaking, what is your belief or understanding about how other patients communicate to you in therapy the information, affect or parts of self that are dissociated?

7. Debriefing

A. Is there anything we spoke about today that you'd like to clarify?

B. Is there anything else you were hoping to share about this topic today that we didn't get a chance to?

C. Do you have any advice for practitioners who work with patients who dissociate in session?

Appendix C

Written Case Account: Open Ended Questionnaire

Thank you for agreeing to participate in this study.

Please recount an experience you've had when a client dissociated in session. Please attempt to complete this questionnaire immediately after the session when a client dissociated in session.

How did you know the client was dissociating?

What was your reaction to the client dissociating?

What did you notice in your own inner experience in response to the client's dissociation? Comment on if any particular affective experiences, images, thoughts, memories etc. that came to mind.

What did you do next?

What meaning, if any, did you make of this experience?

Please include an address where I can send a twenty-dollar check to compensate you for your time:

Appendix D

Letter of Invitation

Dear Colleague,

I am a clinical social worker, and a current doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. You are invited to participate in my dissertation research study. The purpose of this study is to explore the nature of intersubjective communication of dissociated content and material in the therapy dyad. Findings will be used to develop the theoretical construct of dissociative attunement.

Specifically, I am interesting in conducting qualitative interviews with psychotherapists who have had the experience of a patient dissociating in session, where dissociation is here defined as moment(s) of disconnect from reality or continuity of thought or memory that occur in session, and which may be evidenced by a blank gaze or an inability to remember what he/she has just been talking about. I will list several criteria for participation in this study:

- 1. Psychotherapist (clinical social worker, psychologist, psychiatrist or counselor) with three or more years of experience**
- 2. Currently working with a client with an early and chronic trauma history (defined as experiences of trauma prior to the age of ten years old in which the trauma was repetitive in nature) who has dissociated in session, but does not have a diagnosis of DID**
- 3. Willing to describe in detail your experience, including internal responses, to the client dissociating in session.**

This study consists of two parts: a one-hour qualitative interview and a one page written case account. Participants will be compensated thirty dollars for participation in the interview, and an additional twenty dollars for completion of the written case account. There are no known risks of participating in this study. All of your responses will be de-identified, and thus your identity will remain anonymous.

If you are interesting in participating in this research, please contact me at the contact information provided below. Thank you in advance for your consideration. Your engagement in advancing the clinical social work knowledge base is greatly appreciated.

Sincerely,

Jacqueline Strait, LCSW
jacqueline.strait@gmail.com
732-547-3127

Telephone Screening Questionnaire

Thank you for your interest in finding out more about my research study. My name is Jacqueline Strait and I am a doctoral student at the University of Pennsylvania. This research study is for fulfillment of the dissertation requirement for the DSW degree at the University of Pennsylvania School of Social Policy and Practice. The purpose of this study is to explore the nature of intersubjective communication of dissociated content and material in the therapy dyad. Findings will be used to develop a theory to account for the way that dissociation is experienced in the therapy dyad.

As part of this study, I am interested in conducting an intensive interview with therapists, which will focus on the nature of the therapist's internal and subjective experience when a client has dissociated in session. So that we are on the same page, I am defining "dissociated in session" as a moment of disconnect from reality or continuity of thought or memory, which may be evidenced by a blank gaze or an inability to remember what the client has just been talking about. This interview will take approximately one to two hours. I am also requesting that each participant will complete a follow up written account, which will take approximately twenty minutes to complete. Do you think that you might be interested in participating in this study?

IF NO: Thank you very much for your time.

IF YES:

Before enrolling people in the study, I will need to ensure that you meet the inclusion criteria for this study. I will do this by asking you a series of questions. You are free to choose not to answer any or all of these questions. Also, I want you to know that all of the information I receive from you by phone or in person, including your name and any identifying information about you will be strictly confidential and be stored in a password protected computer. Do I have your permission to ask you several questions now to determine your eligibility for this study?

IF NO: Thank you very much for your time.

IF YES:

Are you a psychotherapist, either a psychologist, clinical social worker, psychiatrist, or licensed professional counselor, with three or more years of experience providing psychotherapy?

IF NO: While I appreciate your interest in my study, I regret to indicate that you are not eligible for participation at this time. Thank you for your time.

IF YES:

Are you currently treating an adult client (18 years or older) who has dissociated in session? As a reminder, here I am defining "dissociated in session" as a moment of disconnect from reality or continuity of thought or memory, which may be evidenced by a blank gaze or an inability to remember what he/she has just been talking about.

IF NO: While I appreciate your interest in my study, I regret to indicate that you are not eligible for participation at this time. Thank you for your time.

IF YES:

In reference to this client you are treating who has dissociated in session, is this client a survivor of early life trauma (trauma occurred prior to the age of ten years old) in which the trauma was

repetitive in nature, AND does this client present to treatment with symptoms of dissociation (depersonalization, derealization, amnesia, or identity fragmentation or a diagnosis of a Dissociative Disorder according to the DSM)?

IF NO: While I appreciate your interest in my study, I regret to indicate that you are not eligible for participation at this time. Thank you for your time.

IF YES:

I am interested in understanding your internal and subjective experience when this client has dissociated in session. Are you comfortable describing candidly and in detail your countertransference responses, personal thoughts and reactions and therapeutic interventions made in these instances in which your client has dissociated in session?

IF NO: While I appreciate your interest in my study, I regret to indicate that you are not eligible for participation at this time. Thank you for your time.

IF YES:

I plan to audio record the intensive interviews, transcribe them, and then destroy the audio recordings two years after completion of this study. Would you feel comfortable having the intensive interview audio recorded?

IF NO: While I appreciate your interest in my study, I regret to indicate that you are not eligible for participation at this time. Thank you for your time.

IF YES:

You meet all of the necessary inclusion criteria for this study. I would like to share with you additional details about this study before you decide whether or not you'd like to participate.

I am asking that you partake in an intensive interview which will take place over the course of one to two hours. During this time, I will ask that you share your subjective experiences when a client has dissociated in session. I will compensate you thirty dollars in cash for participation in this intensive interview. Within four weeks after this intensive interview, I am requesting that you complete a brief, one page written account of a second experience of a client dissociating in session that occurs in the four weeks following our initial interview. I will request that you send this account to me via mail, in a pre-addressed and pre-stamped envelope. I will compensate you twenty dollars in a check written out to cash for completion of this written account. If you complete both the intensive interview and the written account, the compensation for participation in this study is a total of fifty dollars.

The intensive interview, should you choose to participate, will take place in any private location of your choosing so as to maintain your privacy. If no such place is available, we can utilize my private office in Center City, Philadelphia at a time when no other people are in the building. In both the intensive interview and the written account, I will be interested in understanding your experience. I will not ask about any private health information or identifying information about your client(s).

The information you share about yourself will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information or information about where you live or work in my discussion of the interview. No information with your name or other identifying information (names and places mentioned in the interview) will be transcribed or retained for any purpose. I am the only

person who will be able to listen to the audiotape. I will destroy the tape two years after completion of this study. Once the written account has been analyzed, I will destroy this document as well. I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview, in the results section and in the final write-up of my dissertation. Instead, I will utilize a pseudonym when discussing the information you revealed, so that your identity will not be linked to the data.

The risks of participating are minimal. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. In this case, I will be happy to provide you with some names and numbers of individuals or agencies that can provide further assistance.

Although being interviewed will not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you. Furthermore, you will be contributing to the development of knowledge in the area of clinical social work and the related mental health disciplines.

Do you have any additional questions for me?

IF YES: Respond to questions.

IF NO:

Your participation in this study is completely voluntary. Would you like to participate in this study?

IF NO: Thank you very much for your time.

IF YES:

Excellent. I appreciate your interest in participating in this study.

I would like to schedule the intensive interview approximately two weeks from today. During the upcoming two weeks, I would like for you to pay specific attention to your inner experience in session and countertransference responses when a client dissociates in session in the upcoming two weeks, prior to meeting for the scheduled intensive interview. Now let's discuss where and when would be preferable for you to meet for the intensive interview.

Appendix F

Participant Consent Form

Title of the Research Study:

Dissociative Attunement: The Development of a Theoretical Construct

Protocol Number:**Principal Investigator: (name, address, phone and email)**

Jacqueline Strait

605. N Atlantic Ave Unit 211

Collingswood NJ 08108

Jacqueline.strait@gmail.com

732 547 3127

Emergency Contact: (name, address, phone and email)

Gregory Strait

605 N Atlantic Ave Unit 211

Collingswood NJ 08108

straitg@gmail.com

203 948 4917

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if decide to participate. The research team is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor and family.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

This study is for fulfillment of the dissertation requirement for the DSW degree at the University of Pennsylvania School of Social Policy and Practice. The purpose of this study is to explore the nature of intersubjective communication of dissociated content and material in the therapy dyad. Findings will be used to develop the theoretical construct of dissociative attunement.

Why was I asked to participate in the study?

You are being asked to join this study because

You meet the following inclusion criteria for this study:

--Psychotherapist (clinical social worker, psychologist, psychiatrist or counselor) with three or more years of experience

--Currently working with a client with an early and chronic trauma history (defined as experiences of trauma prior to the age of ten years old in which the trauma was repetitive in nature) who has dissociated in session, but does not have a diagnosis of DID

--Willing to describe in detail your experience, including internal responses, to the client dissociating in session.

How long will I be in the study? How many other people will be in the study?

The study will take place over a period of 1 month. You will be asked to dedicate one hour to one and a half hours for an in-person intensive interview, and then complete a written case account (instruction to be provided upon the interview) within one month of the intensive interview. This will take approximately thirty minutes. Therefore, participation in this study will take a total maximum of 2 hours over the course of one month.

You will be one of eight to twenty people participating in this study.

Where will the study take place?

The intensive interview can be conducted in a quiet place of your choosing that will be free from distractions. If there is no such place available, I will be happy to meet in my office at 1904 South Street in Philadelphia. You will be asked to complete the written case account electronically and send to principal investigator via electronic mail.

What will I be asked to do?

I will ask you to meet in person for an intensive interview, which will last approximately one to one and a half hours. I will make an audio recording of the interview and may take written notes. Later, I will

transcribe the interview, removing any identifying information about you. Then I will destroy the audiotape.

During the interview, I will ask you questions about your experience in a therapy session during which a patient displayed dissociative symptoms, your internal response to this experience, the impact of this experience on the therapy and the therapeutic relationship, and your ideas about dissociation and dissociative communication in the context of therapy.

Within one month of this interview, I will ask you to complete an open-ended questionnaire that will guide you through a written case account of a second experience in which a client you were treating dissociated in session. This will take approximately thirty minutes. I will ask that you complete this questionnaire electronically and send to the provided email address using electronic mail. Of course I will ask that you remove any identifying information from your written case account in order to protect both yours and your client's confidentiality.

What are the risks?

The risks of participating are minimal. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. In this case, I will be happy to provide you with some names and numbers of individuals or agencies that can provide further assistance.

How will I benefit from the study?

Although being interviewed will not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. Your therapist, social worker, nurse, doctor or will not be upset with your decision.

When is the study over? Can I leave the study before it ends?

You have the right to drop out of the research study at anytime during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so.

You can withdraw from the study by contacting the principal investigator and simply indicating that you are no longer interested in participating in this study. There are no consequences to withdrawing from this study.

How will confidentiality be maintained and my privacy be protected?

The research team will make every effort to keep all the information you tell us during the study strictly confidential, as required by law. The Institutional Review Board (IRB) at the University of Pennsylvania is responsible for protecting the rights and welfare of research volunteers like you. The IRB has access to study information. Any documents you sign, where you can be identified by name will be kept in a locked drawer in my home office. These documents will be kept confidential. All the documents will be destroyed when the study is over.

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information or information about where you live or work in my discussion of the interview.

Any information with your name or other identifying information (names and places mentioned in the interview) will be transcribed or retained for any purpose. I am the only person who will be able to listen to the audiotape. Once the interview has been transcribed, I will destroy the tape. Once the written case account has been analyzed, I will destroy this document as well. I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview, in the results section and in the final write-up of my dissertation.

What happens if I am injured from being in the study?

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?

Participation in this study will come at no cost to you.

Will I be paid for being in this study?

Participants will be compensated thirty dollars in cash for participation in the interview, and an additional twenty dollars by check for completion of the written case account.

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject

Print Name of Subject

Date