

## In the “I”s of the Beholder

### *Dissociation and Multiplicity in Contemporary Psychoanalytic Thought*<sup>1</sup>

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#### Abstract

The contemporary psychoanalytic concept of dissociation leads paradoxically to the conclusion that the self is both a unity and a multiplicity. Against the normative interpretations of Stern, Bromberg, and Davies, the present study conceptualizes dissociation categorically in terms of two subtypes with two distinct levels. The proposed classification scheme is consistent with the growing body of research on the subject. However, a categorical view of dissociation vitiates the soundness of the argument for normative multiplicity. In the absence of an intrinsic link to pathological dissociation, multiplicity is more parsimoniously understood without reification in terms of conflicting aims, beliefs, and feelings within an integrated self.

IS THE SELF a unity or a multiplicity? The paradox of dissociation is that it supports each of these irreconcilable alternatives. On the one hand, dissociation reflects a splitting of consciousness irreducible to the dissociative impact of traumatic experience alone. Constitutionally-weakened ego capacities are a necessary condition for pathological splitting; their absence implies normative cohesion (Janet, 1907; Kernberg, 1984). Yet, according to some contemporary authors (Bromberg, 1993; Davies, 1996), dissociation also preserves continuity by restricting the interpretation of experience. It galvanizes the illusion of unitary selfhood by exploiting the incomplete autobiographical information available to the subject and, from the standpoint of adaptation, furthers the human capacity for multiple engagements. In this interpretation, the self resembles a collection of distinct self configurations rather than a mosaic whose meaning transcends its individual elements. Like a kaleidoscopic image (Davies, 1998), self configurations represent the ever-changing patterns or relationships among self and other integrated developmentally by the illusion of unitary selfhood. No longer a dramatic, but infrequent clinical finding, dissociation fashions the unique experiential configurations achieving consciousness only through the creative use of language. Multiplicity animates a new perspective in which the analytic task consists not

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in uncovering truth, but in creatively constructing new meanings from the raw elements of experience. Expanding subjectivity rather than unmasking repression describes the postmodern therapeutic project.

The following paper critically examines the concept of dissociation and argues that it is neither intrinsically linked to unformulated experience nor best conceptualized dimensionally. A critical review of the literature reveals strong evidence for two types and two levels of dissociation. Specifically, it identifies compartmentalization and detachment as distinct entities which may be characterized further as normal or pathological. The proposed two-by-two matrix is offered as an alternative to current relational views. A more differentiated concept of dissociation is consistent with clinical and research findings (Waller, Putnam, & Carlson, 1996) and less encumbered by postmodern philosophical commitments.

The implications of this position are devastating for multiplicity which its proponents rightly perceive to rest fundamentally upon a normative-dimensional concept of dissociation. If dissociation is a distinctive pathology, then the “I” of experiencer (the self) is not an illusion, adaptive or otherwise. If there is an illusion, it exists primarily in the “I”s of the beholder who construes self-states literally as independent centers of consciousness. Multiplicity is a powerful and clinically useful metaphor that focuses attention on the complexity, discontinuities, and contradictions of human experience. It reflects the analyst’s creative development and playful holding of multiple, often contradictory perspectives of the patient. To view these perspectives otherwise exaggerates the magnitude of normative discontinuities in subjective experience that are more parsimoniously understood in terms of conflicts within an integrated psyche. Trading on the ambiguity of dissociation creates confusion about its defensive function and facilitates reification. It also encourages efforts to utilize dissociation therapeutically as a means of achieving more comprehensive results. I contend that many of the clinical findings discussed under the rubric of dissociation are not pathologically dissociative, but instead reflect commonplace experiences found almost exclusively in non-dissociative disorders and, often, in non-clinical samples. For this reason, greater terminological precision is necessary.

### **Stern’s Position**

Rather than given, consciousness is fundamentally an act of creativity and construction. For Stern (1997), it is creative because meaning does not exist *a priori* in a preformed state, but instead results from the interpretation and linguistic formulation of experience, always from a particular narrative perspective. He captures the phenomenological spirit of this interpretive creation in his concept of unformulated experience which reflects “...the initial phase of all thought processes” (Barth, 1998, p. 690), derivative neither of conflict nor repression. Following Sullivan (1950), he distinguishes conscious from dissociated experience by virtue of whether it has been noted or formulated. With appropriate attention and linguistic formulation, the implications of experience are brought into awareness. Dissociation reflects the avoidance of or failure to formulate these implications. It is a continuum concept defined at one extreme by experiences readily

formulated with appropriate attention or effort and, at the other, by trauma that can neither be spoken nor known.

Unformulated experience is not limited to the immediate contents of awareness. It is bound neither by the totality of conscious and unconscious thought nor the degree to which experiences achieve creative expression linguistically. Because it projects temporally into the future, consciousness never is constituted fully by its immediate contents. It anticipates and is directed toward what lies beyond the present moment. Potential experience always is unformulated; it is experience the subject has not yet had. Since dissociation is defined as *any* nonrepressive interpretive restriction of experience, potential experience is both unformulated and dissociated. Even “[t]he stereotypic use of language is always dissociative, because it precludes new experience” (Stern, p. 113). In this way, unformulated experience encompasses all but the immediate contents of awareness, extending far beyond experiences that are defensively avoided. Although retaining the concept of repression, Stern’s philosophical stance offers no clear procedure for identifying it clinically. Inasmuch as almost all new learning, thinking, and perceiving bespeak movement from an unformulated to a formulated state, his subject lives in a state of perpetual dissociation, finding meaning only episodically and effortfully.

Stern is less interested in dissociation in its traditional sense as a traumatic fragmentation of consciousness. He focuses instead on its normative-defensive possibilities in which “prevention of interpretation” (p. 87) is the critical dimension unifying normal and pathological dissociation. Whereas repression banishes incompatible ideas via disguise without disrupting personal continuity, dissociation divides consciousness and the traumatic experience contained therein, thus limiting the kinds of stories that can be told (Stern, 1997). However, how does the restriction of interpretation differ from the exclusion of meaning, particularly when Stern acknowledges that both dissociation and repression operate outside of awareness on organized mental content? If the former intentionally (defensively) prevents awareness of some “already highly structured” (p. 114) meanings, thus unintentionally restricting the probability of knowing others, interpretive restriction alone may not adequately distinguish these mechanisms.

This distinction is especially difficult to maintain when one considers the impact of these defenses on *subsequent* experience. Even if it uniquely deletes self-knowledge rather than dissociatively restricting interpretation, does not repression restrict “the kinds of stories that can be told”? This point is particularly forceful within a postmodern sensibility. If there are only perspectives on experience, any suppression of meaning necessarily alters narrative possibilities. For this reason, Stern’s analysis is less an indictment of repression than of the modernist framework in which its classical interpretation is embedded.

### **Relational Extrapolations**

If Stern is concerned primarily with a postmodern relational positioning of dissociation, Bromberg links it inextricably with multiplicity. Taking the infant’s inability to integrate discrete experiences as paradigmatic of the fragmented, discontinuous, and nonlinear nature of self experience, he reasons that these experiential units constitute

separate selves. Dissociation is critical to his thinking because it bridges Sullivan’s concept of multiplicity and its postmodern interpretation. Not only does one have as many personalities as one has interpersonal relationships (Sullivan, 1950), but as many self-states as one has unique experiences. Dissociation creates the monadic self-states that are juxtaposed to the possibility of a unique and abiding personal identity. This interpretation also permits Bromberg to conclude that the self integrating one experience is not necessarily the same as that integrating another.

Multiplicity, therefore, is not simply an interpretive stance that more accurately describes the complexity, contradictions, and paradox of human experience. It is not be confused with the position that narrative descriptions always are partial and told from a particular point of view and for a particular purpose. Nor does it permit the reduction of personal identity to an unstructured accumulation of interpretive constructions mapped upon a landscape of unintegrated self-states. No longer a unity within which conflicting aims coexist, the self (alternatively referred to as the “I”, experiencer, or subject of experience) is an illusion that dissociatively conceals the “ongoing dialectic between separateness and unity of one’s self-states” (1996, p. 514). Experience is traumatic when it threatens this illusion and prompts actual fragmentation. Dissociation is adaptive to the extent that it fuels illusion. Its adaptive function also is seen in moments of absorption in which “...full immersion in a single reality, a single strong affect, and a suspension of one’s self-reflective capacity is exactly what is called for or wished for” (p. 514-515).

Bromberg uses the term nonlinear to articulate his vision of the self as system of relationships not adequately represented in any single or hierarchical organization of self-states, but rather as “standing in the spaces” among them. In contradistinction to terms like sequential, hierarchical, and deterministic, nonlinear implies that effects are not proportional to their causes. In complex systems, small, even undetectable differences in initial conditions have dramatic, often unpredictable effects. The so-called “butterfly effect” (Lorentz, 1963) denotes the sensitive dependence on initial conditions.

But to conclude, as Bromberg does, that the self possesses no nonillusory unique organization, hierarchical structure, or patterning is unwarranted. Chaos theory precludes neither hierarchical organization nor integration of component processes. That small differences often have unanticipated effects does not imply that systems lack organization or purpose. Whether in meteorology or organizational behavior, complex systems reflect significant patterning, redundancy, and structure. This is true even of self-organizing systems in which component processes are coordinated and operate synergistically (Gershenson & Heylighen, 2003). While Bromberg correctly asserts that personal identity is reducible neither to the totality nor to any subset of dichotomous, interacting selves, his rejection of nonillusory patterning of the self and personal identity is problematic. Complexity and structure necessitate hierarchical organization which, in turn, allows complex systems to function with purpose. In human beings this unique patterning is what terms like identity, character, and personality connote.

Although the idea of the self as a creative fiction can be found outside of psychoanalysis, few see it as linked intrinsically to a rejection of hierarchical organization

(Dennett, 1991). Dennett, for example, describes the self as “center of narrative gravity” (p. 427), as an abstraction composed of autobiographical statements, beliefs, and perceptions. It is the residue rather than the author of these “self-protective strings of narrative”. But, in contradistinction to Bromberg, he contends that the content of the self is uniquely organized and that its existence and development are biologically determined. From an evolutionary perspective, the self furthers efforts at adaptation by providing an efficient means for the transmission of information, skills, and practices. What distinguishes this account is its positing of organization and purpose without reference to a Cartesian subject.

### **The Dissociative Matrix**

In many respects, dissociation is a common experience. For example, after my morning shower, still groggy from having just awakened, I cannot recall whether or not I washed my hair. Puzzled and frustrated by my inability to recall what transpired only moments earlier, I slowly reconstruct my actions only on the basis of the evidence provided by my wet hair. As in highway hypnosis, I carried out a series of complex, coordinated, goal-directed behaviors automatically with little awareness or focused attention. Although prevalence rates for dissociation fall between three and ten percent of the population (Loewenstein, 1994), these estimates increase to between forty-six and seventy-four percent when its definition is broadened to include examples like the one presented above (Hunter, Sierra, & David, 2004). Similarly, if high scores on the Dissociative Experiences Scale (DES) are interpreted to reflect dissociative pathology, then as many as nine percent of college students suffer this disorder (Murphy, 1994). Findings like these create the impression that normal and pathological dissociation are distinguishable by virtue of the frequency with which they occur. In other words, the difference between them is quantitative rather than qualitative.

The impact of definitional imprecision is not limited to prevalence rates alone. It also has a deleterious effect on the communication of clinical findings. When analysts speak of dissociation, they refer to one or more of the following: Daydreaming; hypnogogic phenomena and reverie; imaginative absorption; heightened suggestibility; altered states of consciousness; selective inattention; unawareness; unformulated experience; fleeting feelings of unreality; anxiety/panic states; splitting; conversion symptoms; amnesia; derealization/depersonalization; and/or the presence of alter egos. In addition, analysts employ the term ambiguously to describe defensive operations which engender these symptoms by preventing the integration of experience. Are all of these accurately depicted as instances of the same phenomenon differing only in severity? Or are they more aptly described in terms of two or more distinct variables? Within the psychoanalytic context, imprecision only adds to the formidable challenges facing analysts who wish to maintain some separation between clinical findings and their interpretation.

In response to this ambiguity, Cardena & Wiener (2004) urge a more integrative approach in which one speaks of a “domain of dissociation” (p. 457). Cardena (1994) identifies two core features of dissociation: Compartmentalization and detachment. Consistent with Janet’s original description, compartmentalization refers to the “coexistence of separate mental systems that should be integrated in the person’s consciousness, memory,

or identity” (p. 19). Neither the coexistence of systems nor unawareness of them implies dissociation. What is critical is that these systems are integrated under normal circumstances. The example of my hair-washing “amnesia” therefore offers weak evidence of dissociation because the activity, although coordinated, normally is executed automatically without focused attention or conscious integration. It is a routine activity forgotten during a time of incomplete wakefulness and fatigue. Like riding a bicycle, it is a complex activity that curiously requires no conscious integration, planning, and monitoring.

It is particularly important for psychoanalysts to note that conscious awareness is not a critical component of compartmentalization. Attention and executive functioning, including the coordination of myriad subordinate neuropsychological systems, regularly occur without awareness. That these functions are brought into awareness under certain circumstances does not mean they otherwise are dissociated. Automacity economizes effort and enhances efficiency. It is therefore inaccurate to designate each and every instance of integration failure also as an instance of compartmentalization; compartmentalization signals an “unexpected failure of integration” (Stern, p. 19) in which recall cannot be brought under volitional control. Because the nonintegration of unformulated experiences is “expectable” (Stern, 2003, p. 87), it is not intrinsically dissociative. The fact that something nonconscious is made conscious with appropriate attention and linguistic formulation does not in itself warrant this inference. This is true as well for many types of state-specific learning whose evidentiary value, contrary to Bromberg (1994), is limited. Fundamentally, compartmentalization reflects a primary deficit in retrieval rather than encoding (Cardena, 1994).

By detachment or disengagement Cardena refers to “qualitative departures from one’s ordinary modes of experiencing, wherein an unusual disconnection or disengagement from the self and/or the surroundings occurs as a central aspect of the experience” (p. 23). Excluded are “ordinary instances of less-than-full engagement with one’s surroundings, experiences, and actions”. Daydreaming, fatigue, and meditative states are instances of less-than-full engagement with one’s surroundings that are not dissociative. In contradistinction to compartmentalization in which processing occurs, but is neither formulated nor retrieved, detachment refers to experiences that are not encoded in a characteristic or normal fashion. The terms “characteristic” or “normal” are important modifiers because they exclude experiences not encoded for non-psychological (neurological) as well as attentional reasons. That I do not attend equally (or at all) to aspects of an experience does not mean I have dissociated them. Attention is selective and less likely to register those elements lacking salience.

Holmes, Brown, Mansell, Fearon, Hunter, Grasquillo, & Oakley (2005) offer several additional reasons for distinguishing these two variables: (a) Both compartmentalization and detachment occur in isolation in specific psychiatric disorders. For example, patients suffering Somatization Disorder frequently manifest signs of compartmentalization without any evidence of detachment. (b) Numerous factor analytic studies of the DES identify these factors. (c) Experimental findings support the idea of a unique neuropsychological profile of detachment, consistent with hyperarousal and anxiety. These include inhibition of the limbic system accompanied by activation of the right prefrontal cortex producing a state of

vigilance, widened attentional focus, and the absence of emotion (Sierra & Berrios, 1998; Noyes & Kletti, 1977; cited in Holmes et al., 2005).

Although these data strongly support the claim that dissociation is best understood categorically, they do not preclude the hypothesis that detachment and compartmentalization are dimensional variables. Despite the fact that they can be reliably distinguished, they may nevertheless vary by degree across individuals and thus support a continuum view. This question can be reframed empirically in the following way: Are dissociative symptoms observed in both clinical and nonclinical samples? If so, do the types of symptoms observed differ between groups?

Waller and his co-investigators offer powerful evidence that two levels of dissociation—normal and pathological—can be reliably distinguished. This opinion is based on a sophisticated statistical analysis of DES results which reveals a dissociative taxon (DES-T) or latent class variable believed to be a marker for pathological dissociation. They cite three specific findings to support this hypothesis: (a) High DES-T scores are observed rarely in nondissociative psychopathology; (b) High DES-T scores occur infrequently in non-clinical samples; (c) The inclusion of “normal” (expectable) dissociative experiences falsely inflates frequency estimates in all samples. For this reason, they recommend excluding absorption experiences from the concept of pathological dissociation because of its ubiquity and lack of discriminant validity. Their findings accord with those of Janet who regards pathological dissociation as a rare occurrence. Constitutionally-weakened ego capacity is not normally distributed or a trait that one possesses to varying degrees. Rather, the presence of pathological dissociation, for Janet, is *prima facie* evidence of a taxon for this disorder, inversely related to resilience and/or coping ability.

These data are summarized in Table 1. The proposed two-by-two matrix highlights the clinical and research findings in support of the hypothesis that there are two types and two levels of dissociation. This framework allows one to differentiate those types of dissociation that are nonpathological and under volitional control from those found in dissociative pathology. Although Cardena suggests that such phenomena be excluded altogether, their inclusion is warranted by the valuable clinical insights they convey so long as they are defined clearly. By contrast, pathological dissociation refers to symptoms rarely found in non-clinical samples and, more significantly, in non-dissociative psychiatric disorders. Although absorption experiences superficially appear to embody both types of dissociation, it is categorized under normal detachment following Cardena’s suggestion. When absorbed in an experience, one necessarily “detaches” from (fails to encode) other facets of the experience and, therefore, experiences difficulty remembering them. Clearly, however, one cannot retrieve experiences that have not been encoded.

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### **Normal Detachment**

Amy is a twenty-three year old female graduate student who enters psychoanalytic psychotherapy with a significant work inhibition. Although having obtained faculty sponsorship for an interesting and ambitious dissertation project, she fails to meet subsequent deadlines and flounders in the absence of structure. To complicate matters, she roils at questions from her father about her progress, believing he suspects her of avoiding the “real world”. Dynamically, her work inhibition powerfully confirms her father’s disparaging view, fueling her depression and further paralysis.

Amy is required to present her work to supervisors and fellow interns. Although generally comfortable in the company of others, public speaking generates inordinate anxiety and self-doubt. She typically ruminates about such tasks, getting little sleep as a result. On one occasion, still dreading the prospect of exposing what she perceives to be glaring personal flaws, she notices a diminution of her anxiety several hours before the talk. Still anxious and activated, she cannot direct her energy purposefully. The feeling is similar to how she feels after a run or tennis match: she cannot focus on any one thing. Rather than concentrating on the final changes to her presentation, she fantasizes about being somewhere else. She likens this mental state to “sleepiness”.

Just prior to the presentation, Amy meets with a supervisor who is warmly supportive and reassuring. He compliments her work and expresses confidence that it will be well received. But rather than feeling reassured, Amy says that his words do not “sink in”. Her attention narrows to the point where she observes qualities about herself and of her supervisor that she has not before noticed. For example, she is appalled by her rapid speech, the nasal tone of her voice, and how often she mutters “uhm” during pauses. More an observer than a participant, she feels like she is watching her interaction from a distance, unable to fully engage. Her mind oscillates between their conversation, her discomfort about the presentation, and the mismatch between her supervisor’s shirt and tie. Importantly, she participates in the conversation, but with divided attention.

Although the mechanism of detachment influences Amy’s processing and perception in this context, it is consistent with the narrowing of attention that occurs under conditions of hyperarousal and anxiety more generally. This state is poorly adapted to the reflective stance necessary in these circumstances. Her attentional resources are strained to capacity, thus producing the experience of sleepiness and inattention. However, at no point does she lose contact with self and/or reality. Although anxiety causes psychological disengagement, identity is maintained and these symptoms disappear several minutes into her presentation.

### **Pathological Detachment**

Under the current visitation agreement, Josh, age twelve, spends alternate weekends with his abusive, mentally unstable father. His propensity to violence is so great that Josh’s mother absconded to another state with the children to escape his stalking of her following their divorce. On one occasion prior to the family’s relocation, he beat and raped her while

Josh and his two siblings sat terrified in another room. The family lives in constant fear of this man.

Initially, Josh does speak of these matters. He describes the events in his life, including visits with his father in a slow, controlled, emotionless fashion. Feelings are expressed mechanically and with detachment: “I’m sixty-four percent sad, 17 percent angry, eleven percent worried, and eight percent confused”. He uses emotion words, but can neither elaborate them nor identify any thoughts that accompany them. Without friends or meaningful social contacts outside his immediate family, Josh is as disconnected from others as he is from himself.

In one session, Josh describes some of the activities and interests he shares with his father. Over his mother’s objections, he competes in motorcross racing. Josh feels pressured to participate lest he anger his father, but also claims to enjoy these activities, despite frequent and serious injuries. His affect is completely at variance with his words, barely conveying enough detail to make the story credible. Like so many events he describes, the account does not come alive in any way.

Only months later does Josh report an incident in which his father struck his younger brother. The boys had been arguing over a television show. Enraged, his father yelled, cursed, and smashed dishes as he threatened to kill them. Josh remembers seeing an object sail past him, followed by his father standing very close to him, yelling and threatening him. However, his very next memory is his mother’s discovery of a bruise on his brother’s arm after the children returned home that evening. He remembers nothing more about the events in his father’s home. Only later, after much therapeutic work, does Josh describe “going somewhere else” in his mind. He likens the experience to watching a television program or having a dream, feeling unsure about whether certain events happened or not. His fragmented recollections, therefore, do not reflect forgetting (compartmentalization), but profound psychological detachment from these frightening events. “Maybe he hit my brother—I’m not really sure”. He is willing to face the truth and draw appropriate inferences about these events in the safety of my office, but, at the time of their occurrence, had to escape overwhelming anxiety and fear. Detachment and opacity of perception protected him from even greater psychological danger.

### **Normal Compartmentalization**

One patient, a collegiate basketball player named Joe, entered treatment because of ongoing problems with his girlfriend. Joe was deeply committed to this deeply mistrustful, almost paranoid woman insisted on knowing every detail about how he spent his time away from her. His gregarious, social nature was a continual source of conflict, particularly when he spoke with other women. Joe was always conciliatory and contrite.

In one session, Joe spoke of his disappointment that his girlfriend had not attended a game in which he had played very well. He proudly reported that he had been “unconscious” and in a “zone”. That is, not only was he immersed completely in the game,

but reacted automatically, almost reflexively, to all of the events within the game. Despite the complex interpretation, planning, and motor execution necessary for this performance, Joe did not think or deliberate about it. His actions were executed with little mediation by conscious awareness.

Similar circumstances surround instances of forgetting that have no organic basis and are not the result of pathological compartmentalization. A college professor reported embarrassment about his difficulty remembering names. Not infrequently, he could not remember the name of someone with whom he had regular contact. The name just escaped him. He experienced this difficulty particularly when he encountered people outside of the setting with which he associated them. For example, although he made a point of knowing each student’s name, he might experience retrieval difficulty if he encountered a student at the grocery store. Less frequently, this occurred with colleagues as well. The professor experienced considerable social anxiety for this reason, ever vigilant when out socially, ever fearful of failing to remember someone’s name when it did not immediately come to mind. Interestingly, with the slightest prompt or cue, accurate recall was immediately restored.

### **Pathological Compartmentalization**

Lauren is an unmarried, thirty-three year old mother of two. Referred to psychotherapy for symptoms of depression and anxiety, Lauren immediately evidenced myriad symptoms of pathological compartmentalization. Although she had no recall for the events, she believed that she had been abused by her older sister during her latency years. She was certain that something terrible had happened, basing this belief on the inexplicable discomfort she felt in her sister’s presence, a combination of dread, anxiety, and anger. Yet, she was unable to call to mind any specific memory of this abuse. The prospect of discussing this was so upsetting that she arrived for one appointment accompanied by her boyfriend so that he could speak for her. As I listened, she closed her eyes and assumed a posture in which her hand was raised with the palm opened outward as if to protect herself from attack. She did this without awareness and with no subsequent memory of it. However, while exploring this enactment, she suddenly felt overwhelmed by the memory of her sister locking her in a closet, threatening to kill her if she told their parents. She vividly described her sister beating her with their father’s belt. This led to further memories of abuse she suffered both physically and mentally at the hands of her sister and sadistic father. She wept as she recalled these painful events.

As the treatment progressed, Lauren related a series of masochistic relationships with men, usually following disappointments in other relationships. She was “not herself” in these relationships, feeling like “another person” because, as she understood now, she did not simply permit, but pursued degradation and abuse. Although no alters were identified, there was a clear shift in identity and her sense of self, such that she not only felt differently, but seemed to act in accordance with different values. For example, generally conservative in her relationships with men and protective of her children, Lauren took great risks when under the sway of these powerful emotions. Although largely unavailable to consciousness, recollections during treatment were paralyzing. While driving on one occasion, she was so overwhelmed by the intrusion of these thoughts that she swerved onto a service road,

unclear about what had transpired for several minutes as she literally relived being terrorized by her sister. She finally called her boyfriend to collect her.

### **Therapeutic Dissociation**

Davies (1998) sees the mind as a “...multiply organized, associationally linked network of parallel, coexistent, at times conflictual, systems of meaning attribution and understanding” (p. 195). Dissociation rather than repression provides critical linkages between key early internalized object relations and their reenactment in the treatment relationship. Whereas Stern emphasizes the importance of a generic expansion of interpretative possibilities denied formulation by their embeddedness in the interpersonal field, Davies advocates the “psychic de-homogenization” (1998, p. 202) of these experiences through a process called “therapeutic dissociation” (p. 196).

What is therapeutic dissociation? Davies describes it as the suggestive facilitation of “...alternate self-object configurations...[allowing]...a particular dissociated aspect of experience..” (1996b, p. 567) to find full expression. These configurations are self-contained and uniquely reflect their historical roots—a striking claim given the postmodern rejection of historical truth, but one privileged, according to Davies, by independently confirmed, dissociatively concealed instances of abuse (1996a).

Davies invites dissociation in the following way:

Let us suppose that I could have a moment with this part of you; that we can assume for the present that this is the only part of you; that this part of you does not need to compromise itself in any way in order to get along with the other parts of you; that we can invite her into our therapy together, and allow her in the most playful spirit imaginable, to be with us, all of the many things she cannot be anywhere else (1998, p. 196).

Recognizing the dangers this technique presents for less integrated patients, Davies recommends it only when the analyst believes that “...the patient can withstand the temporary suspension of more overarching, cohesive levels of psychic organization...” (p. 196) in order regressively to uncover experiences otherwise unavailable to awareness.

Davies’ articulates the logical conclusion of a perspective in which dissociation is the organizing principle of a multiple mind. If the fundamental problem facing our patients is the dissociative impoverishment of subjectivity, then reintegration of dissociated experience is necessary therapeutically. This conclusion rests on the truth of two related empirical claims: First, alternate self configurations are not merely interpretively distinct, but dissociated. Second, therapeutic dissociation “dehomogenizes” the illusion of unity masking these dissociated configurations. Davies attempts to establish both premises on the basis of clinical findings from her treatment of Monica who, several years into treatment, confides that she had imaginative playmates as a child all of whom were “different versions” (p. 200) of her. At Davies suggestion, Monica elaborates memories of these “others” which the analyst understands as releasing heretofore dissociated experiences representing

“...intensely conflictual irreconcilable aspect[s] of self-other experience...” (p. 201). With respect to the first claim, Davies asserts the irreconcilability of these “versions” without elucidating the basis for this inference and despite the fact that the patient speaks of them in an integrated fashion. What else can Monica mean by the statement that these experiences are “all different versions of me”? Davies reifies the iatrogenically suggested others rather than understanding them as a narrative device or transference idiom co-constructed over years of treatment. These experiences are significant because they convey fantasies and desires in a way that invites the analyst’s participation. But they lack the distinguishing features of detachment and/or compartmentalization that warrant the diagnosis of dissociation in a clinically meaningful way. An equally strong case can be made that they represent the functioning of the mind at its highest levels, displaying an appreciation of the complex interplay between similarity and diversity.

Second, Davies assumes therapeutic dissociation to be dissociative without considering the possibility that what she identifies as dissociation is not defensively foreclosed experience, but instead experience not ordinarily attended to and integrated consciously into awareness. This experience is dissociative, if at all, only in a broad, “expectable” sense of the term. Therapeutic dissociation is thus no different from the suggestion to the patient to take a different perspective on experience. For example, if invited to evaluate experience E from the perspective P or, alternatively, to consider E from the standpoint of his or her perspective at time T, isn’t the patient engaging in the very same activity Davies privileges, but without reification and unnecessary epistemological assumptions? Davies construes Monica’s description literally rather than considering the possibility that it represents her unique way of constructing a new perspective.

More devastating to her position, however, is the argument advanced by the social modeling perspective which attributes Davies conclusions to the conflation of dissociative effects with their causes (Kilstrom, 1985). Rather than an altered state of consciousness, Davies identifies a specific type of psychoanalytic interaction in which the patient responds to the analyst’s suggestive influence (Kirsch, 1990). What she construes as causally relevant to the patient’s current condition (i.e., dissociated self-configurations or experiences) is in fact a uniquely “relational” response to (and effect of) her suggestive intervention. While it neither diminishes the importance of these experiences nor is inconsistent with her relational stance, that Davies uncovers a transference response rather than a dissociated self-state vitiates the soundness of her conclusions regarding multiplicity.

Ultimately, the decision to employ dissociation therapeutically rests on the clinical assessment of integration and intact reality testing. Only then is a temporary suspension of cohesion justified. However, Davies’ vignettes lead to contradictory conclusions on this point. In the first, the patient possesses the requisite degree of integration necessary for therapeutic dissociation; in the second, her presentation changes dramatically, raising concerns about the patient’s “apparent decompensation” (p. 203). Davies contends that the experiences reported during this phase of treatment are available only to Niki, one of Monica’s alters, “...in the fragmented and dissociated moments when other aspects of self were absent” (p. 204). To say that the analyst must “maintain an optimal tension between associative and dissociative processes” (1998, p. 205) does not go far enough when

encouraging dissociation may contribute to the worsening of Monica’s condition. Shouldn’t these findings invalidate her initial assessment and contraindicate therapeutic dissociation? Alternatively, do they not discredit her claim that “cris[is] of multiplicity” (p. 196) are distinct from “...more profound disruptions and discontinuities that occur around experiences of trauma and even accompany the emergence of true multiple personality organizations” (p. 196). Viewing such crises quantitatively blurs essential clinical and diagnostic considerations regarding the degree to which reality testing and cohesion are maintained. Only a clear differentiation of normal from pathological forms of dissociation, of normal (metaphoric) from pathological multiplicity, allows proper assessment of these issues. Fundamentally, this differentiation is a categorical one, grounded in the historical, clinical, and empirical evidence that different levels of dissociation reflect qualitatively different vulnerabilities.

### **The Metaphor of Multiplicity**

Metaphor invites an appreciation of heretofore unformulated commonalities by asserting an identity which is recognized immediately as a nonliteral, implied comparison. Specifically, it invites us to consider the importance of giving the fullest possible expression to experiences construed as incompatible with or unacceptable to our personal identity. It is only in this sense that assertions regarding normative multiplicity are made without contradiction. That I hold multiple roles as psychologist, educator, parent, husband, son, friend, and coach implies no necessary fragmentation of my identity. I regularly recognize areas of conflict among these experiences without *being* multiple. To varying degrees and at various moments, these “selves” conflict with each other, but I am no less myself when any particular subset of them is activated. However, multiplicity does not merely assert that the contents of experience conflict with each other. Rather, it claims that the “I” experiencing them is an illusion.

Bromberg asserts that self-states are self-contained, discontinuous phenomenological units of experience. Because of their uniqueness, human experience inheres in myriad self-states. Multiplicity rests on this diversity. For illustrative purposes, consider the existence of two distinct self-states (S1 and S2) within the same person and two corresponding experiential events (E1 and E2), such that S1-E1 and S2-E2 comprise two distinct experiential units or self configurations. Perhaps S1-E1 denotes a moment of deep, loving connection with someone and S2-E2 a moment of anger at that same person. Multiplicity implies that, when angry (S2), I experience my previous love for that person (E1) as if it were someone else’s (S1). The earlier experience is not repressed, but literally belongs to another consciousness (self-state), dissociated from the current subject of experience. This is quite different from the more common experience in which I feel love and hate alternately, but non-dissociatively, toward the same person. The former is a more radical claim rarely observed even in individuals diagnosed with Dissociative Identity Disorder (DID) in which it is more common for one consciousness to assume a primary role, even in the presence of “alters”. Similarly, Freud (1938) notes the durability of the observing ego even when splitting compromises reality testing.

Positing identity as an adaptive illusion is nonresponsive to the real problem posed by multiplicity because, by definition, an illusion is a content rather than the subject of experience. As Frederickson (2000) notes, to stand metaphorically in the spaces of dissociated experience requires a subject who can take a perspective on his or her self states. This subject is precisely the linear, organized self Bromberg wishes to deny. Theorists like Dennett are not subject to this criticism because they reject the Cartesian subject entirely and view consciousness as an emergent property of hierarchically-organized, parallel, self-regulating brain processes. There are no nontranscendental “spaces” to stand in. Davies (1998) recognizes this problem, but believes that a dimensional concept of dissociation alone validly establishes the mind as nonlinear, nonhierarchical, and multiple. Relational authors reject the possibility that “not me” experiences can be explained without reference to multiplicity, despite the observation that intensely anxiety-provoking, episodic, or uncharacteristic experiences often are disavowed nondissociatively. Infrequency facilitates denial, rationalization, disavowal, and/or suppression of the implications of the experience. These experiences are important clinically and observed in patients who do not wish to face disturbing truths about themselves (Renik, 1992). Such patients generally do not evidence pathologically dissociative symptoms, primitive defenses, and/or indications of nonspecific ego weakness.

### **Conclusion**

Dissociation is arguably one of the most important issues within contemporary psychoanalysis. It operates ubiquitously in psychopathology, limited neither to dissociative disorders nor borderline personality organization. Theoretically, it is rivaled in importance only by repression and is synonymous with the view of the mind as fundamentally nonlinear, decentered, and multiple. As its postmodern interpretation increasingly is assimilated, the therapeutic action of psychoanalysis is redefined as the expansion of subjectivity through the creative formulation of dissociated experience. The mutative benefits of analysis are wrought by integrating experience rather than the unmasking of painful truths.

A closer examination of the contemporary concept of dissociation reveals three significant problems with this perspective. First, at the clinical level, dissociation is not intrinsically linked to unformulated experience; nor do these concepts enjoy any association historically. Interpretive restriction of experience may adequately distinguish unformulated from formulated experience, but is confusingly overinclusive when applied to dissociation. The latter always betokens a division of consciousness. In the absence of this distinction, dissociation denotes all past, present, and future experience, including new learning that has not yet been formulated creatively.

Second, a critical review of the literature suggests that a dimensional view does violence to the multifactorial structure of dissociation. Importantly, it fails to distinguish normal dissociation, viewed with suspicion by investigators like Cardena, from pathological dissociation. Whereas lack of descriptive precision confuses the communication of clinical findings generically, the failure to recognize qualitatively distinct levels of dissociation aggrandizes efforts to reduce all conflict to the operation of this mechanism. This inference often is unwarranted.

Third, multiplicity rests upon the unsteady foundation of dissociation, dimensionally conceived. On the one hand, multiplicity consistently is juxtaposed to DID which *is* linked intrinsically to pathological dissociation. This link privileges interventions like therapeutic dissociation because, from the standpoint of diagnostic assessment, the absence of pathological dissociation signals integration. These clinical findings are inversely correlated. On the other hand, the myriad discrete self-states of which Bromberg and Davies speak mandates a division of subjectivity. To transcend its metaphorical status, it must signify something more than mere mental contents which can be understood as conflict within an integrated psyche. This claim lays at the foundation of the multiplicity argument and provides its rationale for rejecting a unique, enduring, unified “I”. Proponents of multiplicity thus trade on the ambiguity of dissociation by importing the defining feature of its pathological form into their normative conception.

Stern’s exegesis of unformulated experience does a great service for psychoanalysis by elucidating the modernist framework in which repression is embedded. But is it fair to contrast a modernist view of repression with a postmodern view of dissociation? Is it useful to designate as dissociated anything other than fully-formed mental contents banished from awareness? If there only are perspectives on the truth, how might this alter our view of repression? In its postmodern interpretation, perhaps repression banishes particular perspectives or interpretations of experience from awareness rather than deleting clear, but incompatible ideas. If this is the case, the distinction between these mechanisms cannot be reduced to interpretive prevention; it must reflect the unique means they employ to reduce anxiety. Repression disguises meaning without disrupting integration; dissociation does not conceal meaning, but instead divides consciousness in a way that dislocates authorship and agency. Viewed in this way, Stern’s insights enlarge rather than diminish the concept of repression.

Kernberg’s work is instructive because he understands splitting as reflecting “...dissociation or actively keeping apart contradictory experiences of the self and significant others” (p. 15). This view at once seems to establish dissociation as a defense and multiplicity as a clinical reality. Yet, a closer examination of his writings reveals that this term generally refers to disparate experiential contents, specifically mental representations, which explain the rapid oscillations in love and hate observed in borderline patients. Other people are perceived in a caricatured, all-good/all-bad fashion. Such disparities in the experience of self and/or others are extremely painful and potentially disorganizing, but do not alone account for the core finding of DID: experiencing one’s own thoughts, feelings, or behavior as someone else’s. The lack of cohesive identity does not imply articulated, self-contained, and/or multiple selves. Similarly, in contradistinction to Davies’ use of therapeutic dissociation, Kernberg advocates clarification and confrontation of “dissociated” areas of experience in order to facilitate integration interpretively. The analyst must help the patient integrate those important experiences he or she wishes to keep apart. He informs us that this approach inspires “...more deeply felt anxiety and guilt, and may also mobilize the conflict more specifically in the transference” (1966, p. 250). It also discourages acting out.

Is the self a unity or multiplicity? Any detailed examination of the human condition provides ample evidence for either conclusion. Phenomenologically, the premature assertion

of unity ignores the critical role of diversity and discontinuity, of the myriad, uniquely individual elements comprising experience. All of us have experienced the butterfly effect in the sense that we have observed how a single look, gesture, impression, or feeling dramatically alters the course of one’s life. Yet, upon reflection, these elements always are hierarchically organized and nonconsciously subordinated to one’s purposes and goals. Relational theorists provide valuable insight into these moments, but at the expense of an equal appreciation of the unique, abiding unity encompassing who we are and what we do. Frederickson, an analyst sympathetic to the relational viewpoint, notes that “...the unity of the person rises above the opposition between unity and multiplicity” (p. 614). Divorced from pathological dissociation, multiplicity connotes the wondrous diversity of human experience and the awe it inspires in the analyst as it is confronted anew in each analytic encounter. Multiplicity metaphorically captures the analyst’s creative struggle to fashion a deeper understanding of the patient. This understanding is limited neither to the past as it is disclosed in the present interaction nor to present transference-countertransference enactments, but instead reflects potential ways of being which exist in the present only as inchoate visions within the analyst’s imagination. The conflicting aims, beliefs, and feelings thus identified represent preliminary organizations of this rich therapeutic interaction. To reify these interpretations is to mistake a nonliteral comparison for an assertion of logical identity. These interpretations exist primarily and, perhaps in their incipient forms, only in the “I”s of the beholder. Playfully elaborated within the potential space of analytic imagination, they provide the raw materials from which therapeutic understanding advances from the excitement of discovery to formulation and co-construction.

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