The Ecology of Dissociation:
Detachment of Psyche and Society

by

Matthew Carter

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

Doctor of Psychology in Clinical Psychology

Meridian University
2015
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For all those disconnected.....
The subject of this Clinical Case Study is dissociation, a concept that dates back over two hundred years, though its definition and etiology continue to inspire much disagreement and debate. Dissociation has been described as a psychophysiological process, a psychological defense, an intrapsychic structure, a deficit, and a wide array of symptoms. Its features have been portrayed on a spectrum from “normal” to “pathological” and can refer to transient states or seemingly enduring traits. The contemporary, foremost understanding of dissociation situates dissociation as an alteration in consciousness in response to the experience of overwhelm, thus linking it to the experience of trauma.

This Clinical Case Study describes the three-and-a-half year therapy of a young Latino boy struggling to overcome a history of domestic violence, abuse, and abandonment, traumatic experiences that led to a fractured family and his highly dissociative way of being in the world. This young man’s story elucidates how the
dissociative process can be both adaptive and self-destructive, and how a culture of disconnection can foster and reinforce dissociation.

This study and its conclusions are informed by the following review of the literature on dissociation, an examination of the many conceptualizations and controversies around the concept, reflecting the lack of consensus as to what exactly dissociation is and how to treat it. This study follows the general notion that the difference between “normal” and “pathological” dissociation lies in degree and duration, both of which being highly influenced by sociocultural factors. With mounting research suggesting pathological dissociation is a consequence of compromised attachment, this study posits that increasing social fragmentation and isolation impairs healthy attachment, individually and culturally, thus increasing and reinforcing dissociation.

Over the course of this young man’s therapy a number of therapeutic methods were employed in an attempt to combat the symptoms of trauma and dissociation. These included, within the context of individual therapy, cognitive/behavioral techniques, art and play therapy, experiential, and somatic techniques. This therapeutic journey also included family therapy with the client, siblings, and caregiver(s). This study follows this work over the three-and-a-half years, the areas of struggle and the areas of relative success, both for the client as well as the clinician.

A primary learning that emerges over the course of this study is the recognition that the client’s symptoms of dissociation, which had left him detached and disconnected, were not only adaptive in inhibiting the high arousal associated with his traumatic childhood, they were also preferred and reinforced by both his family and the culture at large, a culture that is growing increasingly detached and disconnected. An archetypal
lens illuminates how this young man’s life personified the mythic scapegoat and how his much maligned symptoms reflected grave problems both in the family and culture, problems that were projected onto him to be cast off, isolated. This interpersonal process of censure and segregation became an *intrapersonal* one, the client’s social detachment became a psychic one. This study illustrates the consequences of such detachment, socially and psychically, while suggesting the antidote.

Possibilities for further research and treatment are discussed, particularly from the integral perspective of Imaginal Psychology. Imaginal psychology offers a culturally conscious and socially critical lens for understanding this boy’s plight, and concurrently, the growing detachment of mind, body, and society. The transference and countertransference issues presented in this study may also provide further guidance for providers working with trauma survivors, particularly in a cross cultural context.
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No, it is not me, it is someone else suffering.
I couldn't, but let what happened,
Be shrouded in black cloths,
And let them take away the lanterns.
Night.

- Anna Akhmatova
CHAPTER 1

INTRODUCTION

Clinical Topic

Most people, approximately 70% of adults in the U.S., will experience a traumatic event at some point in their lives. These events include childhood abuse, domestic violence, combat, severe automobile accidents, life threatening illnesses, etc. Traumatic events are marked by a sense of horror, helplessness, serious injury, or the threat of serious injury or death and are often accompanied by a host of physical and/or psychological symptoms. These symptoms are typical as the body and mind attempt to manage overwhelm, however, if these symptoms persist for over a month the person may be suffering from post-traumatic stress disorder (PTSD), a mental disorder characterized by symptoms of hyperarousal, re-experiencing, and avoidance. Nearly nine percent of Americans will suffer from post-traumatic stress disorder in their lifetime.

Another hallmark of PTSD are symptoms of dissociation, such as detachment, depersonalization, and derealization. Depersonalization is characterized by a lack of self-awareness and emotional numbness, while derealization is a sense that one is separate from the outside world, a sense of alienation that often comes with intrusive thoughts and anxiety. Ironically, dissociation is recognized as both a symptom of post-traumatic stress disorder and its cause, as peritraumatic dissociation (occurring at the time of the trauma) has been shown to be the strongest predictor of PTSD. Dissociation
is also thought to be at the roots of acute stress disorders, somatoform disorders, certain personality disorders, and of course, dissociative identity disorder (DID).  

Responses to stress generally fall within the broad categories of fight/flight/freeze, with “fight or flight” reactions reflecting sympathetic arousal and “freeze” reactions reflecting parasympathetic (rest and repair) arousal states. As a means to distance the body and mind from pain, dissociation is mediated by, or perhaps through, the parasympathetic nervous system. But why and when will the psyche turn to dissociation for relief? Increasing evidence points to a link between dissociation and insecure attachment, that is, growing up with emotionally distant, disinterested, or unpredictable caregivers. Given that secure attachment is vital to the neurodevelopment of self-regulatory capacities, it is theorized that an insecure attachment will compromise this development, resulting in a predisposition to high states of arousal, and reciprocally, dissociative adaptations. If “successful” in regulating high states of arousal, the dissociative response will likely be repeated and reinforced, and thus, transient states develop into relatively enduring, dissociative “traits.”

Whereas the relationship between trauma, dissociation, and pathology is apparent, the experience of dissociation is far from limited to the pathological. Most contemporary models of dissociation, from the biological to the psychological, view the experience as existing on a continuum from “normal” to pathological. Examples of normal dissociation might be "highway hypnosis," daydreaming, or "spacing out." Moreover, absorption in video games or the internet commonly produce feelings of dissociation, such as losing track of time, feelings of being someone else (depersonalization), and being in a
trancelike state.\textsuperscript{11} Increasing stress, it is believed, will move the mind/body along this dissociative continuum towards pathology.\textsuperscript{12}

The purpose of this study is to explore one young man’s experience of insecure attachment, trauma, and the dissociative symptoms that resulted. The study examines how his developing nervous system, psyche, and behavior adapted to an environment that was fragmented and violent. As detailed in the Progression of the Treatment chapter attempts by this young man, ‘Edward’ (pseudonym), to “embody” his experience, to reverse the hold dissociation had on his mind and body and to assert his needs, were met by an environment that was abrasive and blaming. This study also highlights how cultural artifacts, such as the internet, television, and video games, provided Edward a dissociative outlet, a way to check out of his harsh world. Moreover, his family supported this “checking out” as an improvement, further reinforcing Edward’s dissociative patterns.

This study proposes that Edward’s developmental trajectory (rooted in violence and communal fragmentation, adapting through social isolation and depersonalization) mirrors that of his culture of origin, the United States. To wit, the study illuminates the cultural trends towards an increasingly depersonalized and detached society, suggesting that Edward’s personal narrative reflects the American one, making it ever so easy for him to slip into the dissociative realm. This study further asserts that Edward’s journey into the dissociative abyss to escape overwhelm is being unconsciously replayed across our culture, as the cultural artifact of overwhelm grows. Given that a lack of healthy attachment, or what this study refers to as “detachment,” has been linked to psychic dissociation, what are the cultural implications of a detached society?
Exploration of Topic/Subject Choice

My fascination with Edward’s story is twofold. On a professional level our three-and-a-half years together were extremely challenging, straining and growing my capacities as a clinician while presenting me with big questions about the human experience. On a personal level Edward’s story, as it unfolded, became increasingly reminiscent of my own childhood struggles, and in his strained steps towards healing and wholeness, we often walked side-by-side. Of course, this awareness was not there initially. At first glance twelve-year-old Edward was a short, scrawny kid with a quick but uncomfortable smile and a quiet disposition. The kid was just so wispy, and the stories about his explosive anger were just so incongruous, I just couldn’t believe that he was the “demonio” (demon) that his grandmother, his then guardian, made him out to be.

When Edward’s dissociated aggression did begin to emerge in our work together, like when he would unrelentingly berate his sister, I found him irrepressible and obnoxious (though never personally threatening). In these moments I would try to offer limits and support, but he would mostly ignore me as if I wasn’t there. It was frustrating and cultivated in me feelings of powerlessness. After such incidents Edward would generally have an eerily distorted view of what happened and tended to project blame rather than take responsibility for his part (which, incidentally, was the familial pattern). I would typically review what triggered him, discuss alternatives, perhaps role play, and explore how Edward would like to be. Edward would generally participate, nod his head to suggestions, though I began developing an awareness that the nods were obligatory and his participation was gratuitous. He was just not fully there. Of course, I would often
return the following week to learn that Edward had participated in the same maladaptive cycle that we had discussed the previous week.

Through individual and group supervision I was offered a myriad of suggestions to better understand and work with Edward and his family’s trauma and maladaptive patterns. Open to whatever might help, I utilized art therapy to better tap into the family’s inner experience and to express non-verbally. I experimented with different family games to playfully facilitate communication and cohesion. I worked quite a lot with the grandmother, to help her better understand Edward and his needs and to support her own maladaptive patterns (like yelling and criticizing). In the end, all these paths, while ephemerally fruitful, inevitably led to the same destination - Edward was the problem, the scapegoat who needed to be cast away.

The insidious persistence of the family’s maladaptive patterns was both disheartening and a challenge to my feelings of competence. But it was this perpetual feeling of futility, what Jack Mezirow might call a “disorienting dilemma,” that propelled me to examine more deeply Edward’s lack of responsiveness.13 While my approach to treating Edward and his family had been “trauma informed,” I was not fully taking into account the acuity of Edward’s symptoms of dissociation; the divided consciousness, the faulty perceptions, the lack of bodily awareness. For nearly a year I had been engaging a psyche that was just not present half the time. It wouldn’t be until I started integrating knowledge and practices, such as bodily awareness, movement and other somatic exercises, to directly address Edward’s dissociative symptoms that I began seeing a more “embodied” and engaged Edward. Which begs the question, why didn’t I recognize the salience of Edward’s dissociation sooner?
What has come into focus subsequent to my treatment of Edward, particularly in the process of researching this case study, are the parallels between Edward’s and my own experience, my own personal relationship to dissociation. Through my own personal work I have grown very aware of the effects my own experiences of domestic violence and family fragmentation had on my psyche and behavior. I have worked through issues of trust, anger, and anxiety (i.e. hypervigilance), issues that drove me to detach from others, and in many ways, from myself. Even as an adolescent I was very conscious of my detachment, my disconnection, though I never saw this as dissociation; not until I met Edward, not until I began this study.

In the Learnings and Reflections chapters this realization, that much of Edward’s experience was mirrored in my own, is explored in depth. This study considers the possibility that I was slow to recognize the acuity of Edward’s dissociation because I was slow to recognize my own. I also confront the realization that in both cases the environment was a fertile ground for dissociation as a defense and detachment as a way of being. In sum, I am drawn to this story of a young man’s growth in an encumbering world, a story that is equally biographical and autobiographical, a story that speaks to social trends and problems of detachment- a warning, and perhaps, a prescription.

**Framework of the Treatment**

My course of treatment with Edward began in January 2010, upon me joining the outpatient mental health team at the Edgewood Center for Children and Families, in San Francisco, California. The Edgewood outpatient mental health program provides community based therapeutic services to economically challenged families and their
children, approximately eighty clients per year, from a strength-based, trauma-informed, family systems orientation. Edward and his two siblings had been receiving individual therapy from another therapist within the program since October of 2009, subsequent to a CPS (Child Protective Services) intervention and removal from their father’s care due to reports of physical abuse. Edward’s mother was then living in Mexico City, illegally, as an Argentine citizen. Consequently Edward and his two siblings were placed with their maternal grandmother, in an economically challenged area of San Francisco. When I joined the program I assumed the role as individual therapist for all three kids.

Upon assuming the three cases each sibling already had individualized treatment plans in place based on a formal assessment process. Edward’s assessment detailed the reported family history of domestic violence and family fragmentation and his goals centered on apparent symptoms of post-traumatic stress, such as emotional lability, aggression, and avoidance. Our work together started as weekly individual therapy with all three, but soon shifted to include weekly family work with some combination of the siblings and/or the grandmother, as I identified a greater need to address the highly dysfunctional family system. I would only see Edward’s brother ‘Ian’ (pseudonym) for about a month before he moved to his father’s home, out of San Francisco County.

Over the course of our three-and-a-half years together my work with Edward encompassed individual therapy, family therapy, and collateral sessions with the grandmother, as well as case management (i.e. consulting with adjunct providers) as needed. This period of time also included a brief three month stay (October 2012 through January of 2013) in Edgewood’s residential based services (RBS) program, a program that offered Edward and his family crisis stabilization after Edward assaulted his sister. In
addition to residential care the program also put in place a “care coordinator” who, in addition to overseeing Edward’s residential care, assumed much of the case management duties. I continued as Edward’s individual therapist throughout.

Edward was returned to his grandmother’s care in January of 2013, and although some maladaptive patterns remained, Edward demonstrated substantial progress in school, in sociability, and in controlling his anger. In June of 2013 our clinical team assessed Edward’s individual goals as having been met and made a decision to discontinue the individual work (though the case manager remained as a support) and to focus on family work with Edward and his grandmother (with another provider). Individual treatment, and thus my work with Edward and his family, was discontinued as of July 18th, 2013.

**Confidentiality and Ethical Concerns**

Over the course of my work with Edward and his family there were a number of confidentiality and ethical concerns that needed to be considered. Since Edward’s placement with his grandmother was technically a foster placement, from the onset our work was under the shadow of Child Protective Services (CPS), who was formally Edward’s legal guardian (though his attorney remained the holder of privilege). This meant that Edward’s social worker was the one to sign the consent for treatment, releases of information, and the treatment plan. It also meant a tacit understanding that the therapist would be collaborating with the social worker, who was charged with determining a long term placement option for Edward. Since Edward’s removal his father had been petitioning to regain custody of Edward and his sister (Edward’s brother had
already been “reunified” with their father), though Edward was adamant that he did not want to live with his father, articulating his fear that his father would inevitably return to his abusive ways.

This context presented two clinical dilemmas, one being the ostensibly mandated nature of Edward’s therapy, the other being the issue of confidentiality and therapeutic trust. To address these less than ideal dynamics, I started from a place of transparency with Edward and his family, acknowledging and encouraging dialogue about the presence of social services, my role, and the limits of confidentiality. I clarified what sort of information would be a mandated report (such as disclosures of past or present abuse) and what sort of information would generally be expected by social services, such as treatment goals and progress. As is generally my stance, I vowed that any information that would or should be communicated to the social worker I would first discuss with the family. Edward and his family seemed to respond well to such transparency and voiced no initial concerns, though I am sure that they were assessing me just as much as I was assessing them.

In expected and unexpected ways, these boundaries of confidentiality would be strained a number of times. Over this period, three-and-a-half years, Edward and his family had four different social workers, each with their own perspective and plan, each with their particular pursuit of information. I had to navigate dozens of phone calls and perhaps a dozen “team meetings” with Edward’s several social workers, cautiously walking the line between collaboration and safeguarding the family’s confidentiality and trust. There were, however, a few occasions where I was legally obligated to cross this line, namely, mandated reporting (at least three over the course of our work together).
Another dynamic that I had to navigate was the fact that I was assigned as the individual therapist for three siblings, with their various configurations of sibling conflict. While much of their issues centered on the same family problems, such as the abuse by their father and the absence of their mother, they each had their own experience and needs and I had to hold each of them equally. I also had to foster a safe space for them to be able to talk about their siblings if they wanted or needed to, which I cultivated by consistently re-affirming the parameters of confidentiality. This also meant staying mindful of my own countertransference, tracking if and when I started to align with or dislike one of the siblings.

Additionally, cultural considerations were present from the start, as Edward and his family are Latino and primarily Spanish speaking, while I am a Caucasian male who learned Spanish as a second language. I had to constantly be mindful of my privilege and questioning of my cultural assumptions. As Edward’s therapist I had to assess for how culture impacted his life (Edward was himself bi-cultural, Argentine and Mexican) and our relationship and create an environment welcoming and supportive of these issues. To do this I had to remain curious and receptive, deferring to the family as the expert, and occasionally consulting with Latin team members about the cultural context of our work.

To help me navigate this intricate ethical landscape I was supported by weekly individual supervision from my direct supervisor(s), a licensed marriage and family therapist (MFT), and weekly group supervision with the outpatient clinical team, a team of approximately eight clinicians. Both individual and group supervision allowed for flexibility in conceptualization and treatment approaches, though the agency was oriented towards family systems theories. What was most helpful from my clinical team was the
support that I received in times of uncertainty and despair, re-orienting me to hope and opportunity.

In approaching Edward and his grandmother with the notion of this study I was fairly certain that they would consent, though I also held the reality that they might say no, which would abolish a ton of writing and researching I had already done. When we sat down to discuss it, about three years into our work together, I expressed to them that I had been moved by their resilience in the face of extensive trauma and loss. I told them that I was writing a study on trauma and its effects on individuals, families, and communities, and that I wanted to use their story as an example. A blushing Edward wanted clarification, asking if I was “writing a book” about him and his family. I detailed what the study would entail and its aim, as I saw it. Edward actually seemed rather surprised and proud that I both recognized and wanted to share his difficult story. Similarly, grandmother also seemed pleased to share her and her family’s struggles in such a meaningful way. They both graciously consented. Being that Edward’s was technically a foster care case (making Edward a ward of the court) I also had to get consent from his social worker, which was formally granted. I let all parties know that to protect the identity of Edward and his family any and all identifying information would be either omitted or altered, as in the use of pseudonyms.

**Client History and Life Circumstances**

When I first met Edward he was a slender 12-year old Latino male of average height, with a dark complexion. Edward was born in San Francisco, California to mother ‘Nancy’ (pseudonym) and father ‘Edward Sr.’ (pseudonym). Edward had a twin brother
named ‘Ian’ (pseudonym), who lived with the father in Orinda, California, and a 13-year-old sister named ‘Sarah’ (pseudonym), who along with Edward resided with their maternal grandmother ‘Maria’ (pseudonym) in San Francisco. Edward’s mother, a citizen of Argentina, was living “illegally” and alone in Mexico City awaiting her application to return to the U.S. Edward’s father had inconsistent visits with Edward and his sister.

According to maternal grandmother Edward and his twin brother were born premature and experienced a number of early health problems. Edward entered a home comprised of his mother and father, sister, and maternal grandmother. Through Edward’s early years (approximately age one through five) his father was regularly intoxicated and was often physically and emotionally abusive towards Edward’s mother, reportedly hitting and even choking her in front of the kids. Father was also abusive to Edward’s fraternal twin brother Ian, who demonstrated early behavioral issues. This abuse included threats, beatings, and humiliation, all of which Edward passively witnessed.

When Edward was six-years-old his father moved him and his siblings to Mexico. The mother would join them a year later. In Mexico, per reports, the family lived in abject poverty and the domestic violence continued. In early 2009 the father returned to the United States with Edward and his siblings under the pretense that the father would return for the mother, which never happened. Mother was abandoned in Mexico City, penniless and unable to work legally (she was surviving on what little Edward’s grandmother could send her monthly). Shortly after moving to Redwood City, California, Edward’s brother reported his father’s abuse to a teacher, who followed with a mandated report to Child Protective Services (CPS). An investigation ensued and the three children
were subsequently removed from father’s care and placed with maternal grandmother in San Francisco.

In grandmother’s home Edward displayed a pattern of isolating, high distractibility, and consistently low mood. Edward also showed intermittent bouts of aggression and defiance, generally a result of caregiver limits or demands. This violent behavior, assessed by his prior clinician as post-traumatic re-enactment, included threats of violence, aggression towards his siblings, and property destruction. Over the course of our work together this “re-enacting” included Edward pushing his grandmother, kicking and choking his sister, and threatening both sister and grandmother with knives, all leading to police and/or CPS intervention. Edward however never displayed aggression in school or the community, suggesting that this pattern was more than irrepressible trauma reenactment, but perhaps contextual to the family and their culture.

In late 2009 Edward’s brother Ian reported to his social worker that Edward attempted to hit him with a hand weight. The two often combative boys were eleven at the time. In a questionable turn of events Ian, who happened to be on a weekend visit with his father, was permitted to stay at his father’s home, though no court order was ever given. There he remained. When the three cases were referred to Edgewood for individual services, approximately October of 2009, Ian was living with his father in Orinda though he continued to attend school in San Francisco. The social worker’s plan at the time for the other two siblings was also re-unification with the father, though Edward and his sister were adamant that they did not want to live with their father. This writer assumed the role of Edward’s therapist in January of 2010, and after determining the salience of family work, began ongoing family therapy shortly thereafter.
Progression of the Treatment

My initial work with Edward centered on addressing his apparent symptoms of post-traumatic stress, such as persistent fear and worry, irritability, and anger/aggression (re-enactment). It was also apparent that there were family dynamics that were triggering and reinforcing these patterns, such as consistent criticism and yelling by the grandmother, and to a lesser degree the sister. So, in individual therapy I worked with Edward on identifying the triggers for his anxiety and anger, proposing and practicing healthier coping strategies. In sessions with the family I sought to improve the family’s communication patterns and to develop more empathy and understanding. What emerged over time was that as much as I would propose and practice with Edward, he would rarely be able to put these changes into effect. He would say he forgot, or blame others for his maladaptive behavior. Surprisingly, Edward’s grandmother was equally as rigid, continuing to behave in ways that were inappropriate and triggering to Edward, like calling him derogatory names in Spanish.

About a year into our therapy it became clear that Edward just couldn’t integrate the dialogues we were having, it was like our conversations went “in one ear and out the other.” After much discussion with my clinical team the assumption that emerged was that Edward’s explosive aggression was being suppressed by his chronic dissociation, aggression that he experienced as a young child, which was then being involuntarily re-enacted when triggered (a hallmark of PTSD). Edward’s persistent symptoms of dissociation, such as psychic detachment and emotional numbness, distanced himself from the pain and sorrow of his frightening and fragmented family, while concurrently distancing his psyche from the present moment. This “wandering mind,” with its
characteristic blurring of time and perceptions, made it difficult for Edward’s mind and body(/brain) to access and assimilate new ways of being.\textsuperscript{15} What was needed, I imagined, was a way to diminish Edward’s dissociative symptoms while building healthier capacities to manage the overwhelming aspects of his experience.

In researching the topic of dissociation in children and adolescents, I found the literature stressing the need to utilize body-based interventions, such as the development of sensory awareness.\textsuperscript{16} Through the lens of Perry’s Neurosequential Model of Therapeutics (NMT), I had been utilizing conversations, co-operative play, and social interactions, all cortically mediate interactions. Given that Edward’s symptoms seemed to be “lower brain” based (e.g. the dysregulation of arousal), I needed to start with more sensory and movement based interventions to first regulate and develop these areas.\textsuperscript{17} What this looked like in sessions was helping Edward better identify and regulate his physiological process and finding ways to reduce tension in his body. Sometimes it meant going for walks, sometimes it meant playing soccer together, all the while tracking Edward’s somatic process. As I began integrating this work into therapy with Edward I experienced him as growing increasingly “embodied,” showing more somatic awareness, more presence, and more assertiveness. As a side effect, this emergent assertiveness resulted in more arguments in the home, as Edward began sharing thoughts and feelings that heretofore had been dissociated, like demanding that his grandmother stop calling him derogatory names. With this increased conflict we were continuing the family work, ever striving to increase the family’s mutual empathy understanding.

As my time with Edward progressed he began showing more vitality, less detachment, and increased sociability and social involvement. While the family’s pattern
of criticism and arguing remained unyielding, the incidents of aggression were eliminated (the last being in August of 2012). In May of 2013 our clinical review team concluded that Edward had met his individual goals and that the ongoing focus of treatment should be family therapy, which another clinician had been providing since July of 2012. My relationship with Edward and his family ended on July 18th, 2013.

**Learnings**

The principal learning of this study emerges as the recognition that Edward’s symptoms of dissociation, which had left him detached and disconnected, were not only adaptive in inhibiting the high arousal associated with his traumatic childhood, they were also *preferred* and reinforced by both his family and the culture at large, a culture that is growing increasingly detached and disconnected. The learnings section explores this interrelational dynamic, and further, surveys how this young boy’s experience personified the myth of the scapegoat, suggesting that his much maligned symptoms reflected grave problems both in the family and culture, problems that his world (and successively his psyche) needed to cast off. Like the mythical Pan, the archetypal scapegoat, Edward was abandoned by his mother, walked through the world a solitary figure, and spent most of his day in a slumber, exploding in anger when roused.18 Our protagonist, Edward, spent most of his days in a dissociative slumber, anesthetized from the overwhelming and explosive trauma that lay dormant, a “panic” that would irresspressibly emerge when triggered. Not ready or willing to confront the significance of these symptoms, Edward’s world, explicitly and implicitly, continued to foster his dissociation.
Through my learnings this study illuminates the *imaginal structures* - the implicit, repetitive patterns of sensory, affective, and cognitive aspects of experience - that underlaid Edward’s tragic experience.¹⁹ These imaginal structures, analogous to Carl Jung’s *complexes*, are constituted by an interaction of personal, cultural, and archetypal influences and drive inveterate thoughts, feelings, and behavior. As defined by Aftab Omer, these assemblies of experience constellate around an emotionally charged form or image, such as “life is hard” or “I am weak.”¹⁹ In Edward’s case his early experiences of anger, abuse, and abandonment taught him that the world is not safe and adults were not to be trusted. These experiences coalesced into structures of insecurity and distrust. He also developed structures of self-blame and loathing (characteristic of the scapegoat), likely as a way to assume some semblance of control within an overwhelming world.

This study surveys how these imaginal structures, these personal and cultural complexes, both drove and reinforced Edward’s dissociation.

The Learnings chapter likewise confronts my own imaginal structures that emerged in the course of my work with Edward. Specifically, I confront my own experience as the family scapegoat, the holder of the collective shadow, cast into the wilderness to roam in isolation and anger. Acknowledging my own history of domestic violence and family fragmentation, my own feelings of loss and distrust, I face my own experience of dissociation and detachment. Though this self-reflection I investigate how Edward’s experience reflected my own and vice versa, and how this symmetry may have driven or perhaps obstructed the therapy process.
Personal and Professional Challenges

Broadening the lens further, this study explores the many personal and professional challenges along my therapeutic journey with Edward and his family. The study elucidates the challenges in identifying and working with Edward’s acute dissociative symptoms, especially given my initial lack of training and understanding of the dissociative process. My clinical blind spots and stuck points with Edward are explored, followed with an exploration of how these “disorienting dilemmas” ultimately moved me towards deeper understandings and growth in this area, developing effective tools to work with Edward’s dissociation. This study also exposes my internal and external struggles with Edward’s family system, which seemingly wanted Edward to remain dissociated and docile, and how operating within this system was personally triggering.

The concluding chapters of this study also examine the personal meanings that arose for me over the course of this case, and this case study. This study identifies the many ways that Edward’s experience was familiar to my own, the ways in which I consciously and unconsciously sided with him, protected him, and perhaps, over identified with him. In the final chapters I detail how this exploration has led me to the previously unconscious archetypal and mythological undertones of both Edward’s experience and my own. Lastly, this study shares my process in writing this case study, in reflecting on the learnings I have made over the course of these dual processes.
CHAPTER 2

LITERATURE REVIEW

There is properly no history; only biography. Every mind must know the whole lesson for itself, — must go over the whole ground. What it does not see, what it does not live, it will not know...

- Ralph Waldo Emerson

Introduction and Overview

The history of dissociation, a word derived from the Latin dissociare, meaning “to dis-join,” has spanned over two hundred years, though dissociation remains a concept whose definition and etiology inspire much disagreement and debate. Dissociation has been described as a psychophysiological process, a psychological defense, an intrapsychic structure, a deficit, and a wide array of symptoms. Its features have been portrayed on a spectrum from “normal” to “pathological” and can refer to transient states or seemingly enduring traits. Dissociation is also recognized as both a cause and a result of posttraumatic stress disorder (PTSD). While these understandings have bridged psychology, psychiatry, and neurobiology, they were not born out of medicine or mental health, but rather, and perhaps unexpectedly, began with the study of hypnosis nearly two hundred years ago.

What follows is an exploration the origins of dissociation, which this study preliminarily defines as a “disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor
control, and behavior.” 8 This journey traverses the concept’s early roots in hypnosis and the parallel development of psychoanalysis. This review of the literature will first survey the psychoanalytic/psychodynamic perspective on dissociation, which established dissociation as a psychic defense against distressing thoughts, feelings or memories. The chapter then traces this conceptual lineage through Charcot, Breuer, Freud, and Janet, the “father of dissociation.” 9 This review of the literature demonstrates how Janet and his progressive ideas, which placed dissociation at the center of psychopathology, were overshadowed by the growing popularity of Freud and psychoanalysis. As a result, the theory of dissociation was obscured and absorbed by the concept of repression, the “foundation stone on which on which the structure of psychoanalysis rests.” 10

The proceeding review of the literature details the “rebirth” of dissociation in the 1970s, largely driven by the work of American psychologist Ernest Hilgard, who borrowed from the work of Pierre Janet in developing his “neodissociation theory.” Hilgard’s theory, largely influenced by the “cognitive revolution” of the 1960s and 70s, redefined dissociation in cognitive terms, asserting that the mind consisted of a hierarchical system of cognitive structures linked to a central controlling and monitoring structure (the executive ego). 11 Hilgard believed that certain conditions, including but not limited to trauma, could alter the integration of these structures, resulting in states of divided consciousness (dissociation) wherein perceptions, thoughts, feelings, and actions became isolated and autonomous. This explained how two or more cognitive processes could occur simultaneously, as in driving a car while daydreaming, while also establishing a continuum of dissociation from normal to the pathological. 11
Though well received, Hilgard’s theory was not without its detractors. Psychologist Nicholas Spanos would dispute Hilgard’s idea that dissociation was an altered state of consciousness, offering what he called a cognitive-behavioral (later renamed socio-cognitive) perspective. Spanos argued that dissociative behavior was not involuntary, but rather goal-directed, learned behavior, created and reinforced through social interactions. Contemporary cognitive behavioral perspectives on dissociation unite these two poles, viewing dissociation as a dual problem of cognitive processing and behavioral reinforcement, with correspondingly dual solutions.

The chapter then explores the 1980s and the surge of interest in dissociation as a symptom, particularly multiple personality disorder (MPD), now called dissociative identity disorder (DID). The decade of the 80s saw dissociative disorders (including MPD) finally adopted as a diagnostic category in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), and dissociation questionnaires were developed and disseminated to provide a way to empirically measure (and validate) the experience of dissociation. The best known of these measures was the Dissociation Experiences Scale (DES), developed by Drs. Eve Carlson and Frank Putnam. The chapter then reviews the work of Dr. Frank Putnam specifically, as his research on infant behavioral states led to the development of his discrete Behavioral States (DBS) theory of dissociation (1997), the first distinctly developmental perspective on the topic.

Putnam’s DBS theory proposes that the organization of human behavior begins with five basic, discrete states that are present at birth, with new states added over time as earlier states are refined or replaced. Early on, these states are modulated by caregivers,
however, through maturation these states become linked as the capacity for self-regulation is internalized. Trauma and neglect can impede the integration of these states, resulting in split off, dissociated states that often arise outside of conscious awareness or control.\(^{19}\) Thus, “pathological” dissociation is not a defense, but rather a developmental deficit, similar to Janet’s conceptualization.

Onno Van der Hart and his colleagues would embrace and elaborate on Putnam’s developmental theory in forming their theory of structural dissociation of the personality (2006).\(^{20}\) Utilizing the language of British psychiatrist Charles Samuel Myers (1940), Van der Hart and his colleagues theorize that the overwhelming experience of trauma can produce a schism of the personality into an “apparently normal part of the personality” (“ANP”) and an “emotional part of the personality” (or “EP”) that segregates traumatic material. While the ANP strives for a normal life and the avoidance of traumatic reminders, fragments of the EP (traumatic material) tend to intrude into the experience of the ANP (explaining the intrusive symptoms observed in PTSD).\(^{21}\) Severe or prolonged trauma can lead to secondary structural dissociation and the emergence of additional emotional parts of the personality, accounting for dissociative identity disorder.\(^{22}\)

While the work of Putnam, Van der Hart, and others illustrate how trauma can induce dissociated states and ultimately skew normal development, contemporary attachment theorists demonstrate how pathological dissociation does not proceed from trauma alone. The section on developmental perspectives specifically highlights the work of Italian psychiatrist Giovanni Liotti, who recognized that individuals who experience pathological dissociation often have a history of compromised attachment. Liotti concluded that insecure attachment, that is, growing up with emotionally distant,
disinterested, or unpredictable caregivers, predisposes a child to pathological dissociation, a theory that was later corroborated by longitudinal studies. Furthermore, Liotti posits that attachment disorganization is in itself a dissociative process, a coexistence of reciprocally segregated, contradictory ego states. Liotti also elucidates how the caregiver’s unresolved trauma can result in attachment disorganization and thus predispose a child to pathological dissociation.

The literature review also includes the growing neurobiological evidence of this link between disorganized attachment and dissociation, emphasizing the work of Drs. Allan Schore and Bruce Perry. Schore, a leading researcher in the field of neuropsychology, illustrates how the attachment relationship directly influences the wiring of the brain, building the neurological capacities for self-regulation. Early disruption of attachment can thwart this development, resulting in enduring deficits in affect regulation. The inability to modulate increasing arousal, Schore explains, will invariably lead to a dissociative response. Similarly, renowned child psychiatrist Bruce Perry describes dissociation as an adaptive response to high arousal, a way of disengaging from threatening stimuli in the external world and attending to an ‘internal’ world. Perry demonstrates how these adaptive states, from hyperarousal to dissociation, can become neurologically reinforced and repeated, developing over time into enduring threat response patterns. Perry asserts that these maladaptive dissociative “traits” often account for what is misdiagnosed as attention deficit/hyperactivity or oppositional defiant disorders.

Plunging deeper into the world of neurobiology, the chapter discusses the work of Stephen Porges, whose Polyvagal Theory illuminates the potential underlying
psychobiology of dissociative adaptations. Porges’ theory proposes a phylogenetic, triune stress response system; the sympathetic nervous system and the ventral and dorsal vagal branches of the parasympathetic nervous system, each having its own adaptive strategies for responding to stress. The sympathetic branch is involved in mobilizing the body to fight or to flee from potential threats, while the two branches of the parasympathetic nervous system function as both an inhibitor to sympathetic arousal and as a facilitator of rest and repair.

The parasympathetic nervous system is mediated by the vagus nerve, which extends from the lower brain and splits into two branches - the ventral and dorsal vagus. The ventral vagus innervates the muscles of the heart, neck, and face, and thus plays a key role in the expression and regulation of affect, functions that Porges refers to as the “social engagement system.” The third branch, the dorsal vagal, provides inhibitory input to the heart while also regulating the diaphragmatic organs. The dorsal vagal system can also, under extreme stress (including overwhelming affect), initiate an immobilization response, shutting down bodily systems in anticipation of severe harm. It is this system, the dorsal vagal, that appears to be the mediator of dissociative PTSD, hypoarousal, "tonic immobility," and "total submission."

Having spanned the psychodynamic, cognitive/behavioral, developmental, and the biological, all individually focused perspectives on dissociation, the chapter then broadens its lens to the collective. From a sociocultural perspective it emerges that dissociation is highly culturally patterned, greatly influenced by cultural norms and expectations. For example, Western models of dissociation tend to center on pathology, while other cultures may view altered mental states, switching of mental states,
“possession,” and trance states as desirable rather than pathological. In particular, dissociative identity disorder (DID) is seen as primarily a Western phenomenon, perhaps a reflection of the Euro-American emphasis on the self-contained individual. In more “communalistic” cultures multiplicity of self, as in dissociative identity disorder, is generally experienced as an embodiment of communal agents (e.g. ancestors or spirits) with a collective meaning.

From this landscape of dissociative theory, this study forwards the notion that the difference between “normal” and “pathological” dissociation lies in degree and duration, both of which being highly influenced by sociocultural factors. Starting from the premise that pathological dissociation reflects a disruption in the mind and body’s integrative functions, a deficit linked to compromised attachment, the course of this study explores how increasing social fragmentation and isolation may impair healthy attachment, individually and culturally. This study proposes that the breakdown of the extended family and the prevalence of divorce amidst (or perhaps because of) increasing economic pressures has resulted in fewer and less available attachment figures and subsequently, less and less attuned (attachment) interactions. These attachment gaps are often filled by television, video games, or the internet, all potentially dissociative, depersonalizing activities. Consequently, this confluence of sociocultural factors both compromises the development of secure attachment while promoting dissociative and depersonalizing behavior, behavior that can quickly become patterned.

Whether an adaptive mechanism or a deficit in integrative functions, pathological dissociation, from a biological perspective, has been linked to high arousal states, states associated with fear and perceived threat. So what if the environment is pervasively
threatening? What if the culture is dominated by fear? Leaning on Stephen Porges’ concept of *neuroception*, this study posits that a culture of fear and aggression, from media to domestic to transnational violence, heightens baseline arousal, in turn promoting dissociative adaptations. Concurrently, the ubiquity of latently dissociative diversions, e.g. television, video games, and the internet, offers temporary relief from escalating arousal (i.e. stress), and in doing so, further reinforces dissociative patterns.

Expanding the lens further, this study establishes that the experience of dissociation is at once both culturally constructed and archetypal, across cultures. Carl Jung (1875-1961) identified dissociation as a universal and necessary psychic activity in the development of personality, an essential function that only became pathogenic in response to traumatic experience. Dissociation, Jung believed, was the process from which evolved *complexes*, core patterns of thoughts, emotions, memories, and perceptions, organized around a common theme or archetype. These patterns, or *images*, as Jung referred to them, split from consciousness due to certain “incompatible tendencies” and tend to behave like relatively autonomous “foreign bodies in the sphere of consciousness.” For Jung, trauma produced its own complex, one with a “high emotional charge.”

Contemporary trauma expert John P. Wilson furthered this notion, identifying trauma as an archetypal image (the “trauma archetype”), and its personal manifestations, including dissociation, as a complex (the “trauma complex”). For Wilson the trauma archetype is part of a collective unconscious, representing universal forms of traumatic experience and the prototypical stress response patterns present in all human cultures. The trauma complex is a “unique, individual constellation of the trauma experience,”
shaped by culture and taking form in accordance with symbolic, mythological representations of reality. Thus, dissociation is a personal manifestation of the common experience of trauma, and will look very different and mean different things in relation to the culture and its symbols.

Staying with this *imaginal* perspective on dissociation this review of the literature explores Donald Kalsched’s theory of an archetypal self-care system, an inner psychological agency that, in response to early trauma, will split the psyche into "progressed vs. regressed" parts of the self. The dissociated parts will, according to Kalsched, invariably constellate around archetypal images, one the protector and the other its opposite, the persecutor. The protector daimon acts as a benevolent figure, protecting the psyche from the unbearable affect of the traumatic experience, including traumatic reminders in the outer world. Fantasy is this daimon’s instrument, promoting a sort of auto-hypnotic twilight state. But because these destructive energies are not integrated or expressed they fester in the inner world, where they inexorably become persecutory and self-destructive. What results in an escalating cycle of dissociation and re-traumatization. For Kalsched, this “self-care system” is a central trauma complex.

Whereas Jung and others defined personal complexes, Jungian psychologist Joseph Henderson proposed the existence of *cultural* complexes, a historical lineage of collective “attitudes” that subsists in the personal unconscious, influencing beliefs and behavior. This study proposes, building off of John P. Wilson’s personal trauma complexes, the existence of *cultural trauma complexes*- implicitly inherited complexes of collective trauma. This proposition is exemplified by Dr. Joy DeGruy and her notion of a
“Post Traumatic Slave Syndrome,” a psychic legacy of transgenerational trauma born out of the transatlantic slave trade.\(^{48}\)

This study further concludes that dissociation- the detachment of consciousness and connectedness- is a cultural complex in and of itself, and moreover, a cultural trend. The section on sociocultural perspectives details the work of international trauma experts Vedat Sar and Erdinc Ozturk, who contend that societal conditions associated with overstimulation promote dissociative “shutting down.”\(^{49}\) Culturally this *dissociative complex* shows up as collective numbness and apathy, a culture of “I don’t care.” This study asserts that this cultural complex is part and parcel of our increasingly disconnected society.

This review of the literature concludes with an exploration of integral perspectives on dissociation and the proposal that there is an interrelated relationship between the psychological and cultural, personal and archetypal dimensions of dissociation. The conclusions of this study suggest equally integral solutions to this rising trend of personal and cultural detachment, trends that compromise our ability as human beings to be empathic, compassionate, and connected. This call for connectedness emerges as the fruit of this difficult journey. And like all stories of growth, this bearing of fruit begins with roots, the roots of this concept we call dissociation.

**The Roots of Dissociation: A Psychoanalytic/ Psychodynamic Perspective**

The psychodynamic/psychoanalytic perspective on dissociation evolved to understand dissociation as a psychic defense that guards the ego (or Self) from distressing thoughts, feelings or memories by splitting and warding off these experiences.\(^{50}\)
Symptoms emerge as a result of the psychic expenditure necessary to keep these experiences at bay. This perspective sees repression as a form of active dissociation, though for the better part of the 20th century dissociation was obscured by the concept of repression, owing to the popularity of psychoanalysis and its flamboyant founder. The chapter that follows explores the common roots of dissociation theory and psychoanalysis, roots that lay not in medicine or mental health but in the study of hypnosis nearly a century and a half ago. Which is where our story begins.

In the late 1870s renowned French neurologist Jean Martin Charcot (1825-1893), then chief physician at Paris’s Salpêtrière Hospital, began using hypnosis in his treatment of hysteria. Charcot observed the symptoms of hysteria (such as anesthesia and paralysis) as similar to those of hypnotic trance, concluding that hypnosis was a form of experimental hysteria, “an artificially produced morbid condition—a neurosis.” Charcot thus began hypnotizing his patients in order to induce and study the symptoms of hysteria. This work led Charcot to other radical ideas, like the symptoms of hysteria having a psychological origin, not a physiological one, and the possibility that these symptoms were the result of trauma. Discovering that several of his patients had suffered a traumatic experience prior to the onset of their symptoms, Charcot speculated that traumatic experience produced certain pathogenic ideas (ideas that produce physical symptoms) that became dissociated from consciousness and thus, isolated from rational thought. Thus, trauma was ultimately dissociative in nature and it was this dissociation (of “traumatic ideas”) that produced the symptoms.

Always the showman, Charcot presented these revolutionary theories to large audiences through live demonstrations in which patients were hypnotized and guided
towards remembering their trauma. As their “hysteria” emerged Charcot introduced hypnotic suggestions intended to counter the patient’s symptoms (i.e. their “traumatic ideas”), often resulting in their amelioration. Word of this “new treatment” spread quickly, attracting physicians from all over the world, turning La Salpêtrière into a “mecca of neurology.” Those attending included French psychologist Alfred Binet (1857-1911), American psychologist William James (1842-1910), and a young Austrian neurologist by the name of Sigmund Freud.

In June of 1885 Freud, then a 29-year-old junior physician and lecturer at Vienna General Hospital, was awarded a travel grant to study at La Salpêtrière, where he arrived in October. Freud’s research in brain anatomy had led him to an interest in the potential biological roots of nervous disorders, which inevitably led him to the “Napoleon of neurosis,” Charcot. On October 20th, 1885, Freud attended his first of many Charcot “lessons” and was immediately captivated, calling Charcot “brilliant,” and “like a worldly priest.” Feeling “quite at home,” Freud would spend the next four months attending Charcot’s lectures and working with him in Charcot’s clinic. Though no stranger to hysteria, or its treatment with hypnosis (having been introduced to both by his friend and colleague Josef Breuer in 1882), alongside Charcot Freud developed a newfound fascination for the illness and its etiology. This burgeoning interest moved Freud to abandon his neurological research, devoting himself to what would become his life’s work; psychoanalysis.

After returning to Vienna in April, 1886, Freud accepted a directorship at a private children’s hospital, opened a private practice specializing in “nervous disorders,” and resumed his collaboration with Josef Breuer (1842-1925). Following in Charcot’s
footsteps, Freud began using hypnotic suggestion with patients to counter their symptoms, though he ultimately found the process unreliable. Breuer, on the other hand, had been using hypnosis to facilitate expression, not suggestion. From his work with Bertha Pappenheim (the famous “Anna O.”) Breuer found that tracing a symptom back to its first appearance invariably brought him to an emotionally laden, “forgotten” event, and in the patient’s recounting of this memory the symptom disappeared. Breuer theorized that these “forgotten” memories had become dissociated within an altered (“hypnoid”) state of consciousness, and it was this “splitting of the mind” that produced the pathology, not the event or its memory (anticipating a modern understanding of PTSD etiology). Thus, Breuer’s “talking cure” served to reintegrate this dissociated material into conscious awareness, purportedly discharging (“abreacting”) the compartmentalized, pathogenic affect.

Intrigued by Breuer’s work, Freud started using this “talking cure,” which he and Breuer later coined “the cathartic method,” with his own patients, with similar results. Freud soon found that he could achieve the same results (catharsis) without the use of hypnosis, instead using what he called the “concentration technique” (asking clients to lay down and close their eyes). An enthusiastic Freud persuaded a reluctant Breuer to publish these early findings in a paper entitled On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication (1893). In it, Freud concurs with Breuer that the hysterical phenomena was caused by “psychical trauma” experienced during a dissociative (hypnoid) state, resulting in a splitting-off of traumatic memories and emotions. Freud then takes Breuer’s ideas a step further, arguing that in some cases this splitting of consciousness did not involve hypnoid states, but rather, resulted from a
motivated forgetting of unpleasant realities, “intentionally repressed from conscious thought.” 67

The symptoms, then, were a result of the ego’s failed attempts at segregating the pathogenic idea from consciousness, a “defense hysteria.” 68 Now there were two hysterias— one rooted in dissociation, the other, repression. The paper concludes by presenting the “psychotherapeutic procedure” found to cure the “two conditions,” by allowing the “strangulated affect to find a way out through speech, introducing it into normal consciousness…or by removing it by the physician’s suggestion.” 69

Psychoanalysis had officially been born.

The landmark ‘Communication’ aroused considerable interest within the international scientific community, particularly from French philosopher and psychiatrist Pierre Janet (1859-1947), who was then director of Charcot’s laboratory at La Salpêtrière (1893). 70 Janet had been studying hypnosis and hypnotic phenomena since 1883 and hysteria since 1887, publishing a number of articles along the way. 71 This research coalesced in Janet’s 1889 thesis “Psychological Automatism” (L’automatisme psychologique), a book that William James claimed “made quite a commotion in the world to which such things pertain.” 72 In it Janet describes his theories of hysteria and dissociation (mental disaggregation), which for Janet were synonymous. 73

Drawing from his study of fourteen hysterical women and five hysterical men, Janet observed that much of the behavior of hysterics occurred in the total or partial absence of awareness and without volition, “subconscious” patterns of behavior that Janet called automatisms. Janet also found, as did Charcot, that his work with hysterical patients invariably led to “forgotten” memories of childhood trauma, concluding that the
phenomenon of hysteria was rooted in dissociated traumatic memories. Janet theorized that the overwhelming nature of trauma had a disintegrative effect on the mind, a “narrowing of the field of consciousness,” impairing the mind’s ability to synthesize and integrate traumatic experience. The result was split-off, isolated streams of consciousness which Janet called “fixed ideas.” These ideas were not just thoughts, but psychobiological systems that included affects, sensations, memories, and behaviors. Janet recognized that these dissociated fragments of experience often manifested as nightmares, flashbacks, and behavioral re-enactments, hallmark symptoms of our current understanding of post-traumatic stress disorder (PTSD).

While Charcot was the first to establish hysteria as a mental illness, one rooted in trauma, Janet became the first to articulate the mechanism for which trauma became pathogenic- the dissociative process- establishing him as the leading scientist in the study of hysteria. Clearly Janet, the father of dissociation, influenced Freud’s (and Breuer’s) early work. Yet, Janet and Freud oddly never met or corresponded, though they shared the same inspiration and similar pursuits. After reviewing Freud and Breuer’s Preliminary Communication Janet publically, perhaps sarcastically, remarked, "I am happy to see that the results of my already old findings have been recently confirmed by two German authors." From Janet’s perspective Freud and Breuer’s “traumatic memories” were his “fixed ideas,” their “unconscious” was his “subconscious,” and their therapeutic methods were identical- to make the unconscious conscious. It seemed a consensus was growing. However, in the years that followed Freud increasingly emphasized the process of repression, the “cornerstone on which the whole structure of psychoanalysis rests,” turning his attention away from hypoid states and from the
phenomena of dissociation. As their work diverged, Freud and Janet became rivals, as did their theories, though Janet and his dissociation theory were ultimately overshadowed by the increasing popularity of psychoanalysis and its ambitious originator.

In April of 1896 Freud presented a lecture to the Psychiatric and Neurological Society in Vienna entitled *The Aetiology of Hysteria*. In it Freud announced his findings that with every one of his eighteen hysterical patients he had uncovered (“reproduced”) repressed memories of early childhood sexual abuse, generally by a “close relative.” Freud was sure he had found a *caput Nili*, a “source of the Nile” in neuropathology, concluding that early sexual abuse (particularly its repression) was the source, a precondition, of all hysteria. Freud proposed that these improper, premature sexual experiences created distressing, “incompatible ideas” that the ego repressed from consciousness, ideas that emerged and became pathogenic when the patient was presented with some present reminder of this early experience. To Freud’s great disappointment, his abuse theory, the so-called “seduction theory,” was met with an “icy reception,” with chairman and eminent sexual psychopathologist Richard von Krafft-Ebing calling it a “scientific fairytale.”

This rejection moved Freud to rethink his seduction theory. Among other problems with the theory, Freud had to confront the implications of his brother and sisters’ hysterical tendencies, if hysteria was indeed caused by incest. This dilemma unfortunately coincided with the death of Freud’s father, October 23rd of 1896, which deeply impacted him personally and professionally. The following July Freud began a systematic self-analysis, which he considered an invaluable step in his intellectual (and presumably his theoretical) development. Two months later, in September of 1897,
Freud announced to his friend Wilhelm Fliess that he was abandoning his seduction theory, saying that after he had “pulled (himself) together, (he) was able to draw the right conclusions from (his) discovery: namely, that the neurotic symptoms were not related to actual events but to wishful fantasies, and that as far as the neurosis was concerned psychical reality was of more importance than material reality.” 87 Hence, his eighteen hysterical patients had not been sexually abused by close relatives, these repressed memories were really wishful fantasies, and it was the repression of these instinctive, irreconcilable fantasies that produced the symptoms. Thus was born the "Oedipus complex" and the concept of infantile sexuality. 88 Trauma had been de-emphasized, dissociation dismissed, and the metaphysical had replaced the phenomenological.

The primacy of dissociation would be revisited by a couple “post-Freudian” psychoanalysts, first by Hungarian psychoanalyst Sandor Ferenczi in the 1920s. Ferenczi believed dissociation to be a normal, intrinsic mechanism of human development, a mechanism that also served to segregate traumatic memories and overwhelming affect. Ferenczi called these segregated experiences “splits in the personality,” foreshadowing the contemporary model of dissociation and dissociative identity disorder (DID). 89 However, Ferenczi’s strained relationship with Freud left Ferenczi and his ideas in the margins of the psychoanalytic community. In the 1940s Scottish psychoanalyst Ronald Fairbairn would draw from Janet’s theory of dissociation in developing the concept of splitting, which Fairbairn defined as a specific and selective use of repression to segregate feelings of parental rejection (“the rejecting object”). 90 Splitting would evolve into a core concept of object relations theory, while Fairbairn’s musings on dissociation garnered little attention and were again dismissed.
The Cognitive/Behavioral Perspective on Dissociation

Dissociation would continue to remain on the periphery until the 1970s, when the concept was renewed and revised by American psychologist Ernest Hilgard, whose interest in dissociation had likewise come through hypnosis. Hilgard had begun researching hypnosis in the 1950s as a means of treating pain, however, Hilgard became fascinated by the issue of divided consciousness. Establishing the Stanford Laboratory of Hypnosis Research in 1957, Hilgard began conducting research into divided consciousness and hypnosis susceptibility. Hilgard’s research, influenced heavily by the work of Pierre Janet, also happened to evolve alongside rapid advances in linguistics, computer science, and neuroscience. Emerging from this “cognitive revolution,” Hilgard developed a “neodissociation theory” that redefined dissociation in cognitive terms. Hilgard’s theory made three key, very cognitive proposals about the dissociative process; first Hilgard posited that there were separate, subordinate cognitive systems, each with their own unity and autonomy of function. Although these systems interact, they may at times become isolated from each other. For Hilgard, this explained shifts in consciousness and apparent lapses in awareness, such as “highway hypnosis.” Secondly, Hilgard assumed that there is a hierarchical control that manages the interaction between these substructures, ensuring that consciousness proceeds in some organized fashion. Lastly, Hilgard proposed that there was an even greater, overarching monitoring and controlling structure, what he called the “executive ego,” which plans, monitors, and manages the other functions. Thus, Hilgard proposed that the mind was composed of multiple, hierarchical cognitive systems or structures, which may interact with each other but which are also relatively independent. Hilgard’s beliefs about the multiplicity of the
mind made him one of the first modern psychologists to observe that the idea of a unified consciousness is an illusion.\textsuperscript{93}

With dissociation recast in a modern cognitive psychological framework, the growing cognitive psychology movement suddenly became very interested in the topic.\textsuperscript{91} Through the 1980s and 90s Hilgard’s theory would continue to be researched and revised, though prominently rejected by psychologist Nicholas Spanos, who disputed the idea that dissociation was an altered state of consciousness.\textsuperscript{12} Offering what he called a cognitive-behavioral (later renamed socio-cognitive) perspective, Spanos argued that dissociative behavior was not involuntary, but rather goal-directed, learned behavior, created and reinforced through social interactions.\textsuperscript{13} Spanos’ theory likewise met with criticism, nevertheless, his divergence towards behaviorism illustrated how dissociative patterns could be created and reinforced by the environment.\textsuperscript{94}

Contemporarily, the cognitive perspective is generally wed to the behavioral, seeing dissociation as a dual problem of cognitive processing and behavioral reinforcement, with correspondingly dual solutions.\textsuperscript{14} Dr. Helen Kennerley, a clinical psychologist and prominent cognitive therapist, has formulated dissociative reactions in terms of a cognitive understanding of emotion, while recognizing the role of classical and operant conditioning. Dr. Kennerley demonstrates how conditioned stimuli can both trigger and reinforce dissociative reactions; for example, dissociative states may trigger self-harming behavior, offering escape from aversive emotions. Self-harm in turn may induce further dissociation, reinforcing the cycle. Dr. Kennerley advocates cognitive behavioral strategies for reorienting dissociative clients to the present.\textsuperscript{95}
A colleague of Kennerley, Dr. Fiona Kennedy, has recently proposed a model of dissociation based on Aaron Beck’s cognitive model of personality, which conceptualized personality as a collection of ‘modes’ or sets of schemas that represent encoded cognitive, affective, behavioral and physiological information. These schemas encode internal and external events as well as activate modes (i.e. behavioral patterns) in response, generally unconsciously, without volition. Borrowing from Beck, Kennedy proposes three levels of information processing: automatic (threat) perception and response schemas; strategic information-processing modes (including thoughts, feelings, physiological and behavioral responses); and personality structure (linked to autobiographical memory, consisting of integrated self-states). According to Kennedy’s ‘levels theory,’ when these levels of information processing become overwhelmed, as in trauma, dissociation can occur within and between these modes in three categorical ways: through ‘automatic dissociation’ (during pre-conscious processing of incoming stimuli), ‘within-mode dissociation’ (thoughts, feelings, behaviors, and physical responses which become inaccessible to conscious awareness), and ‘between-mode dissociation’ (dissociated self-states, or aspects of the personality). Initially this compartmentalization within and between the first two levels serves a defensive function, keeping overwhelming information outside of conscious awareness. However, over time the unintegrated material will invariably surface as post-traumatic intrusions and will ultimately disrupt the formation of the self (the third level). Kennedy recommends a characteristically CBT approach to reversing this dissociative process; exposure, systematic desensitization, and integration of the traumatic material within a structured and safe therapeutic relationship.
The Developmental Perspective on Dissociation

The 1980s brought an upsurge of interest in dissociation as a symptom, particularly multiple personality disorder (MPD), now called dissociative identity disorder (DID). The decade opened with dissociative disorders finally adopted as a diagnostic category in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-III), establishing the scientific legitimacy of the disorder. Subsequently, reported cases of MPD skyrocketed, numerous academic papers were published, and several novels and movies personified the disorder. Dissociation questionnaires were also developed and disseminated to provide a way to empirically measure (and validate) the experience of dissociation. The best known of these measures was the Dissociative Experiences Scale (DES), developed by Drs. Eve Carlson and Frank Putnam, which became the model for several subsequent assessment tools.

Dr. Putnam’s later research on infant behavioral states led to the development of his discrete Behavioral States (DBS) theory of dissociation, the first distinctly developmental perspective on the topic. Putnam’s DBS theory proposes that the organization of human behavior begins with five basic, discrete states that are present at birth; regular, non-REM sleep, irregular or REM sleep, alert inactivity, fussy, crying, and alert activity. At birth these states are modulated by caregivers, however, over time they become linked as the capacity for self-regulation is internalized. As development proceeds new states are added as earlier states are refined or replaced. In healthy development these linked states will group into sequences, developing a sense of an enduring, unified personality or “self.” However, trauma can overwhelm the developing mind and impede the integration of these states, resulting in split off, “trauma induced”
behavioral states, states that often arise outside of consciousness. The emergent personality, or "state space," of a dissociative child will thus contain one or more states that are cut off from (or very poorly integrated with) the remainder of the child's state space. Transitions to and from these trauma-induced states (what Putnam calls "switches") are substantially discontinuous, typically quite uncontrolled, and marked by a disrupted sense of self. These states and switches, Putnam proposes, are the very same later found in the manic and depressive states of bipolar disorder, in the panic and normal moods of panic disorder, and the alter personalities of DID.

Putnam’s ideas expanded dissociation theory in a number of ways, first by integrating the literature on dissociative disorders with findings from developmental psychopathology, producing the first developmental theory of dissociation. Secondly, Putnam’s notion of discrete behavioral states established psychic fragmentation as a norm rather than post-traumatic pathology. Thus, it was a lack of integration, rather than disintegration, that resulted in dissociated states. This idea was carried forth by Ellert Nijenhuis, Onno van der Hart, & Kathy Steele, three contemporary experts in the field of dissociation. Their modern, integral theory of structural dissociation similarly holds that dissociation is a “lack of integration among psychobiological systems that constitute personality.” Analogous to Putnam’s discrete behavioral states Nijenhuis, van der Hart, & Steele propose self-organizing behavioral systems, or “psychobiological action systems,” that develop and integrate over time, under “good enough” developmental conditions. These action systems include activities of everyday life (such as those related to work, play, and relationships), what Nijenhuis, van der Hart, & Steele refer to
as the “apparently normal part of the personality” (“ANP”), and defensive action systems (as in fight, flight, or freeze), deemed the “emotional part of the personality” (or “EP”).

Under the impact of trauma these two types of action systems become segregated and divided against each other, producing a schism in the personality. While the ANP strives for a normal life and the avoidance of traumatic reminders, fragments of the EP (traumatic material) tend to intrude into the experience of the ANP (which explains the intrusive symptoms observed in PTSD). Severe or prolonged trauma can lead to secondary structural dissociation, characterized by dividedness of two or more defensive subsystems. For example, there may be different EPs that are devoted to flight, fight, freeze, total submission, and so on. This is seen in as complex PTSD, complex forms of acute stress disorder, complex dissociative amnesia, complex somatoform disorders, and some forms of personality disorders. Early, extreme trauma may result in tertiary structural dissociation, wherein there are two or more ANPs as well as two or more EPs, characteristic of dissociative identity disorder (DID).

Nijenhuis, van der Hart, & Steele distinguish trauma-related dissociation from other phenomena that are often termed dissociation, what they refer to as “alterations in consciousness,” such as absorption, daydreaming, imaginative involvement, trance-like behavior, and “highway hypnosis.” For them, dissociation is distinctly characterized by a division of the personality (as a result of trauma) and thus conceptually different than altered consciousness, with different underlying processes. Putnam, however, found through his research that non-traumatized individuals sometimes demonstrated pathological dissociation, and not all trauma survivors dissociate. This would suggest
that trauma and dissociation may be related but distinct processes. It might also suggest another variable in the development of pathological dissociation.

In his 1992 article entitled *Disorganized/Disoriented Attachment in the Etiology of the Dissociative Disorders* Italian psychiatrist Giovanni Liotti posits that disorganized attachment, that is, growing up with emotionally distant, unpredictable, or threatening caregivers, predisposes a child to pathological dissociation. Liotti proposes that attachment disorganization is in itself a dissociative process, a coexistence of reciprocally segregated, contradictory ego states of approach and avoidance.\textsuperscript{105} Liotti does not suggest that disorganized attachment is the only etiologic factor in dissociation, but theorized that disorganized attachment patterns constitute an initial step in the developmental trajectories that leave an individual vulnerable to developing dissociation in response to later experiences of trauma. Additionally, Liotti demonstrates how the caregiver’s unresolved trauma can result in attachment disorganization and thus predispose a child to pathological dissociation.\textsuperscript{25}

In a 1997 longitudinal study researchers Ogawa, Sroufe, Weinfield, Carlson, and Egeland tested Liotti’s hypothesis on a sample of 126 children from low-income environments followed from birth to age nineteen. At age nineteen dissociative symptoms were measured utilizing the Dissociative Experiences Scale (DES). It was expected that childhood trauma would be a strong predictor of adult dissociative symptoms, and it was, modestly. However, maternal psychological unavailability and disorganized attachment in the first twenty four months of life were by far the strongest predictors of dissociative symptomology, corroborating Liotti’s hypothesis.\textsuperscript{23} A more recent (2009) study done by Dutra, Bureau, Holmes, Lyubchik and Lyons-Ruth further investigated the association
between infant attachment and dissociation in a similar longitudinal study of high-risk children from birth to age nineteen. Using the Observation of Maternal Interaction Rating Scales (HOMIRS) to assess mother-infant interactions at twelve months and the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE) to assess maternal disrupted affective communication at eighteen months, Dutra et al. found that it was a lack of positive maternal affective involvement, maternal flatness of affect, and overall disrupted maternal communication that were the strongest predictors of dissociation in young adulthood, further substantiating the link between compromised early attachment and pathological dissociation. While the evidence for this link continues to mount, the field of neuroscience is uncovering the potential biological mechanisms that underlay this relationship between attachment and dissociation, between connection and disconnection.

The Biological Perspective on Dissociation

The development of neuroscientific tools such as functional magnetic resonance imaging (functional MRI) and positron emission tomography (PET) has allowed us the ability to visually map the brain and its functioning in real time. This new vantage point has illuminated how neurological functioning shifts in response to the environment, particularly the attachment relationship (or lack thereof), and how these shifts literally sculpt the developing brain. Dr. Allan Schore, a leading researcher in the field of neuropsychology, elucidates how this interpersonal, neurobiological relationship establishes neural capacities and tendencies that will ultimately drive behavior. As Shore describes, an infant and their developing nervous system relay upon the attachment figure
to regulate their shifting arousal levels. As the infant becomes dysregulated the responsive caregiver will attempt to “co-regulate” their nervous system via facial expressions, vocalizations, and gestures. Through sequences of attunement, mis-attunement, and re-attunement, the infant’s nervous system will align with that of the regulated caregiver. Over time, as this affect synchrony is repeated, the infant’s developing brain creates a neural map that will grow into independent, self-regulatory capacities. Thus, as Alan Sroufe asserts, we can think of secure attachment as the dyadic regulation of emotion.

But what if this dyadic regulation is compromised, what if the caregiver is unavailable, inconsistent, or insensitive? Without a secure, “good enough” attachment figure available to co-regulate the infant, the areas of the brain that process and regulate social-emotional stimuli will be undernourished and ultimately, underdeveloped. The growing child will have difficulties managing stress and high states of arousal, likely engaging in maladaptive behaviors as a way to self-regulate and feel safe. But what if the caregiver is the source of the stress? What if the caregiver is neglectful or abusive? The child’s natural inclination to seek safety from their primary caregiver will conflict with their fear response to avoid. They will experience a profound dissonance, and in severe or repeated cases, what emerges is a disoriented, disorganized attachment.

In his book *The Science of the Art of Psychotherapy* Allan Schore presents the “origins of pathological dissociation,” detailing how a disorganized attachment relationship compromises the development of the brain’s self-regulatory capacities, specifically in the brain’s right hemisphere, the seat of human emotions. Not only will a disorganized attachment relationship compromise the child’s developing neurological
capacities, such a stressful, insecure environment will also elevate the child’s baseline level of arousal (resulting in consistent hyperarousal). Unmitigated hyperarousal, Schore posits, will invariably lead to a dissociative response that functions to inhibit the arousal and fear response.111 Thus, the dissociative response is fundamentally an impairment of the right brain.

Renowned child psychiatrist Bruce Perry also describes dissociation as an adaptive response to high arousal, a way of disengaging from threatening stimuli in the external world and attending to an ‘internal’ world.28 Perry elucidates how an infant will instinctively move through a continuum of responses in response to insecurity, from hyperarousal through dissociation. Perry states,

In the initial stages of distress, a young child will use vocalization, i.e., crying, to get a caretaker to know that they are under threat. This is a successful adaptive response to threat if the caretaker comes and either fights for, or flees with, the young threatened child. In the face of persisting threat and, depending upon the age of the child and the nature of the threat, the child will move along the hyperarousal continuum (the child's version of 'fight or flight') or into the dissociative continuum.28

Because children are not particularly well equipped to fight or flee (adaptations of the sympathetic nervous system), they are more apt to resort to dissociation (a parasympathetic adaptation), and move there more quickly. Dissociative behaviors exhibited in the acute and post-acute trauma include numbing, compliance, avoidance, and restricted affect. These children can be described as robotic, non-reactive, "day dreaming", or staring off into space with a glazed look.112 These, of course, are biological and behavioral adaptations to transient stress. However, Perry demonstrates how these adaptive states, from hyperarousal to dissociation (hypoarousal), can become neurologically reinforced and repeated, developing over time into enduring threat
response patterns. Because the brain changes in a use-dependent fashion and organizes during development in response to experience, the specific pattern of neuronal activation associated with the acute responses to trauma are those which are likely to be internalized. If, in the midst of a traumatic experience, the child dissociates, and stays in a dissociative state for a long period of time (e.g., by re-exposure to evocative stimuli), the child will internalize a sensitized neurobiology related to dissociation, predisposing them to the development of dissociative disorders. In this way transient states become relatively enduring patterns, or “traits.” Perry asserts that these maladaptive “traits” often account for what is misdiagnosed as attention deficit/hyperactivity or oppositional defiant disorders and get treated as such.

In his book *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation*, researcher Stephen Porges illuminates the underlying psychobiology of dissociative adaptations. Porges’ polyvagal theory proposes three hierarchical stress response systems that relate to different branches of the autonomic nervous system; the sympathetic nervous system and the ventral and dorsal vagal branches of the parasympathetic nervous system. Each of these systems, Porges explains, carries its own adaptive strategies for responding to stress. The sympathetic branch is involved in mobilizing the body for a stress response, i.e. raising heart rate and blood pressure, triggering the release of glucose and adrenalin (epinephrine), etc. By diverting blood away from the organs not necessary to the immediate survival of the organism and increasing blood flow to those organs involved in intense physical activity, the sympathetic nervous system prepares the body to fight or to flee from potential threats.
The parasympathetic nervous system (PNS), on the other hand, functions as an inhibitor to sympathetic arousal, and as a facilitator of rest and repair.\textsuperscript{32} The PNS is mediated by the vagus nerve, which extends from the lower brain and splits into two branches- the ventral and dorsal vagus. The ventral vagus innervates the muscles of the face, jaw, throat, middle ear, larynx, and neck, while also extending to the heart.\textsuperscript{113} By regulating the flow of information between the heart, neck, and face, the ventral vagus plays a key role in the expression and regulation of affect. Porges refers to this system, the phylogenetically most recent of the three, as the social engagement system.\textsuperscript{32}

The third branch, the dorsal vagal, the phylogenetically oldest of the three systems, provides inhibitory input to the heart while also regulating the diaphragmatic organs. Thus the dorsal vagal is responsible for regulating heart rate, respiration, and digestion. The dorsal vagal system can also, under extreme stress, initiate an immobilization response, shutting down bodily systems in anticipation of severe harm. To conserve energy the nervous system, via the dorsal vagus, will reduce heart rate and blood pressure and initiate bodily and emotional anesthesia, having ripple effects across consciousness. According to Elizabeth F. Howell, a leading expert in the field of dissociation, dorsal vagal activation appears to be a mediator of dissociative PTSD, hypoarousal, "tonic immobility," and "total submission."\textsuperscript{33}

The Sociocultural Perspective on Dissociation

Having spanned the psychodynamic, cognitive/behavioral, developmental, and the biological, all individually focused perspectives on dissociation, we broaden our lens to the collective, to the cultural. From a sociocultural perspective we find that the
experience of dissociation is highly culturally patterned, greatly influenced by cultural norms and expectations. For example, Western models of dissociation tend to center on pathology, while other cultures may view altered mental states, switching of mental states, “possession,” and trance states as desirable rather than pathological. In particular, dissociative identity disorder (DID) is seen as primarily a Western phenomenon, perhaps a reflection of the Euro-American emphasis on the self-contained individual (i.e. the fragmented Western psyche is seen and experienced as different selves, versus different self states). In more communalistic cultures multiplicity is generally experienced as an embodiment of communal agents (e.g. ancestors or spirits) with a collective meaning.

In the back of the recently updated Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the American Psychiatric Association now lists a “glossary of cultural concepts of distress.” In this glossary they list ataque de nervios ("attack of nerves") as a culturally based syndrome among individuals of Latino descent, characterized by intense emotional upset, somatic symptoms, and symptoms of dissociation (e.g. depersonalization, derealization, amnesia). These "ataques" generally occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, witnessing an accident involving a family member, or family conflict. Here we see an etiology that clearly reflects the salience of community in Latin cultures, with a culturally relevant symptom cluster (e.g. vehement emotions and somatic complaints). Here the body bears the burdens of the family.

Reestablishing the premise that pathological dissociation reflects a disruption in the mind and body’s integrative functions, a deficit linked to compromised attachment,
how might increasing social fragmentation and isolation impair healthy attachment, individually and culturally? The United States currently has the highest family fragmentation rates in the industrial world: nonmarital births for the nation as a whole are nearly 40 percent and divorce rates are estimated at about 40 percent for first marriages and 50 percent for second ones.116 As of 2011, over a third of U.S. children (over 20 million) lived in single parent homes, nearly double since 1960.117 The support of the extended family is also in decline. Multigenerational families, which accounted for 25 percent of the population in 1940, accounted for only 16 percent in 2008.118

Concurrently, economic pressures such as reduced job opportunities and a rising cost of living continue to mount. When economic pressure is high parents are at increased risk for emotional distress, increased relationship conflict, harsher parenting, and reduced nurturance.119 They may also have little time for their children, as these economic pressures have necessitated more and more nonrelative caregivers (child care), with nearly a third of all U.S. children under five in non-relative care (as of 2011).120 This juxtaposition of rising stress, more single parents, and less familial supports has resulted in fewer and less available attachment figures. Today’s children receive less and less attuned (attachment) interactions, which we have seen are instrumental to the child’s neurological and emotional development. Worse still, these attachment gaps are often filled by “electronic babysitters”—television, video games, or the internet.

According to the U.S. government, on average, children aged two to seventeen spend approximately 4.5 hours a day watching some kind of screen, with 2.5 to 2.75 hours a day spent watching television.121 A 2000 survey showed that the average American preschooler watches 28 hours of TV a week.121 All of this increasing screen
time is both taking the place of interpersonal interactions, central to the development of attuned, attachment relationships, as well as flooding underdeveloped nervous systems with heightened stimuli. At the same time, more and more communication is done electronically, via email or text messaging. Lacking the non-verbal nuances of face-to-face interactions, such computer mediated communication has further disembodied and depersonalized social connections. Consequently, this confluence of sociocultural factors, from the fragmentation of the family and increasing economic pressures, to increasing screen time and electronic communication, both compromises the development of secure attachment while normalizing and promoting dissociative and depersonalizing behavior. The pathology of dissociation finds and easy home in the world of detachment.

So, if dissociation, from a biological perspective, has been linked to escalating arousal, what if the sociocultural environment is pervasively threatening? What if the culture is dominated by fear? Stephen Porges posits that our nervous systems have an evolved, unconscious neural process of threat detection, a process that scans the environment for cues to distinguish whether situations or people are safe, dangerous, or life threatening. This evaluative neurological process, what Porges calls neuroception, will then initiate a stress response relative to the perception of potential threat. For example, sounds and images of violence and aggression may trigger heightened arousal and pre-dispose the child to maladaptive behavioral responses. But what if the sounds and images are coming through the television, be it a video game or the evening news?

Images of violence sell, and therefore ubiquitous and increasingly available to children. Messages of fear garner attention, and so they promoted. As we have learned
the brain will adapt to the environment; the outer world is mirrored internally, and then projected back in behavior. This study proposes that a culture of fear and aggression, from media to domestic to transnational violence, heightens baseline arousal, in turn promoting behavioral adaptations such as dissociation. Concurrently, the ubiquity of latently dissociative diversions, e.g. television, video games, and the internet, offers temporary relief from escalating arousal (i.e. stress), and in doing so, further reinforces dissociative patterns. Thus, the detachment of mind and body is not just a psychological problem, not just an individual problem, but a communal one, in need of communal solutions.

**The Imaginal Perspective on Dissociation**

Broadening our lens further a review of the literature demonstrates how the experience of dissociation is at once both culturally constructed and archetypal, across cultures. Over a century ago Carl Jung (1875-1961) identified dissociation as a universal and necessary psychic activity in the development of personality, an essential function, a sort of mental *individuation*, that only became pathogenic in response to traumatic experience. Dissociation, Jung believed, was the process from which evolved *complexes*, core patterns of thoughts, emotions, memories, and perceptions, organized around a common theme or archetype. These patterns, or *images*, as Jung referred to them, split from consciousness due to certain “incompatible tendencies” and tend to behave like relatively autonomous “foreign bodies in the sphere of consciousness.” We can call complexes *personifications* of archetypes, the *means* through which the archetype manifest in the personal psyche. These complexes, Jung theorized, were
responsible for the symbolic expression in dreams, what came to become the cornerstone of Jung’s Analytical Psychology.\textsuperscript{127}

Jung proposed that trauma produced its own complex, one with a “high emotional charge which brings about the dissociation of the psyche.”\textsuperscript{128} Jung theorized that in trauma this natural differentiation of function is intensified and the dissociative splits between autonomous forces (complexes) in the psyche become more extreme, leading to “splinter psyches.” A splinter psyche, then, is "not under the control of the will and for this reason possesses the quality of psychic autonomy,” a phenomenology congruent with the current understanding of dissociative identity disorder (DID).\textsuperscript{129}

Contemporary trauma expert John P. Wilson furthered this notion, identifying trauma as its own archetypal image (the “Trauma Archetype”), and its personal manifestations, including dissociation, as a complex (the “Trauma Complex”).\textsuperscript{39} For Wilson the Trauma Archetype is part of a collective unconscious, representing universal forms of traumatic experience and the prototypical stress response patterns present in all human cultures. The Trauma Archetype evokes altered psychological states, which include changes in consciousness, memory, orientation to time, space, and person, that appear in the Trauma Complex.\textsuperscript{130} As opposed to the universal nature of the Trauma Archetype, Wilson writes, “the Trauma Complex is the unique, individual constellation of the trauma experience, in cognitive-affective structures located in the self and intrapsychic processes.” These constellations are shaped by culture and will take form in accordance with symbolic, mythological representations of reality.\textsuperscript{39} Thus, dissociation is a personal manifestation of the common experience of trauma, and will look very different and mean different things in relation to the culture and its symbols.
Jungian analyst Donald Kalsched asserts that dissociation is the central mechanism in the Trauma Complex. In his book *The Inner World of Trauma: Archetypal Defences of the Personal Spirit* Kalsched also elucidates his own *imaginal* interpretation of the dissociative process. Integrating the ideas of Jung, Freud, and other theorists, Kalsched posits an archaic, intrapsychic, self-care agency which he calls the *archetypal self-care system*. This psychological system will, in response to early trauma, split the psyche into "progressed vs. regressed" parts of the self. The dissociated parts will, according to Kalsched, invariably constellate around archetypal images, one the protector and the other its opposite, the persecutor. Kalsched explains,

The self-care system seems to carry out its ‘purposes’ through two mechanisms - a preservative effort involving self-hypnosis and encapsulation of a pre-traumatic regressed part-self on the one hand, and a destructive, dismembering activity, involving aggression in the service of dissociation on the other. Encapsulation seems to be a process through which ‘good’ self-states are preserved and isolated from ‘bad’ self-states, while dissociation is the mechanism by which the split compartments of the mind are maintained and amnesia barriers erected among them.

The protector daimon acts as a benevolent figure, protecting the psyche from the unbearable affect of the traumatic experience, including traumatic reminders in the outer world. As a side effect this psychic “protector” becomes a major resistance to all spontaneous expressions of self in the world, promoting a sort of auto-hypnotic, dissociative state. Meanwhile the persecutor daimon, the holder of the ‘bad’ self-states, projects these states inward, becoming self-persecutory and self-destructive. What results is an escalating cycle of dissociation and re-traumatization. For Kalsched, healing these dissociative wounds emerges from an integration of these two archetypal poles.

In Jungian theory these archetypes emanate from a collective unconscious, a "psychic system of a collective, universal, and impersonal nature which is identical in all
According to Jung this collective unconscious does not develop individually but is genetically inherited as “primordial images” and instincts that characterize and convey fundamental human roles and behavior. Examples would be archetypes of the Father (seen as stern, powerful, and controlling), the Mother (feeding, nurturing, soothing), and the Child (representing beginnings, innocence, and salvation). Other archetypes include the Hero, the Maiden, and the Wise Old Man. This “imaginal inheritance,” according to Jung, is only conscious secondarily, and yet ceaselessly surrounds and shapes the unconscious mind, and thus, thoughts, feelings, and behavior.

In 1947 Jungian psychologist Joseph Henderson wrote a letter to Jung suggesting a third, mediating layer of the unconscious between the personal and the collective, what Henderson called the cultural unconscious. For Henderson the cultural unconscious retained and represented the cultural “attitudes” transmitted through the environment and across generations via education, family life and the “spirit of the times.” These attitudes, asserted Henderson, shape a “collective culture pattern” of images and ideas that unconsciously influence the individual. And like the personal unconscious, Henderson believed, the cultural unconscious also carried complexes—“emotionally charged aggregates of ideas and images that cluster around an archetypal core.” These cultural complexes, as a kind of intrapsychic peer pressure, can influence individuals to think and behave in ways that they might not otherwise, as we see in stereotyped roles, prejudiced beliefs, and prescribed behavior.

Integrating Henderson’s notion of cultural complexes into Wilson’s idea of personal trauma complexes emerging from collective trauma archetypes, this study
proposes the existence of cultural trauma complexes, a historical lineage of collective trauma that subsists in the personal unconscious. Particularly in America, a nation rooted in violence and oppression, the shadow of collective trauma darkens the cultural landscape and lives on in complexes of hypervigilance, traumatic reenactment, and avoidance- three hallmarks of post traumatic stress disorder. Our nation’s legacy of colonization, slavery, and subjugation is conveyed through the cultural unconscious and lives on as collective fear and distrust of others. We see the reenactment of violence on our streets and in our homes, we assume roles of oppression in our privilege, and we are relieved of these burdens in our denial and avoidance.

Dr. Joy DeGruy exemplifies these complexes in identifying a “Post Traumatic Slave Syndrome,” a psychic legacy of transgenerational trauma born out of the transatlantic slave trade.48 DeGruy asserts that Post Traumatic Slave Syndrome, an exemplar of a cultural trauma complex, is passed down from generation to generation implicitly and manifests in the African-American culture as patterns of low self-esteem, distrust of others, anger, and violence.136 DeGruy sees these individual patterns as internalized and perpetually reenacted collective trauma. For white Americans, DeGruy says, the horrific legacy of slavery endures in the form of white privilege, or conversely, white guilt, and is likewise culturally toxic.137 DeGruy maintains that healing these cultural wounds requires that we not turn a blind eye (avoidance), that we confront the uncomfortable, and that we acknowledge and re-examine our relationship to the wounds and the wounded.138

Whereas Wilson describes dissociation as a dimension of the trauma complex, this study suggests that dissociation- the detachment of consciousness and connectedness-
is a cultural complex in and of itself, and moreover, a cultural trend (as we discussed earlier). As psychologists Jon G. Allen and William L. Smith outline in their seminal article *Diagnosing Dissociative Disorders* (1993), dissociation acts as a sort of “shut-off mechanism to prevent overstimulation or flooding of consciousness by excessive stimuli,” as in traumatic experience. International trauma experts Vedat Sar and Erdinc Ozturk assert that societal conditions, such as mass media flooding our collective awareness with violence and fear based ideas and images, can be equally overstimulating and likewise lead to psychic “shutting-off,” i.e. dissociation. Culturally this *dissociative complex* shows up as collective numbness and apathy, a culture of “I don’t care.” While such emotional detachment may be self-protective in the short-term, in the long term this overcompensation against overwhelm impedes empathy and understanding, compromising true caring and connectedness. We propose that this cultural complex is both a symptom of our increasingly disconnected society, as well as an unmistakable marker of what we are collectively needing—reconnection.

**Conclusion**

We have surveyed the origins of the concept of dissociation—from its roots in hypnosis, to its cultivation at the hands of its “father,” Pierre Janet, to its disregard and desertion by Freud and his followers. We discussed the “rebirth” of dissociation amid the cognitive revolution of the 1970s and the subsequent emergence of developmental models of dissociation. As we have seen, the 1990s brought an influx of new methodological tools for mapping brain function, illuminating the neurological correlates of dissociation. We learned from neurobiologists such as Giovanni Liotti and Allan
Schore how early attachment relationships literally shape brain development, particularly areas of the brain that mediate self-regulation, and how disruptions in these early relationships can compromise this development, leaving the brain more liable to dissociative “shutting down” to regulate high states of arousal.

We then examined the breakdown of the extended family and increasing attrition of attachment figures, juxtaposed with the not so coincidental upsurge in “screen time,” two factors contributing to increasing social isolation and disconnectedness. We discussed how compromised attachment in turn compromises neural development associated with affect regulation and how our hyper-stimulating society can ultimately overwhelm the nervous system, leading to dissociative “down regulation.” Joseph Henderson and others demonstrated how this ecology of dissociation, these cultural patterns of suffering, overstimulation, and compensatory “shut-down,” can be passed down transgenerationally, manifesting in patterned beliefs and behavior. We concluded by proposing that these cultural complexes of detachment- of psyche, of society- require a corresponding “call to arms” for connectedness, individually and collectively.

The successive chapter examines the life of a young boy caught in the vortex of personal and cultural trauma complexes. His story, Edward’s story, embodies our theories about detachment and disconnection, and imbues them with his deep suffering and dwindling trust in himself and others. Edward emerges as our teacher as to what a psyche, perhaps our society, needs to regain individual and interpersonal connectedness. His resilience that slowly grew into resolve gives hope to all of us who have been wounded, to all of us who have felt disconnected.
CHAPTER 3

PROGRESSION OF THE TREATMENT

*Something we were withholding made us weak
Until we found out that it was ourselves
We were withholding from our land of living
And forthwith found salvation in surrender.*

- Robert Frost

The Beginning

In January of 2010 I joined the outpatient, community based mental health program at the Edgewood Center for Children and Families, a leading social services organization in San Francisco, California. I immediately assumed the clients of the therapist I had succeeded, including Edward and his two siblings, who had been engaged in individual therapy with the previous therapist for about four months. A comprehensive initial assessment had been done and his multiaxial diagnoses looked like this:

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Diagnosis</th>
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<tbody>
<tr>
<td></td>
<td>Disruptive Behavior Disorder NOS (Not Otherwise Specified)</td>
</tr>
<tr>
<td></td>
<td>R/O Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td></td>
<td>Parent-child Relational Problem</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Axis II</th>
<th>Diagnosis</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No Diagnosis</td>
</tr>
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</table>

<table>
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<tr>
<th>Axis III</th>
<th>Diagnosis</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No General Medical Conditions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Axis IV</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Problems with Primary Support Group, Problems Related to the Social Environment, Educational Problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Axis V</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GAF Score= 41 (current)</td>
</tr>
</tbody>
</table>
In her assessment the prior clinician noted that Edward’s intermittent, explosive aggression was likely a symptom of post-traumatic stress, though she wavered on giving Edward the diagnosis of PTSD, opting instead for the more benign, the more behavioral “Disruptive Behavior Disorder NOS” diagnosis. Edward’s treatment plan, signed by both Edward and his grandmother, centered on reducing Edward’s verbal and physical aggression and improving family communication.

Before ever meeting Edward and his family I had a full history and many mental images of their struggles. I had read the accounts of Edward’s anger and aggression towards his family, behavior that seemingly reflected the domestic violence he witnessed as a young child. I was already feeling the sorrow of this fragmented family, torn apart by an alcoholic father, the loss of its mother (who was abandoned and living illegally in Mexico City), barely being held together by a diminutive, equally traumatized 70 year-old grandmother. My first meeting with Edward I was expecting to see a hardened, understandably angry young man. Instead, I met a very slight and shy, baby-faced 13 year-old who avoided eye contact.

This first meeting with Edward and his family was at their home, typical of the community based program for which I worked. The grandmother Maria, a monolingual Spanish speaker, greeted me at the door and introduced me to Edward and his older sister, who both responded with an unenthusiastic “hi” (Edward’s twin brother Ian, who I was also assigned, was then living with the father, though he continued to attend school in San Francisco). The diminutive Edward presented as friendly but uneasy, greeting me with fleeting eye contact and a limp handshake. Throughout the session, which was conducted primarily in Spanish, Edward responded with mostly short answers as I
attempted to explore both his struggles and his strengths. When asked why he thought he was receiving therapy Edward responded with a seemingly rote “to communicate better.” When asked what he would like to see change in his family Edward replied “for my grandmother to stop yelling.” He also acknowledged that he and his sister weren’t particularly close and would frequently argue. To foster rapport we concluded the session discussing Edward’s interests, which were pretty much limited to “fútbol.”

After meeting with Edward I sat down with the grandmother Maria to gather more information and to get her perspective on therapy. The diminutive septuagenarian presented as warm and receptive, expressing appreciation for the previous therapist. She openly but sorrowfully spoke about the family’s history, including her own experience of severe childhood abuse, her immigration from her native Argentina, and her grief of being separated from her only child (Edward’s mother). We then spoke about Edward’s pattern of anger and aggression and how Edward “changes from an angel to a devil.” From this initial conversation three things became readily apparent: 1) The family, including the grandmother, had an extensive, transgenerational history of trauma; 2) The grandmother blamed most of the family’s existing problems on Edward’s father, and 3) Edward’s behavior (and I would later learn, his appearance) consistently reminded the grandmother of the father, which triggered the grandmother’s own traumatic symptoms. Clearly Edward’s “symptoms” existed within a familial culture of trauma, a culture that hitherto was not being addressed.

About six months prior, when Edward and his siblings had been removed from their father’s care, Child Protective Services (CPS) had referred the father to parenting classes and the family for family therapy, ultimately towards re-unification. At the time I
assumed the cases of the three siblings Edward’s twin brother Ian, via a process that has
never seemed legally cogent, was living with his father in Orinda and the two were
attending family therapy with another provider. Edward and his sister were refusing to
attend family therapy, aware that the court/social worker’s plan was ultimately to reunify
them with their father. Though the two were adamant that they did not want to live with
their father, they continued to visit with him on the weekends.

Given that Edward’s father continued to be a part of his life, literally and certainly
psychologically, not to mention the plan for reunification, I supposed that it would be
vital to involve him in Edward’s treatment. Having read the accounts of the father’s
violence, hearing the vivid and vicious stories from the resentful grandmother, I was
admittedly uncomfortable making that first phone call. After a few messages Edward’s
father finally called me back, offering to help in any way he could. The next few weeks
would be spent on gathering more information, building rapport with Edward, and
continuing to enlist the support of his family.

**Treatment Planning**

As mentioned above, when I assumed Edward’s case he already had a diagnosis
and treatment goals in place. His initial assessment, completed by the prior clinician at
the one-month mark, categorized his intermittent pattern of aggression as Disruptive
Behavior Disorder NOS (312.9), though she did suggest a rule-out of post-traumatic
stress disorder (PTSD, 309.81). Edward’s initial goals primarily focused on reducing
Edward’s aggressive/violent behavior (seen as symptoms of trauma), by helping Edward
to better identify his triggers and to practice the use of coping skills. Hitherto the
.modalities used were primarily individual therapy with some collateral work with the grandmother. According to the progress notes, most of this work focused on exploring Edward’s traumatic past, helping him identify his traumatic reminders and reactions, and integrating new skills. While this individual work continued, I doubted how effective it would be given Edward’s apparent lack of attachment and support. So I began integrating family sessions; with the sister, with Edward’s twin brother (at their school, before Ivan moved to a school in Orinda), and with the grandmother, to further assess and address the family dynamics. What developed in these sessions, as I anticipated, was each of them taking turns re-enacting traumatic interactions—yelling, criticizing, blaming, and threatening one another. And they showed very little openness or ability to repair these interactions. This was the hostile world this family inhabited, a world that Edward had to navigate, and I was confident that for significant and sustained change to occur Edward and his family needed to inhabit a new world, one of empathy, understanding, and support.

After the first six months of treatment, three with this writer, Edward’s semi-annual treatment review was due (March of 2010), requiring us to review and reformulate our goals. When asked about his progress and the appropriateness of his goals Edward seemed pretty detached and disinterested, responding with little more than “I don’t know.” I suggested we include a family goal to address the apparent dysfunctional communication patterns in the family, which seemed to get Edward’s attention. Edward agreed, and we agreed to formulate such a goal with his sister and grandmother present.

The following session I met with the whole family, Edward, his sister, and their grandmother, and I relayed my observations of the family interactions. I noted how the
family seemed to consistently communicate their needs through yelling and criticism, suggesting that we could find better ways of communicating. Edward, his sister, and grandmother all agreed, though I had to weed through and redirect the relentless blaming. A goal was included to address and reduce this yelling/criticism through family sessions. I also suggested that the family could benefit from spending more quality time together, from participating in mutually enjoyable activities, so I asked them to explore activities they enjoyed doing together. In the end we came up with a handful of activities the family enjoyed doing together and I included a goal for the normally isolative Edward to engage in at least one family activity per day, versus one or two per week. Edward consented to the new goals, though he was certainly not enthusiastic or optimistic. I would soon come to learn that this acquiescence was also a maladaptive defense, one that would help Edward dissociate from his unmet needs and the needs of his abusive environment.

The Therapy Journey

The first few months of therapy, individual sessions with Edward were typically spent discussing his life and feelings over a game of Uno. Edward was always friendly, though he would seldom initiate conversations and would generally respond to questions with short answers, sometimes after exaggerated pauses. Thinking that he might not understand and/or be responding rote ly, I would sometimes ask Edward to restate my questions in his own words. Sure enough, he would sometimes reply that he didn’t hear or understand the question, though he answered anyway. I would ask Edward, “what were you thinking about just then?,” wondering if he was distracted with a thought
or image. Edward would typically deny that he was distracted, saying that he didn’t fully hear or understand the question(s).

Exploring these interactions, the rote responses were certainly not an issue of language or intelligence, nor do I think it was disinterest or avoidance, per se. I suggested to Edward that he was “está en las nubes,” a Spanish saying for daydreaming or “having one’s head in the clouds.” Edward agreed with my assessment and thereafter our work became tracking when and how he would drift off into the “nubes,” bringing it to his awareness if I observed these flights of consciousness, asking him to report on “where he went.” With a rudimentary understanding of the dissociative process, I theorized that a young Edward responded to the violence in his home by mentally dissociating, consistent with grandmother’s stories of young Edward being physically frozen, eyes glazed over, in the midst of his parents yelling and throwing things. These responses, “successful” in numbing young Edward’s overwhelm, thus became reinforced and repeated, evolving into consistent patterns of negotiating a world that can be threatening. With this hypothesis in mind, I wondered if it would be more effective working with the source of these patterns- Edward’s overwhelming experience of his abusive father.

On April 1st, 2010 I conducted my first session with Edward and his father, both of whom presented as willing but apprehensive. We started by discussing Edward’s weekend visits with his father, which for the most part continued without incident. Edward’s father expressed concern that Edward was generally quiet and detached during these visits. Edward hesitantly disclosed that he at times experienced spontaneous flashbacks of his father yelling or being violent, admitting that he was scared that his father will revert back to this behavior. I validated and normalized these fears, providing
for both of them psychoeducation around trauma and post-traumatic stress. I encouraged the father to respond to Edward with empathy rather than defensiveness. Father apologized for his violent actions, which he attributed to his alcoholism, saying that he wanted to "make up" for these actions. Edward did not respond, continuing to look down with an apparent flat affect. Both Edward and his father said that they thought the session went well and expressed an interest in ongoing sessions.

I came away from this session with more conviction that Edward was indeed experiencing symptoms of post-traumatic stress disorder, as evidenced by the intrusive memories and the characteristic avoidance of traumatic reminders (i.e. his father). In the following individual session with Edward I explored his experience of the preceding session, endeavoring to work more directly with the traumatic memories that had emerged. When I asked Edward about the feelings and images associated with his traumatic childhood, Edward did not seem activated by or opposed to the questions, though he mostly replied “I don’t know” and “I don’t remember.” Unlike the typical teenager asked about tough times, it did not feel like Edward was avoidant of the material, it was more like he was indifferent, detached. Without the presence of material to “process” this trauma focused work didn’t go very far. It would be months before I had a solid grasp on the dissociative process that clouded Edward’s consciousness while serving to dampen his overwhelm. Meanwhile, not much changed.

Over the next few months Edward’s pattern of behavior remained pretty consistent. Per grandmother’s reports Edward would have a couple “good weeks,” which probably meant that he was mostly quiet and detached, and then an aggressive episode (e.g. slamming doors, cursing, pushing his sister). The grandmother would then go into a
bitter, “I don’t want him here” mode, struggling to reconcile her own disparate feelings or the relationship with Edward. She would instead ignore him, openly disparage him, and often threaten to call CPS to have Edward removed from the home. Edward would initially argue, often blaming his behavior on others (which could be understood as a “fight” response to feeling overwhelmed), before resigning himself and isolating in his room (a “flight” response). Edward would then fall back into his pattern of detachment, parking himself in front of a computer or video game (a dissociative response), and the aforementioned cycle would continue.

Conflicts in the home generally centered on the use of the family’s only computer, which epitomized grandmother’s difficulties setting limits. In the aftermath of one of these conflicts I suggested grandmother disable the use of the computer as a consequence and as a motivational tool. Grandmother was apprehensive, saying that she was afraid of Edward getting angry, yelling, and throwing things. I explained to the grandmother how this fear and capitulation, though understandable, actually reinforced Edward’s maladaptive behaviors, as he seemed to attain more power and control the angrier he became. The grandmother said she understood, though her fear, which was rooted in her own experience of domestic violence, would continue to incapacitate her. Going forward I continued to reinforce grandmother’s capacities and confidence in setting limits, while providing her a referral for her own therapist in hopes of teasing apart and resolving some of her own residual trauma.

On September 22, 2010, during a session with Edward and his sister the two siblings began arguing and Edward became belligerent. As I attempted to redirect and de-escalate Edward he responded to his sister’s criticism by kicking her in the chest. I
immediately separated the two into their respective rooms, then attempted to process with Edward what he was experiencing and how he could better express what he was feeling. As the minutes ticked passed our scheduled time it became clear that Edward was not de-escalating, and it was not safe to leave the family on their own. I encouraged grandmother to call the San Francisco Child Crisis team, who intervened by sending a worker to the home. I left after nearly two hours at the home, as the crisis worker sat with the family until Edward was able to calm and retire to his room for the night. Subsequent to their intervention the Child Crisis team made a referral for Therapeutic Behavioral Services (TBS), an in-home, intensive, behaviorally focused intervention for children who are at risk of being removed from their home. By November a TBS worker was coming to the home twice a week to work with Edward on his anger and aggression and on the family’s overall communication, with the two of us collaborating on our roles and interventions. Meanwhile, Edward’s father was refusing to see or speak to him until Edward “changed his behavior.”

In December of 2010, on his way home from school, Edward was robbed at knifepoint by a group of unidentifiable teenagers who demanded his Ipod™ and wallet. Reportedly they robbed him and then pushed him down. Afterward Edward returned home and went straight to his room, not saying a word. I was already scheduled to see Edward later that day, but got a call from the grandmother to let me know what to expect. When I entered the home, only a few hours after the incident, Edward was sitting in his room staring blankly at the ceiling. I let Edward know that his grandmother had informed me of the incident and I expressed my shock and sadness. Edward did not move or respond. I placed my hand on his shoulder, seeking to reassure him, and to “bring him
into his body.” I provided some basic psychoeducation about trauma, like “it makes sense that your body feels overwhelmed and wants to shut down after experiencing something so scary.” Edward made eye contact and nodded in recognition. We concluded with a game of Uno. Before leaving I provided the grandmother some basic psychoeducation about post-traumatic states, what Edward seemed to be experiencing, to best support him over the next couple of days. She was receptive, and sympathetic to Edward’s experience.

In the days and weeks that followed Edward was exceedingly reserved and detached. He would get up, go to school, come home and go straight to his room, all the while saying little to anyone. Reports from the family and school were that he was presenting as flat, distant, and disinterested. Clearly Edward’s preexisting tendencies towards dissociation (i.e. divided consciousness and avoidance) had been amplified by the assault. Interestingly, this traumatic incident both unearthed the family’s empathy for Edward and eliminated his hostility, as Edward was plunged into a docile, hypoaroused state. All of a sudden the world was worried about Edward, not afraid of him. All of a sudden his grandmother was being caring, not critical. It occurred to me that Edward’s world preferred him dissociated, docile, and I approached my supervisor with the concern that Edward’s environment was inadvertently reinforcing the dissociation.

My supervisor and I discussed ways to work more directly with Edward’s dissociation, drawing from her training in somatic psychology. Working from the hypothesis that Edward’s early trauma established psychobiological tendencies towards dissociation when stressed, tendencies that continued to cloud Edward’s awareness and distance him from his feelings, we discussed ways to help Edward be more mindful of these tendencies, how to re-orient himself to the present, and alternative ways of coping
with stress. In subsequent sessions I suggested to Edward that we experiment with some somatic exercises, to which Edward agreed. One such intervention entailed Edward and I standing face-to-face, with me asking him to “feel into his legs.” My verbal cues kept Edward’s eyes on me (oriented) as I directed him to extend his arms out in a pushing motion. A conventional boundaries exercise, I asked Edward to track and report on how the movements felt, aiming to build his somatic awareness. I asked him what he was feeling, to which he replied “weird.” Normalizing his feelings, I then raised my arms to his and asked Edward to meet my hands between us. Providing a supportive resistance I invited Edward to push back on my hands, to oppose my force, while continuing to track the shifts in his body. Despite my consent and continued encouragement Edward struggled to oppose my force, meeting my arms with feeble ones, and an uneasy smile. I asked Edward what was coming up for him as he opposed my force. He responded with shrugged shoulders and the word “nada.” We tried again, yet Edward just couldn’t muster much force. For a teenager branded with the label “aggressive,” Edward struggled to mobilize the energy of aggression, even when pushed, literally. Was this the same boy who kicked his sister right in front of me?

Typical of the dissociative process, Edward seemed to have two distinct “personalities,” one built around managing and surviving in the world (by making himself small and quiet) and another stuck in the traumatic experience of his childhood. It was the latter “personality” (what is here termed “subjectivity,” an embodied aspect of Edward’s subjective experience) that held the associations of anger and aggression, which emerged when triggered. “Angel and devil,” as grandmother put it. Repairing this split, in theory, meant integrating the two poles so that Edward could feel the energy of
assertiveness without the negative associations of aggression and violence. But before this integration could take place we had to continue working on Edward’s awareness of these polarities and continue developing his skills to self-regulate these polarizing states.

In our individual sessions I continued to offer Edward somatic exercises to help him orient to the present, to support him in tracking his feelings and sensations, and to stretch his ways of being. Edward participated well and began showing an increasing awareness of his internal process, i.e. being able to notice if and when his heart started beating faster (as in hyperarousal) or his hands got colder (hypoarousal). As this work progressed Edward seemed to become more “embodied,” as seen in changes to his posture, physical movements, and engagement with the environment (like offering me a firm handshake). This “embodiment” coincided with what seemed like growing confidence and comfort asserting himself, which had some unforeseen side effects. When he would have otherwise acquiesced, Edward began to express his disagreement and to set boundaries with others. For instance, he no longer accepted when his grandmother would offhandedly call him “pendejo,” a Spanish slang word Edward defined as “dumbass.” He demanded she stop, though his grandmother would continue to use the word on occasion, sparking an argument. Ultimately, Edward expressing his feelings produced more conflict in a world that preferred him passive.

Another, more positive side effect of this growing confidence was Edward becoming more comfortable in social situations. Whereas he had pretty much been friendless and isolative, Edward began making friends at school and began showing interest in being social. He became aware of who was popular and how he wasn’t. He even developed a “crush” on a girl. Around this same time, September of 2011,
grandmother discovered that her wedding ring, the ring given her by her deceased husband, had gone missing. She later found the ring hidden in Edward’s sock drawer and became incensed. When grandmother confronted Edward about the ring Edward’s sister disclosed that Edward had been stealing clothes from local stores for weeks. Speechless, Edward essentially locked himself in his room and refused to come out. Edward later confided to this writer that he felt embarrassed by his clothing and wanted “fancy things” to be more accepted by his peers, and therefore took his grandmother’s ring with the intention of selling it. Validating Edward’s desire for acceptance, I explored with Edward what it meant to be “accepted” and how he wanted to be accepted. I then explored with Edward what he risked for this acceptance, in stealing from stores and from his grandmother. Edward listened, though he was clearly preoccupied with being accepted by his peers. The issue of stealing was subsequently added to Edward’s treatment plan and became an additional focus of therapy.

Around this same time, September of 2011, our clinical team agreed to bring another therapist on board to provide the family therapy, so that I could concentrate on Edward and his needs. While I continued to have regular contact with the grandmother (and the father, who continued refusing to see Edward until his “behavior changed”), a new clinician offered a clearly defined focus on the needs of the family. It also eased the diffusion that I had been feeling for some time, trying to balance the needs of three individual clients and a family. The reconfiguration seemed to go well and the added support aided in the family’s progress. As 2011 was coming to a close Edward had eliminated his stealing behavior, had not acted out aggressively for months, and was
playing soccer daily with friends. Due to these improvements TBS services terminated in December due to Edward achieving his goals.

In February of 2012 Edward’s sister informed grandmother that Edward had been stealing from stores again. Grandmother immediately called me, rather than confronting him. When I brought up the issue to Edward he reluctantly reported that he was being bullied at school and felt unsafe. To Edward, having “nice” things was the quickest way to acceptance. I validated his feeling, normalizing the influence of peer pressure, while challenging the idea that wearing different clothes had or would change anything. We then discussed ways to address the bullying situation, such as telling a teacher or school counselor, though Edward said that would only serve to label him a “snitch” and likely increase the teasing. Exploring different options, Edward realized that it was mainly one boy in his physical education class that made him feel uncomfortable. I suggested to Edward that he change P.E. classes and we role played how he could ask his school counselor for such a thing (encouraging him to access his assertiveness). In the end, Edward was able to approach his school counselor and advocate for the change. Subsequently, the classes were switched and the stealing behavior stopped thereafter.

In the summer of 2012 Edward’s father was still refusing to see him, though Edward’s sister continued to visit their father. She would often return with gifts and stories of fun trips and activities that she, her brother Ian, and father shared in. As one might expect this boasting often triggered Edward’s anger and he would often retaliate with criticism, though the conflicts were few and far between. The sister just wasn’t home that much. With no activities lined up for the summer (Edward refused to attend any summer camps), Edward spent most of the day on the computer or playing video
games, totally detached. He soon fell into a pattern of staying up very late on the internet, until two or three in the morning, saying that he was downloading music and connecting with friends. He would then sleep until the early afternoon and often didn’t change his clothes or groom himself. He did not want to go outside and had no interest in social activities—these were clear symptoms of depression. I encouraged Edward to get on a more regular sleep schedule (and urged grandmother to make that happen) and to get some exercise. I also began taking him for walks, though a couple of times he refused to leave the house. As well, I bought Edward a calling card and asked grandmother to make sure he used it to call his mother in Mexico. He did a little bit of all these things, to little overall effect. As a sort of last resort we also arranged an evaluation with our staff psychiatrist, who both encouraged Edward to get on a better sleep schedule, to get more exercise, while also prescribing him an anti-depressant medication. Between getting a bit more exercise, grandmother limiting the internet (or at least trying to), and the medication, Edward was ultimately able to stabilize his sleep schedule and restore his baseline mood and energy, just in time for the start of school, August 2012.

Things were going fairly well the first few weeks of the school year. Then in late September 2012, Edward got into a fairly typical argument with his grandmother and decided to leave the apartment and take a walk. On his way down the stairs his sister intervened and shouted at Edward that “the only reason (grandma) kept him was for the (foster care) money.” This comment sent Edward into what he described as a blind rage with him putting his hands around his sister’s neck and threatening to kill her (what I assessed as a traumatic re-enactment). The sister reportedly ran away and locked herself in her room. The grandmother immediately called the social worker and I followed suit,
to ensure that the department had all the information. The social worker determined that Edward was a “threat of harm to himself or others” and was removed from the home and placed in a short term residential program on the Edgewood campus in San Francisco.

The aim of this program was crisis stabilization, removing kids from dysfunctional home environments so as to rework these dynamics in a separated, safer way before returning the child home. In addition to providing Edward residential care, the program also put into place a case manager ("care-coordinator") and “parent partner” to the treatment team that already included me and the family therapist. The expected stay for Edward in this program was two to three months.

Weekly individual therapy and family therapy (with another provider) continued while the residential staff ensured that Edward was in an environment that treated him with respect, regardless of his behavior (which was consistently good throughout). The program required Edward to be more physically active and more social, and he demonstrated that he could make friends easily. The case manager made sure that Edward got to school on time and that he did his homework. He was finally getting a clear and consistent structure (and caregiving), and even though he complained about being there just about every day, he continued to progress and do well (he did not have an incident of aggressive behavior the entire length of his stay).

Over the course of the next four months Edward was slowly transitioned back home, via regular family visits and therapy to track and reinforce the desired changes. Though things were far from perfect they were manageable, with Edward more confident in his feelings and his ability to manage them and grandmother more assured of her ability to set limits. Most of all, Edward had an entirely new, increasingly vibrant social
life outside the home (in lieu of his dissociative, digital world) that served to offset the ingrained trauma of his grandmother’s home.

Edward’s increased “presence” in the world manifested in our work together as more focus and engagement, more reciprocity. Edward initiated conversations more, made more eye contact, and was more open about asserting his wants and needs (like wanting to end therapy early to be with friends). Our therapy evolved from the somatic work to include more dialogue and reflection. We began discussing the meaning behind things, like his and his family’s behavior, and what he wished for in the future. Most importantly, Edward began to demonstrate the ability to take responsibility for his part in the negative cycles, for his negative behavior, a sign that he was increasingly able to identify and manage feelings of shame and blame.

In June of 2013 our clinical team determined that Edward had demonstrated significant progress towards his individual treatment goals, such as reducing aggressive behavior (not having had an incident of physical aggression since August of 2012), eliminating stealing, and increasing sociability. Being that much of the negative family dynamics, like poor and generally passive aggressive communication, remained, our clinical team decided to discontinue individual therapy and shift the focus to the family work (with another provider). Edward’s case manager would remain as Edward’s personal support and advocate. This of course meant that my three-and-a-half year relationship with Edward would come to an end. It was a hard decision, but the right one, given Edward’s maturation and changing needs. Edward had few accomplishments in his life, and the prospect of “completing” individual therapy offered both a tangible and symbolic gesture that Edward was not the problem, at least not the sole one.
I remember well the session in which I informed Edward of the team’s decision; visiting Edward at summer school, inviting him to take a walk across the street to a park. As young children joyfully ran around us, I let Edward know the plan to discontinue our individual work and thus, our relationship as he knew it. I highlighted and reinforced all the difficult work we had done together and all the progress he had made. I reiterated that he was not the problem, and suggested that the focus needed to be on the family, which Edward felt was the problem. Upon hearing the news Edward was quiet and contemplative, seemingly in shock (or perhaps drifting into dissociation), as to be expected given his history of abandonment and loss. I normalized these apparent feelings of surprise and disappointment, noting the amount of loss that he has had in his life. Edward nodded and re-engaged eye contact, which I took as a sign of his increased ability to be self-regulate and stay grounded. We discussed the reasons and new plan. Edward ultimately said he was sad but understood and actually seemed appreciative of the idea that he was progressing and perhaps less in need of therapeutic support. We would spend the next couple of weeks continuing this process of reflecting on our work, Edward’s progress, and ongoing concerns. We ended our work together with a celebratory session, a dinner at Edward’s home with him, his sister, and their grandmother, honoring the positive work that Edward had accomplished in our time together. Treatment was thus discontinued on July 18th, 2013.

**Legal and Ethical Issues**

Over the course of this work with Edward there were a number of legal, ethical, and cultural issues that needed to be considered. Since Edward’s placement with his
grandmother was technically a foster placement, CPS was ostensibly Edward’s legal guardian. This meant that it was the social worker who needed to sign the informed consent form and Edward’s treatment plans, and it was ultimately the social worker, via court rulings, who was going to determine much of Edward’s fate (like if Edward was going to reunify with his father as social services intended, to which Edward was adamantly against). Because of these dynamics I had to regularly collaborate with Edward’s social worker, attend team decision meetings, and at times, compose court reports. Given the circumstances, I had to consider: 1) the “mandated” nature of the treatment, 2) the influence of social services and the legal system, and 3) the clinical need and appropriateness of disclosing treatment information to social services or legal representatives. I also had to be mindful of legal obligations juxtaposed with client confidentiality.

To address these less than ideal dynamics, I started from a place of transparency with Edward and his family, acknowledging and encouraging dialogue about the presence of social services, my role, and the limits of confidentiality. I clarified what sort of information would be a mandated report (such as disclosures of past or present abuse) and what sort of information would generally be expected by social services, such as treatment goals and progress. As is generally my stance, I vowed that any information that would or should be communicated to the social worker I would first discuss with the family, a vow that was tested many times, particularly vis-à-vis mandated reports (three over the course of our work together).

In retrospect I believe that I skirted this line well, utilizing collaborativity to pull together the many involved providers while also safeguarding the trust that I had
accumulated with Edward and the family. In the case of the mandated reports, I first discussed the need to make such a report with the family and encouraged them to be there with me as I called the respective reporting agencies (CPS and APS). I suggested they feel free to speak to the representative on the other end of the phone, to ask whatever questions they might have, to share whatever information they thought was pertinent. In all three cases I believe there was an initial rupture of trust between me and Edward, something I named and invited dialogue about. It was my experience that it only took a few subsequent sessions to restore the feeling of trust between us, though I acknowledge the possibility that Edward idealized me in many ways and found it difficult to feel and express anger towards me.

Relative to my relationship with Edward, I also had to navigate the fact that I was initially assigned as the individual therapist for three siblings, with their various configurations of sibling conflict. While much of their issues centered on the same family problems, such as the abuse by their father and the absence of their mother, they each had their own experience and needs and I had to hold each of them equally. I also had to foster a safe space for them to be able to talk about their siblings if they wanted or needed to, which I cultivated by consistently re-affirming the parameters of confidentiality. Lastly, I had to be mindful of my own countertransference, tracking if and when I started to align with or dislike one of the siblings.

Cultural considerations were also present from the onset, as Edward and his family are Latino and primarily Spanish speaking, while I am a Caucasian male who learned Spanish as a second language. I had to constantly be mindful of my privilege and questioning of my cultural assumptions. As Edward’s therapist I had to assess for how
culture impacted his life (Edward was himself bi-cultural, Argentine and Mexican) and our relationship and create an environment welcoming and supportive of these issues. In this pursuit I had to remain curious and receptive, deferring to the family as the expert, and occasionally consulting with Latin team members about the cultural context of our work.

**Outcomes**

Edward’s case highlights the interrelated relationship between so-called symptoms and the environment in which they arise. Edward’s symptoms of dissociation, like divided consciousness and interpersonal avoidance, gave him a way to detach from an aggressive, unstable world. These implicit memories lay dormant, soothed by the dissociative trappings of the digital world, but would burst forth when triggered by some trauma related cue. As my work with Edward began loosening some of these dissociative restraints, bringing him back into his body, back into the present moment, Edward began to show more presence and vitality. He grew more assertive with his feelings and needs, more sociable and socially connected, and showed more focus and motivation at school.

As we discussed earlier, a side effect of this renewed vigor was an increase in familial conflict as Edward began voicing his previously dissociated feelings. This was often experienced by the grandmother as defiance or disrespect, which generally resulted in her yelling and disparaging him and Edward yelling and disparaging back. Ongoing family therapy helped quell the aggression, though much of the dysfunctional family patterns persevered (like grandmother’s harsh criticism and blame). Still, Edward showed an improved capacity to manage his anger, halting his physically aggressive behavior
(like pushing, hitting, kicking, etc.), with the incident of choking his sister being the last (September of 2012). He showed an increased ability to talk about his anger and what triggered it, though he continued to assign much of the blame and responsibility to others.

About a year after we terminated, Edward’s care coordinator informed me that Edward was eagerly moving towards his 18th birthday and was continuing to do well. He was continuing to live at his grandmother’s home, there had been no incidents of physical aggression, and he continued to do “OK” in school. I was pleasantly surprised to learn that Edward had a girlfriend, which, given his prior issues with trust and intimacy, was a sign of how much progress Edward had made. Not surprisingly, much of the dysfunctional family dynamics, like the mother’s separation, the father’s inconsistency, and or course, the grandmother’s austerity, lived on. Nevertheless, given this family’s traumatic history, high level of stress, and lack of resources, I would say that our work, far from a “life saver,” was more a life preserver, helping them stay afloat in a deep, tumultuous sea of despair. My hope for Edward, as he nears adulthood, is the chance to start over in a new environment, one that can see and support his many gifts and underlying benevolence.
CHAPTER 4

LEARNINGS

*Life is a series of experiences, each one of which makes us bigger, even though sometimes it is hard to realize this. For the world was built to develop character, and we must learn that the setbacks and grieves which we endure help us in our marching onward.*

- Henry Ford

This chapter discusses my learnings through the process of psychotherapy with Edward and his family. The following presents “what happened” for Edward, as I see it, over the course of our work together and how I was also affected. The chapter will detail what I view as the imaginal structures that underlay Edward’s experience, the patterns of experience that he enacted to manage in an unmanageable world, adaptations that inevitably became maladaptive. This chapter also explores my own imaginal structures that were activated over the course of my work with Edward and his family, and how the shared journey with Edward deepened my own learning along the way.

This journey holds Edward’s struggles to survive in a chaotic world as both deeply personal but also archetypal, a familiar story in the annals of the human experience. Seeing through this archetypal lens, this study envisions Edward’s experience as a personification of the Greek myth of Pan, and his exile by his grandmother a parallel of the mythic story of the scapegoat. The conclusion of this chapter discusses the components of the Imaginal approach to psychotherapy that arose, intentionally and unintentionally, over the course of my therapeutic work with Edward and his family. The
chapter concludes that such an integral approach best encapsulated this child and family’s experience, as it most freely accounted for and addressed the multi-layered problems in this young boy’s experience.

Key Concepts and Major Principles

Among the various ways to conceptualize dissociation, as well as Edward’s experience of it, this study leans on two key concepts and one major principle. The first of the two key concepts is the idea that compromised attachment, particularly at a young age, will disrupt the child’s development of self-regulatory capacities, predisposing them to unmanageable arousal states. If unmitigated, this escalating arousal will invariable lead to dissociative coping. Thus, compromised attachment is a pathway to dissociation. The second key concept is that if a particular stress response is “effective,” which we can narrowly define as 1) bringing psychic relief and 2) ending in survival, then that response will be neurologically reinforced and likely repeated again under threat. Thus, defensive states evolve into enduring traits.

While a traumatic childhood and compromised attachment planted the seeds of dissociation, it was Edward’s environment that cultivated and reinforced it, the major principle and learning of this case study. Edward grew up in a familial culture where speaking out put one at risk for being yelled at or even hit, and so he withheld. Asserting one’s needs often ended with rejection or guilt, so he repressed. Turning away from these threats, Edward found relief in the dissociative trappings of video games and the internet, detaching into the digital world for hours upon hours. In these anesthetized states Edward
found solace, a sense of control, and contentment. And in these states Edward was considered a good boy, further reinforcing his dissociation.

What Happened

What I believe was happening for Edward when we first met was the experience of just another loss, another abandonment. He had been working with a therapist for four months before she relayed that she was leaving the agency and thus, he was again going to be working with someone new. Edward had already had the experience of losing a therapist, in addition to a number of social workers, in addition to the loss of his abandoned mother and estranged father. Edward was already carrying around an imaginal structure of distrust, the sense that people were not reliable, a structure equally rooted in personal and cultural history. And here I was, another new person, full of questions and enthusiasm.

When we began Edward was friendly enough, he had gotten good at smiling and nodding his head to avoid conflict or engagement. But his mind and his body were committed to withdrawal. Knowing little about the dissociative process, I turned to my training as a psychotherapist to lead the way. I utilized play and art therapy to facilitate communication, trying to build insight and understanding about Edward’s life. Edward especially liked playing card games, and for a while, making arts and crafts. But there was not much reciprocity there. Edward seemed to be going through the motions.

I believe Edward saw me as an ally, though it must have been confusing that I was at once the therapist for him and his sister (and his twin brother for about six months). I believe I did a good job of framing my role, holding boundaries between the
siblings, and advocating for Edward’s needs. Yet, I found myself often being drawn into the grandmother’s polarizing complaints about the kids, like “you need to talk to him, he just eats all the cereal, he’s so selfish,” trying to elicit empathy for their position. I think that Edward appreciated someone taking his side, empathizing with his needs, which I felt in the developing trust between us.

As the trust grew Edward was more comfortable “experimenting” with different interventions. I began to introduce more “body based” interventions, like asking Edward to extend his arms in boundary setting movements, while I then pushed back on his extended arms as a test to his boundaries. I utilized interventions like this to both engage Edward’s rather flaccid body and to help him practice asserting his energy in appropriate ways. Edward’s initial reaction to such intervention was a sly smile and clear discomfort. Yet, he gave it a try.

There was another time I asked Edward if he could forcefully respond to me with a vocal “NO!,” to feel and explore this energy. The idea was that Edward tends to repress the energy of assertion, as it likely was associated with aggression and therefore fear. Of course, as with repression, when this repressed energy was triggered it would explode outward in an unconscious, uncontrollable rage. By asking Edward to tap into fragments of this energy I was hoping to experience and process small, manageable fragments of it. Again, Edward was clearly uncomfortable with this intervention and could hardly muster an audible “no!”

I think that Edward probably thought these interventions were strange, certainly new, but still participated because he liked and trusted me. As time went on we continued doing more active, energizing interventions, like taking walks, playing soccer together,
all the while reflecting on Edward’s experience of his body and how his body would change during these activities. I think what developed in Edward over time was a greater capacity to identify his somatic experience, a greater capacity to regulate his internal states, and a raised confidence in his ability to assert himself.

As Edward grew more confident and more social it seemed that he grew less interested in therapy, which made sense. As he gained friends and expressed himself more he was in less need of a confidant, especially an adult one. He started getting his interpersonal (attachment) needs met in other, more developmentally appropriate ways. I recall asking Edward, about midway through our course of therapy, what he did want me to help with. He responded, “help me with my dad.”

Throughout the entirety of our time together Edward had a conflicted and confusing relationship with his estranged father. The father would pop in and out of his life, sending Edward mixed messages. Edward seemed to hold hope that I could recruit the father, perhaps help him better understand Edward, and restore their relationship. But the father never really wanted to meet his teenage son half-way. He blamed Edward for their conflict and wanted Edward to do all the work (i.e. literally telling me that if Edward wasn’t going to call him and apologize for his behavior he, the father, was not going to be the first to pick up the phone), which both mirrored and reinforced Edward’s lack of personal responsibility. So while I occasionally revisited the endeavor to engage Edward’s father, their relationship took a backseat to more accessible issues.

The week that Edward was removed from his grandmother’s home his sister had just returned from a weekend visit to their father’s home. She overtly pranced around the house with her new clothes and backpack that the father had bought for her. The
underlying message was that Edward could have new things too if he acted like a good kid, which at the time meant him cutting his hair the way the father wanted. A few days later Edward and his grandmother were arguing about something and Edward decided to take space, to leave to avoid escalating conflict. Edward exited the apartment and his sister followed him to the stairs where she told him that the grandmother didn’t want him there, that she only let him live there for the (foster care) money. This expression of shame and betrayal triggered something deep in Edward that he could not control and he lashed out, hitting his sister and then grabbing her around the neck. She managed to escape and return to the apartment where she shut and locked the door. In that moment I think the shame set in for Edward. In fact, true to the dissociative process, Edward said that he didn’t really remember hitting or choking his sister, only the aftermath.

This incident was reported by the grandmother to the family social worker, who a few days later removed Edward from the home and placed him in a short-term residential program within our agency. With Edward’s removal I would be able to continue as Edward’s individual therapist while the family would get additional supports, and Edward would be able to return home when it was deemed appropriate, be it two weeks or twelve months. Even though I had conflicted feelings about the removal, I did think it was for the best. Edward really needed to be away from his toxic home environment in order to heal. And grandmother needed to be away from the volatile Edward to better see him, to better see her role in his struggle, and to hopefully integrate new learning and behavior to better help him settle.

The day that Edward was placed in the program he was highly agitated, refusing to eat. He basically went on a hunger strike for two days in protest (surely an unconscious
way of reclaiming control). Edward constantly asked anyone and everyone around when he was going to be able to go home. I tried my best to validate his feelings, while also suggesting that he needed time away from grandmother so that the two of them could practice the skills to help them communicate better. Edward was adamant, to his credit, and rightfully so, that he wasn’t the problem (or at least, not the only problem), so why did he have to be removed? Of course, he was also struggling to come to grips with what he did with his sister, not only because she had always been his closest ally, but he had also re-enacted upon her the type of abusive behavior he witnessed his father inflict on his mother.

As the days and weeks passed Edward continued to ask when he was going home, though he was doing quite well in the program. Though he was thought of as a bit peculiar, staff really liked Edward and Edward seemed to make friends easily, with staff support. With staff inviting him out and facilitating activities Edward started becoming more physically active. With staff supporting his school work Edward started getting better grades. With staff prompting, Edward would limit his time on video games and the internet and became more social. Patterns that remained for years were beginning to change in weeks. In four months in the program Edward did not have a single incident of aggression, evidence that this aggression was tied to his family home, demonstrating that what Edward needed was more structure and attuned attention in order to change.

Given Edward’s progress towards his individual goals, juxtaposed with the unremitting problems within the family, our clinical team decided that it was time to terminate individual work with Edward, with Edward’s case manager (care coordinator) continuing to support Edward’s individual needs, and another provider continuing the
family work. More than anything, the ending would be a symbolic gesture of Edward’s hard work and underlying goodness. This decision was not taken lightly, I was well aware of Edward’s imaginal structures around loss and abandonment. In fact, because of this I felt that having an appropriate, “positive” goodbye might be reparative for Edward. I was also well aware of Edward’s issue with his father (and my own issues with my father(s), and how he might experience me as a father figure. With all this in mind, I endeavored for a very conscious closure.

When I relayed the news to Edward he was understandably surprised and saddened, dropping his gaze to the ground. As I stressed his progress and successes Edward was absolutely silent and still. I normalized how he might be feeling, noting all the loss he had experienced in his young life, highlighting both his father and mother’s absence. I also shared my own feelings of loss, telling Edward that I was sad as well, that I would miss him. Edward raised his glanced and nodded his head, tears in his eyes. I felt his appreciation, though I could tell he did not want our relationship to end. I let him know that we had three more weeks to meet and proposed we end with a celebratory dinner. We ended with a pizza party at his house, and our closing was very appropriate, and appropriately jubilant.

Returning to the “key concepts and major principles” of this study, I believe that Edward’s symptoms of dissociation were ultimately rooted in a compromised attachment. The instability of his childhood home just did not support healthy development, coupled with the constant threat of yelling and violence, Edward did not seem to develop the capacities to self-regulate states of high arousal. And so his young psyche dissociated, distancing his awareness from a painful reality, and in doing so, fragmenting the
overwhelming facets of trauma. In turn, these traumatic fragments would re-emerge as traumatic re-enactments when triggered, creating a cycle of violence and dissociation. Edward’s dissociative self, hiding in an increasingly popular digital world, was just safer, for him and for those around him.

Our clinical team would often joke that the program became Edward’s “attachment figure,” providing the “secure base” he needed to explore his world and his selves, a joke that in retrospect probably capsulated “what happened” for Edward. I, along with others who joined Edward’s team along the way, became “co-regulators” for Edward’s volatile arousal states, an essential role that his parents did not/could not provide, and his grandmother was just as dysregulated as he was. I had the experience that we, his treatment team, were “re-parenting” Edward’s wounded child, enveloping him in empathy and compassion, held by a firm but supportive structure. While we provided the model and support to help Edward develop these capacities in himself, it really took freeing Edward from his toxic, traumatic home environment to buttress and bring these capacities to life. As Edward grew more social the dissociative trappings of the internet and video games became less alluring, and so these reinforcers fell by the wayside. “What happened” for Edward is he was re-connected.

Imaginal Structures

How I was Affected

My first thought upon meeting the quiet, diminutive Edward was- “this is the kid that everyone is so afraid of?” It just didn’t fit. In that moment my preexisting images of
the violent, uncontrollable Edward disintegrated into a sort of fable, a narrative that I would not fully believe until I saw it with my own eyes. My early experience of Edward was that of a friendly, likable, though it was hard to connect with him. He was just so flaccid, so spacey. There was not much energy there and I found myself working hard at engaging him to no avail. I did most of the talking and I didn’t seem to be getting anywhere. In retrospect I think I was resonating with Edward’s feelings of powerlessness. I wasn’t feeling effective, I wasn’t feeling connected, feelings that were outside of my awareness, feelings that were dissociated.

Edward’s grandmother also presented as friendly, almost too friendly. It wasn’t long before I had a sense of her emotional lability; her hypercriticism, her rigidity. I observed her yelling at the kids, hitting a window, bending a spoon in anger, and pulling out her hair in frustration. Being around her made me tense. After about a year of working with the family I started to dread going to their home. Parking in front of their apartment, walking up their stairs, I never knew what to expect, how much energy I was going to have to expend just to contain the family. The energy and behavioral drive was that of avoidance, a familiar maladaptive strategy rooted in my early experience of overwhelm. While I found the awareness and drive to push through these feelings, I was admittedly relieved when I started working solely with Edward, though in the back of my mind I knew that the work really needed to happen within the family system.

When Edward was removed from the home after choking his sister I was split between feeling disappointed that Edward behaved in this way, leading to his final confirmation as family scapegoat, and relieved that he was going to get away from such a toxic, blaming environment. As the weeks passed with Edward in the residential
program, and the reports kept coming in about how nice of a boy he was, how he
generally listened to staff, was making friends, and never got into conflict, I admittedly
felt validated that it was indeed the environment that elicited Edward’s patterns of
detachment and aggression.

The decision to terminate with Edward was a tough one for me, I held onto his
case far longer than I was supposed to following a promotion to a supervisory role. I had
a lot invested in Edward and his family clinically, and certainly personally. But the
decision to terminate individual services was the right one, and certainly not one arrived
at hastily. When it was decided that I would say goodbye to the family I experienced
many feelings; from sadness for losing the connection, pride for the growth that Edward
had shown, and relief that the heavy intellectual and emotional weight of this case would
lift. When I looked into Edward’s eyes and relayed to him that we were ending our work
together I knew he would be hurt, I knew it would stir old feelings of loss, and seeing the
tears in his eyes, I freely shared my own feelings of sadness, along with feelings of pride
for the young, vibrant man that he was becoming.

My Imaginal Structures

Illan rua Wall, law professor and author of *Human Rights and Constituent Power:*
*Without Model or Warranty,* defines an imaginal structure as “a tendency to fit characters
and situations into pre-given forms and figurations.” ² These “pre-given forms” would be
stored patterns of experience- analogous to Jung’s personal complexes and Henderson’s
cultural complexes- that move us to think, feel, and act in familiar, repetitive ways. So,
reviewing the landscape of my treatment with Edward I recognize familiar terrain (i.e.
imaginal structures) that arose. First and foremost, the issue and identity of the archetypal father was a common thread. My biological father abandoned me and my mother when I was eight months old. Months later my mother began dating a man whom she would marry about a year later. That man, James Carter, I knew as nothing other than my father until I was around seven, when my mother tried to explain the “truth,” and why she waited until I was “older” to tell me. Of course I dismissed the idea, refusing to believe that the man that I knew as my father was not so.

It was around this time that the man I knew as “pops” became increasingly involved with drugs and alcohol. This burgeoning lifestyle led to an arrest and incarceration for attempt to sell and distribute marijuana, for which he would spend over six months in state prison. When he was released he returned to the family, which then included me, my mother, and my two half-siblings. It wasn’t long after that that resumed a lifestyle of drugs and alcohol, which also happened to coincide with starting an affair.

I have always experienced my father as a gentle and caring, though very flawed man, who always accepted me as his son. This, among many reasons, is why it hurt so much that he left our family to be with another (my young experience of the divorce). Though my siblings and I continued to visit our dad every other weekend, there was a big gap in my life after the split, a gap that I attributed to drugs and alcohol. Later in life I would learn that my father had long been experiencing post traumatic stress from his tour in Vietnam, symptoms which he self-medicated with alcohol. Most of the glaring mistakes he made as a man, as a parent, were influenced by the inebriation of alcohol.

In my first family session with Edward and his father, I had to sit with and set aside my own experiences of the absent, alcoholic father, finding a way to tap into the
father’s own pain, his history of being abused by his father, and my empathy for the father. In this session Edward’s father acknowledged the abuse that he inflicted on the family, especially those early years (Edward’s first three or four years) when he was drinking heavily. Admitting he was “out of control,” Edward’s father apologized and expressed his desire to make amends. I recognized feelings of satisfaction and success after this session, I was feeling hopeful, though after the session not much changed; Edward’s father continued to be distant and unpredictable with his interest in Edward’s life.

The imaginal structure that was active for me in this dynamic between Edward and his father was the feeling that a “boy needs his father,” that for Edward’s sake I should help mend their relationship. While Edward did share this opinion, generally, I was constantly bombarded by stories and opinions from the grandmother of just how diabolical this man was. And much of his actions were that, diabolical. I had to stay mindful of this desire to reconnect Edward with his father, the risk being that I was attributing too much hope and expectations to a deeply flawed man, a man who was extremely abusive to his wife and young children. But at the same time he had participated in months of individual and family therapy (with another provider) and swore that he was sober and looking to make amends. Above all, I had to follow the wishes and needs of my client, Edward.

Another imaginal structure that presented itself within this context was my tendency towards a caretaking role. Being the oldest of three siblings I felt a certain obligation to be the “man of the house” when my father left. In his book *The Sibling Society*, Robert Bly suggests that this feeling is rooted in “father-hunger,” a son’s longing
for the absent father, wherein the son literally takes the place of the father. Bly notes that this is accompanied by an increased obligation to care for the mother’s needs, which I definitely felt, as my mother struggled mightily after my father left. Not only were we plunged into financial difficulties, my mother’s health also deteriorated. While not a perfect kid, I remember feeling guilty about sharing my own needs, about voicing my own opinions about what was going on around me. For the most part I kept it to myself, as Edward tended to do. Instead, I felt very paternal towards my siblings, for better and for worse. I can see now how I was especially hard on my brother, feeling like I had to teach him how to be a man, as our father was in the throes of alcoholism and other addictions.

With Edward I had to also be mindful of this tendency of caretaking (obviously inherent in the role of psychotherapist) presenting itself in unconscious ways, such as being overly paternal. This may have shown up as over asserting my beliefs or opinions in the home, feeling like the grandmother was doing a poor job caretaking Edward and I was going to show her the better way. The wisdom in this structure, both for my own experience and for my experience as Edward’s therapist, was that this structure did hold intuitive hunches about what I, and Edward, needed from our caregivers. This structure held/holds certain expectations about what a child needs, and a certain charge when those needs aren’t getting met. I would like to think that I allowed this structure to inform my work for Edward, which entailed a lot of advocacy for his needs. As a kid struggling to assert himself, the early months were a lot of hypothesizing about what he was feeling and needing and relaying these to Edward as “guesses.” As time went on Edward was better able to assert himself and I believe this structure was less present, less needed.
The Client’s Imaginal Structures

Spanning the landscape of Edward’s life, we see a number of imaginal structures that both shaped and restricted his life. This earliest and most obvious one being that the world is not safe. As an infant Edward was exposed to his mother and father yelling at one another, throwing objects, and physically assaulting one another. Edward then watched in horror as this violence was turned on his twin brother. At the age of two, three, and four Edward’s brother Ian was hit, ridiculed, even locked in a storage chest as punishment for misbehavior. Edward generally watched in a frozen state of insecurity and immobility. Subsequently Edward experienced more loss, more betrayal, leading to his estrangement from both parents and being scapegoated by his grandmother as the problem in the family. It is no wonder that Edward did not trust others, especially adults. And so, imaginal structures around self-protection and self-reliance developed.

In conjunction with the idea that adults are unpredictable and potentially dangerous, I believe that Edward carried another imaginal structure that tried to make sense of all this chaos by assuming control of it, i.e. blame. Blaming himself, feeling that all this maltreatment and loss was somehow the result of his behavior, at least offered the ability to change it, since he could change his behavior. He wasn’t going to change the behavior of his parents, that feeling just lead to more helplessness. And so he took on the responsibility that his parents (and grandmother) could not. This showed up for me in Edward’s negative self-image, always hyper conscious and critical of how he looked. He went through a period where he thought his skin was too dark and applied bleaching agents to his skin to lighten it (his mother and her family were lighter skinned, his father darker). While this “color inferiority” complex was certainly a projection of the mother
and grandmother’s negative feelings about the father, the family was undoubtedly influenced by the rather ubiquitous cultural complex that values light over dark skin. Towards the end of our treatment, as Edward grew a more positive self-image he abandoned this belief and actually began applying tanning lotion to darken his skin color.

Another, later developing, imaginal structure that we had to combat was Edward’s belief that if he wore nice clothes and owned nice things (like expensive electronic devices) that people would like and accept him. This imaginal structure was particularly insidious because 1) it drove him to steal in pursuit of this belief and 2) it was constantly reinforced by the consumeristic culture surrounding him. He likely did get more attention when dressed in designer expensive clothes, clothes that he had stolen from department stores, and he had not received much in the way of consequences. So, for Edward the reward was far greater than the risk. Over time, working through this imaginal structure, Edward abandoned his stealing behavior, and seemed to grow more comfortable in who he was and his own individuality.

**New Learnings about My Imaginal Structures**

Through the process of this case study, reflecting on Edward and our course of treatment together, the image of the mythic scapegoat came to mind. Edward, both in appearance and behavior, was the embodiment of the family’s shadow. Amongst a family of verbally aggressive people Edward was mild mannered and submissive, intermittently thrown into the reciprocal when his dissociated trauma emerged. The grandmother would in fact call the Edward “the problem,” saying that if he left the home their problems would cease (an assertion that was later proved wrong when Edward was indeed removed
and the grandmother turned her criticism towards Edward’s sister). Edward’s family had suffered horrific and sustained trauma going back generations—this was indeed a transgenerational, cultural complex of violence that Edward was enacting. Too break free from this complex the family needed someone, anyone, to be the bad guy, and the father was too hard and too far a target. And so Edward was blamed and cast away.

I resonate with this story, now and likely then, in the midst of our treatment. Given all that was going on in my family of origin, I too was an introverted, largely detached kid who acted out in ways that likely frustrated my mother. When I was around age fourteen I was struggling with school and unhappy at home. My mother, weighed down by the stress of raising three kids on her own with little income and no child support, found relief in weekend partying with her girlfriends. She would often come home drunk and occasionally bring home strange men who would sleep over. During this period I was really struggling, I was really unhappy with my mother’s choices, perhaps very worried, yet I could not voice these concerns. And so I acted them out in defiance and detachment. My mother and I would argue, but certainly, what she was mad about was not what I was mad about. Something had to give. So my mother decided to contact my biological father, a man that I literally didn’t know, telling him that he “needed to take me,” that she “couldn’t handle me.” She framed it as going to visit him, this man that I had only seen once or twice in passing since he abandoned me as an infant. I thought I was going to spend the summer in Las Vegas, which seemed fun. It was a few weeks later that my mother informed me over the phone that I wouldn’t be coming back, that I was going to stay there with him and start a new school (a whole other schema of loss). No matter how hard I cried and pleaded, I was not coming back. I was cast off.
Of course this event, what I experienced as abandonment and betrayal, took many years to process and come to grips with. A few years ago, while my brother was helping me dig trenches in my front yard, we were sort of talking around our shared childhood experiences. When this period came up, of me being forced to leave the family, my brother spontaneously offered, “mom sacrificed you.” He explained that, from his perspective, our mother was just so stressed out and unsupported, trying to ease this pain in a number of ways, that she couldn’t handle three kids. His comments rang true to me, and I took solace in the idea that my leaving, which was highly traumatic, in some ways provided more time and attention for my younger siblings (which of course, taps into the “caregiver” structure I discussed earlier).

Having experienced the archetype of the scapegoat, a myth that we explore below, I had to watch for (at least) two things in my treatment of Edward and his own, unique needs. Jungian analyst Sylvia Brinton Perera, from her book *The Scapegoat Complex*, asserts that the experiencing of scapegoating “(results) in the constellation of the savior who will redeem the victim- the good mother or father who will make restitution and provide the nurturing experience denied the outcast.” 4 This is an interesting juxtaposition to the imaginal structure of the caretaker. Perhaps these two archetypes- the scapegoat and the caretaker- are in some ways reciprocals. At the same time, they both have the same underlying motivation, to save and protect the community by abdicating individual needs. So, was I endeavoring to be the good father who would redeem Edward and provide the nurturing experience that he was being denied?

Perera also states that “the scapegoat`s habit of carrying the shadow means the therapist must pay attention to his or her own shadow material when it comes up in
therapy. This passage moved me to reflect on my own anger as it presented itself over the course of my work with Edward. I know that I quite often felt leery pulling up to Edward’s house for sessions. I quite often felt frustrated with the grandmother and all her exaggerated negativity, and her stubbornness to change it. I felt irritated with Edward’s father, who would consistently blame him and send Edward mixed messages about his interest in being in his life. Yet, I don’t remember feeling angry at Edward himself, perhaps disappointed, but not angry. Such feelings would be understandable, given the challenging behavior that Edward would sometimes present with in family sessions, or perhaps the frustration of working so hard to help Edward and seeing very little change. If these feelings of anger and frustration were to be expected, where were they?

In reflection I can see how I over-identified with Edward’s experience, as it mirrored my own, and in some ways being angry (which evokes blame) at Edward and his symptoms would have meant confronting those feelings in myself, past and present. And thus awareness of anger, both Edward’s and my own, became dissociated. Given our shared experiences, this shared adaptation makes sense. Robert Bly suggests that -

Sons who have a remote or absent father clearly can receive no modeling on how to deal appropriately with male anger, what it looks like, what it feels like, what it smells like, how to honor it, or let it go, or speak it without hurting someone. Such sons are usually so frightened of anger that they repress it entirely. Others, with no better modeling, become violent.

Both Edward and I experienced the absent father, and it seems both of us experience fear of anger- ours and others. Bly suggests that this fear results in the repression of anger; this study suggests that this fear, as it relates to past experiences of overwhelming anger, resulted in dissociation- a disconnection of/from awareness. This over-identification with Edward’s experience would also explain why I was slow to recognize the full extent of
Edward’s anger and dissociation. I over-empathized with him—his symptoms were in many ways my symptoms, and thus I experienced them as benign, they felt “normal.”

**Primary Myth**

Myths are symbolic stories that convey shared, archetypal images of our human experience across time and culture. In this story our protagonist Edward bears the burdens of domestic violence, abandonment, and shame, as the identified patient (IP) in a highly dysfunctional family system. The traumatic images and emotional pain that Edward carried was so great that dissociation became his psyche’s only reprieve. Of the many mythical stories that could speak to the archetypal weight of this boy’s suffering, two stand out—the myth of the Greek god Pan and the mythological scapegoat, as we explored above.

In the Greek myth of Pan, Pan was so ugly at birth—horned, tailed, with goat legs—that his mother Penelope ran away from him in fright. Pan then haunted the woods and pastures of Arcadia, personifying the spirit of wild, untamed nature. As the story goes, the lonely Pan amused himself by giving lone, luckless travelers sudden frights (the word 'panic' derives from Pan, referring to a sudden甜，刺耳的甜是潘的笛子的音乐。
terror). As a symbol, Pan personified the animalistic, instinctual aspects of human nature before Christianity appropriated his image to symbolize the Devil. As such, man’s instinctual propensities were labeled as pagan and unholy and the Devil became the scapegoat for the sins of man (“the Devil made me do it”).

There are many images in the myth of Pan that speak to Edward’s experience of the world, first and foremost, the abandonment of the mother. In Pan’s story he is rejected by his mother as she fled in disgust, in Edward’s story it is Edward’s mother who is abandoned by the father in Mexico, with a failed promise to return for her. Pan lost his mother at birth, Edward at age eight, but in both cases the abandoned child grows in to a solitary figure. Pan wandered the woods alone, while Edward wandered the landscape of his life alone, without an attachment figure or close friends. Pan was also known for napping most of the day, and anyone who woke Pan from his slumber would incur his angry shouts. For Edward, his dissociative slumber pacified the rage that laid dormant, fury that would surface intermittently, producing ‘panic’ in those around him.

Edward’s emotional lability and aggression were nothing new to this family, these patterns existing in the family before he was even born. Edward’s grandmother would recount the physical abuse she suffered as a child at the hands of her father, including being clubbed over the head resulting in a fractured skull. Edward’s mother was an emotionlly unstable woman who married an abusive alcoholic. Edward’s father reportedly abused the mother when she was pregnant, abuse that continued after her birth of Edward and his twin brother. Then as a young child (before the age of four) Edward witnessed his father punish his brother by hitting him with objects, locking him in a storage trunk, and physically forcing him to ingest regurgitated food. Given the
insidiousness of this transgenerational trauma it is no wonder that Edward’s psyche escaped the present, dissociating into an altered consciousness. And it is no surprise that the violence he witnessed growing up would surface from time to time in traumatic re-enactments of what he observed.

Yet, it was Edward who was the identified patient of this family. In my initial assessment of Edward and his family it was clear that the grandmother blamed Edward for the struggles of the family, that he was the “black sheep” in a shadowy flock. The grandmother would later confide in me that when she looked at Edward she really saw Edward’s father, a man she overtly despised. Her rage for the father, her own feelings of shame for not being able to protect her daughter, not to mention her own feelings of helplessness and grief for her daughter’s abandonment in Mexico, all were being projected onto Edward, the scapegoat.

The concept of a scapegoat, a person who is blamed for the sins of others, originates from a Hebrew ritual that is described in the Old Testament book of Leviticus. Each year a priest symbolically transferred to a goat the sins of the people of Israel. The goat was thrown over a cliff outside the city of Jerusalem, and its sacrifice was believed to remove the nation's sins. The ritual was originally performed to pacify Azazel, a fallen angel who became a demon of the wilderness. The word “scapegoat” was coined in 1530 by William Tyndale, who in his translation of the Bible translated the Hebrew word “Azazel” as “ez azel,” meaning “goat” (ez) which “escapes” (azel).

According to Sylvia Brinton Perera, from The Scapegoat Complex, Scapegoating, as it is currently practiced, means finding the one or ones who can be identified with evil or wrong-doing, blamed for it, and cast out from ‘The Community’ in order to leave the remaining members with a feeling of guiltlessness, atoned (at-one) with the collective standards of behavior. It both
allocates blame and serves to “inoculate against future misery and failure” by evicting the presumed cause of misfortune.13

Thus the scapegoater(s) are relieved of their collective guilt, while the one identified as the scapegoat embodies this projected shadow. The scapegoat will inherently feel aberrant, set apart, tabooed, and thus repress their feelings and needs.14 Serving as the container for the denied feelings of the group, there is no room, much less interest, for their needs. Perera writes,

At the extreme end of the spectrum of repression is anesthesia of needs. In such cases one identifies with the accuser’s demonic imperatives against need satisfaction, and dissociates to prevent body messages from reaching consciousness.15

With these instinctive energies dissociated they remain split, eruptive, and frightening, destined to emerge in volatile ways. Here we can see clear parallels with the dissociative process, and with Edward’s experience as this fractured family’s scapegoat. Young Edward witnessed his alcoholic father hit and choke his mother, berate and beat his brother, only to be later abandoned by his father, who ironically refused to visit a teenage Edward until he “acted right.” As a young defenseless boy amid this chaos, Edward’s fragile psyche resorted to splitting off his experience, a defensive state that would grow into an enduring trait. Still, the impulses to assert, to defend, remained in wait and ultimately manifested in various maladaptive ways. As Perera asserts,

Since the scapegoat-identified individual tends to be the victim of split-off and unconscious impulses as well as the negative judgments against the expression of impulse, the helpless-me can do quite unspeakable, even sociopathic things.15

The generally limp and aloof Edward did do some unspeakable things, like threatening his sister and grandmother with knives, pushing his grandmother, and choking his sister. In each case Edward felt threatened, and so we see the dissociated
impulse to defend emerge in explosive and exaggerated ways (that just so happen to follow the tracks of the trauma that Edward observed). Edward also developed a habit of stealing, which he said was to “have nice things” so that he could be accepted. Here again normal impulses, the drive for acceptance and connection, are expressed in desperate, ultimately self-destructive ways.

Perera also writes that “The parents and others who scapegoat…(are) themselves caught in the scapegoat complex. Their denial of personal shadow…makes them brittle and defensive.”

This was definitely true of Edward’s grandmother, who couldn’t accept or integrate her own shadow and was very brittle (hypersensitive) and defensive (blaming Edward for everything, refusing to take responsibility for her own actions). Her anger at the father found an outlet in Edward (who according to her, looked like his father) and her helplessness to protect her daughter, Edward’s mother, transmuted into hypercritical and controlling behavior. The grandmother seemed determined to cast Edward and these shadowy feelings away. Likewise, Edward’s father likely saw in Edward’s anger and aggression his own demons and firmly rejected them both.

**Personal and Professional Development**

My three-and-a-half years working with Edward challenged me in many ways, personally and professionally. And of course, the two overlapped greatly. Professionally, the extent of Edward’s dissociative symptoms were very challenging and not something I had much experience with prior to treating Edward. When we started together I explored the tried and true methods of processing trauma, such as revisiting the trauma narrative, empathizing with and validating his experience, challenging cognitive distortions (i.e.
that he was to blame for his abuse), and working to build “coping skills.” I leaned on my strengths as a clinician- an empathic smile, humor, and play. What I would learn after these interventions didn’t get very far, vis-à-vis changing behavior, was 1) Edward was not very “present” to receive and respond to these interventions and 2) his environment was consistently bombarding him with triggers and reinforcement for his maladaptive coping strategies. After about a year of trying various trauma informed methods with Edward I began exploring the literature on dissociation more deeply, which led me to more somatic approaches.

Somatic approaches emphasize the bi-directional relationship between the soma and psyche, and it became clear that the only way to access and integrate Edward’s psyche was by enlisting his listless, defended body. Through this exploration I learned about the about the “window of tolerance,” how learning can only happen within this window between over-arousal and under-arousal. Through readings and attending training on somatic methodologies I began trying out these methods with Edward, as we discussed above. At first I found that it was hard getting Edward “into” his body, which of course, confirmed the level of psyche/soma dissociation that he was experiencing. As we repeated these methods, as I began orienting our interactions towards movement and sensation over reflection and rethinking, experiencing over explaining, I noticed Edward more “present” in his body. I observed this in more upright posture, more eye contact, and a firm handshake rather than a limp one. These results reinforced my interest in more experiential, somatically oriented models.

What has become clear in retrospect is that my shifting interest into the world of soma was not just about Edward, it was also about my own curiosities and needs around
attending to the body. As a “wounded healer” who didn’t confront my own sexual abuse until my late twenties, there were many imaginal structures related to the body that I had to rework. Much of my young adult life I was averse to touch, with unconscious armoring which would manifest in anxiety and even panic attacks when triggered. These holding patterns ran parallel to my own dissociative tendencies. As a teenager I was mostly “checked out,” and certainly didn’t want to be touched. Working through these issues in my own individual therapy was more than the gathering of insight, it was a journey to reclaim my body as an ally. My interest in somatic psychotherapy was undoubtedly fueled by my own subconscious needs.

As my work with Edward progressed I observed that it wasn’t enough to “enliven” Edward, as a more assertive Edward just meant (at least initially) that he was more vocal about his needs and disagreements, which often resulted in more conflict. I had to continue working with his family to better understand and cultivate this emergent Edward, lest the maladaptive patterns of the environment negate this development. The two, Edward’s inner and outer worlds, were interrelated, and I felt like I had to pendulate back and forth between stoking the fire of Edward’s inner world and cooling the ire of his outer one. Here too is a personal message, to not neglect the connections of the outer world in the pursuit of developing the inner. I believe that this case and this case study have challenged both poles and would like to think the learning I take away from both is the importance of balance.
Applying an Imaginal Approach to Psychotherapy

Imaginal psychology, a moniker that James Hillman used synonymously for his archetypal psychology, has evolved into an integrative vision of psychology that remains true to Hillman’s emphasis on the imaginal, while integrating elements from humanistic, transpersonal, somatic, and social psychologies.\textsuperscript{18} Imaginal psychology is still, however, primarily concerned with the myths that we live and live in us, “the stories we tell ourselves about ourselves.”\textsuperscript{19} The theory and practice (or \textit{praxis}) of imaginal psychology is a journey through how we affect and are affected by one another, how we can (and need) to share these experiences, in both verbal and non-verbal ways, and how this sharing of experience is often \textit{gated} by maladaptive patterns of being (imaginal structures).\textsuperscript{20} As Omer et al. assert in the 2012 article “Wisdom Journey: The Role of Experience and Culture in Transformative Learning Praxis,”

This externalized dynamic, referred to as \textit{gatekeeping} is conceived as the individual and collective dynamics that resist and restrict experience, demanding perfection and thus paralyzing the individual from taking various risks, seeking out new experience, and shifting out of static and familiar identity. Gatekeeping is understood as an adaptive dynamic which may arise as a protective measure and can help a living system survive under specific circumstances, but becomes maladaptive when the circumstances change. An essential feature is that because its dynamics partly arise as protective measures from ways we have been hurt or threatened by others, it can help to defend from experiences of dependence on others and as well protecting one from failure, by denying individuals and systems new experience.\textsuperscript{20}

Through a praxis of \textit{reflexive participation}, imaginal psychology supports the participant through deconstructing the imaginal structures that gate experience, seeing their common cultural/mythical meanings, and then offering a framework to transmute these stuck points into a creative action.\textsuperscript{21}
While I cannot say that I endeavored to treat Edward from an imaginal framework (mostly because I was still traversing this learning when our paths crossed), I do see the many colors of imaginal psychology reflected in the kaleidoscope of my work with Edward. My initial work with Edward was a conscious effort to establish rapport and trust with him and his family, especially given the level of betrayal he/they had already experienced. Working from a client-centered frame, I utilized empathetic dialogue along with play and art to gentle build a safe container for an exploration of the more volatile feelings and images in Edward’s experience. While these interactions seemed to deepen our relationship, they did not seem to affect much in the way of behavioral change. Edward continued to struggle with what I assessed as symptoms of post-traumatic stress, namely hypervigilance, avoidance, and traumatic reenactment, masked by acute dissociative symptoms (now recognized as symptoms of trauma in the DSM-V). These symptoms continued to sabotage his relationships and his functioning at school, eventually resulting in the removal from his home.

Recognizing that the symptoms of trauma were “gating” his inner experience (i.e. he just wasn’t present enough to have an awareness of his experience, much less a corrective one) I shifted towards more somatic based interventions, seeking to get Edward into a therapeutic “window of tolerance.” We started taking more walks, playing soccer, and “experimenting” with somatic exercises, all the while we would track Edward’s bodily sensations (dialogical mindfulness). Over time I feel this work helped Edward become more present, more embodied, and thus receptive to interpersonal engagement. He was better able to track how he was affected and how he was affecting
others. Then we were able to better introduce and deconstruct the underlying imaginal structures of his experience.

In reflecting on Edward’s patterns of experience, like the idea that he was replaying many of the behaviors that he despised in his father, he became increasingly open and aware of the idea that he carried the residue of transgenerational trauma. His family had a legacy of fragmentation and he was but one actor in this tragedy. I did turn to this idea of his part in a larger story, a sort of narrative intervention for externalizing the problem-saturated story to reduce shame and over-identification with the story. The concept of *multiplicity*, described by Omer as “the existence of many distinct and often encapsulated centers of subjectivity within the experience of the same individual,” also helped with this, as we were able to parse out what seemed like “himself” and what seemed like aspects of his family living on through him. When Edward’s anger emerged, especially the anger that seemed exaggerated, I would ask him “does this feel like your anger or someone else’s?” If he said it felt like his father’s or anyone else’s anger I would ask him to speak as that person, and we would dialogue. I would ask this externalized part of Edward what it wanted, what it was afraid of, and how it wanted to protect. Edward was a little reticent of this work at first, but I believe he came to enjoy and learn from it.

Imaginal psychology prioritizes experience over explanation, transformative learning over informative learning. I can see how our early work was more informational, leaning on dialogue. As our somatic work thawed Edward’s frozenness, I could start leading him through experiences that were embodied, experiences that provided corrective experiences on an implicit level. As Edward’s vitality emerged, as
seen in his increased sociability, increased interest in soccer, and increased engagement
with school, I started promoting him to channel this energy into creative action. First and
foremost this meant engaging relationships, which is where the family therapy piece
came in. It was my hope that the family system could hold and support this emerging
Edward. However, the weight of the family’s imaginal structures would not allow much
space for this new Edward to emerge. The imaginal structure of the family was that this
boy was the problem, the scapegoat, and they struggled to confront and transmute this
structure.
CHAPTER 5

REFLECTIONS

*Everyone and everything that shows up in our life is a reflection of something that is happening inside of us.*

- Alan Cohen

Personal Development and Transformation

Sociologist Jack Mezirow (1923-2014) offered the world of education a Transformative Learning Theory, a blueprint of how transformative learning (versus informative learning) takes place. Mezirow outlines ten phases from which emerges transformation;

1. A disorienting dilemma
2. Self-examination
3. Sense of alienation
4. Relating discontent to others
5. Explaining options of new behavior
6. Building confidence in new ways
7. Planning a course of action
8. Knowledge to implement plans
9. Experimenting with new roles
10. Reintegration.

Dorothy MacKeracher later condensed these ten phases into four, identifying how experience moves us towards transformative learning. In the first of MacKeracher’s phases transformational learning something happens that challenges our assumptions about the world, and our normal ways of thinking and being. The resulting distress
throws us into transitional stage. In the second of MacKeracher’s phases we reflect on the inconsistencies inherent in the transitional stage and we begin to experience a change in perspective(s) emerging. In the third phase the learner puts this change into words that represent the change, sharing this emerging change with others. In the fourth and last of MacKeracher’s phases, similar to Mezirow’s final phase, the learner is able to integrate these ideas of change into action, and begin to act in ways congruent with this change.3

Reading and reflecting on these phases I recognize my own transformative journey, both as Edward’s therapist and in composing this case study. Over the course of my initial work with Edward I had many “disorienting dilemmas,” experiences that challenged my assumptions underlying how I knew myself and others, in this case as a therapist.4 There were moments, such as leaving Edward’s home after a particularly tense, blame filled session, where I questioned my abilities as a therapist, questioned my patience as a person, and question the process of change. With Edward and his family I had tried so much—devoting extra time, seeking extra supervision, always valuing the voice of the family as the experts of their lives. But the conflicts continued, Edward continued to walk through life limp and lifeless and the grandmother continued to blame and bully him.

Through self-examination, relating these feelings of ineffectiveness (discontent) to my supervisor, we discussed different ways to be with Edward, different starting points, informed by trauma theory and somatic psychology. Developing a new but definitely not static plan to switch things up, I began implementing these new ideas with Edward, literally leading experiments with him and reflecting on these experiences. I actually felt more comfortable leading with experience; taking Edward out of the house,
being active, getting his body moving, and then engaging in dialogue. Seeing the positive results I was more apt to continue these changes, changes that I quickly integrated into my image as a psychotherapist.

Prior to Edward I had little training and professional experience on the dissociative process. I had attended a few trainings on trauma that spoke to the dissociative continuum, I had seen pretty checked out kids before, but I had never worked with anyone as shut-down and just plain vacant as Edward. Delving deeper into trauma theory and to somatic psychology I began accumulating a somatic understanding of what was going on for Edward, the psychological adaptiveness of dissociation. Deciding to write this case study on my work with Edward I knew that it would be a daunting task, being my most challenging case to date, as well as a topic (dissociation) that I had only a fledging idea about. Through this process I have come to understand just how ill prepared I was coming out of graduate school to tackle such an insidious disorder of the human spirit. I began recognizing the dearth of literature on dissociation, in relation to trauma, and was struck by the utter lack of consensus in the field. I also came to realize that the literature that was available spoke almost entirely to the individual experience of dissociation, not the familial or the cultural experience of dissociation, which were undoubtedly salient in Edward’s experience.

The process of reflecting on Edward, his life, his struggles, and our work together, it became clear that I empathized with Edward on many levels. It became quite clear to me that dissociation was quite present for me as a child and teenager, patterns that I was able to shake later in life. In thinking about Edward’s presentation- the lack of eye contact, the apprehensive hand shake, the monosyllabic answers, the social avoidance-
these all rang true to my experience as a kid and teenager. This insight was information that always existed in my psyche, having it reflected back by Edward in such stark, archetypal ways brought this knowing into my body. I felt the coldness of being a shutdown kid, drifting off to the periphery to avoid an untrustworthy world. I can remember quite well the frozen feeling of watching my step-mother throwing objects at my father, going after him with a knife, threatening to kill him. That feeling of wanting to scream out “STOP!” but having no words, wanting to run but having no legs.

The process of writing this case study has certainly been disorienting. Not only in the reflecting on the evocative material, but also developing an awareness of just how similar my childhood experience was to Edward’s. Where I once felt like a visitor in Edward’s world, as his therapist, the process of thinking and writing about this study felt like I was living in his world. There were moments of stuckness, where I would spend days trying to write and re-write a single sentence or two. It would only occur to me later that this was more than “writer’s block,” I was dissociating from the story. Somatically this rang true, as I can remember the moments of blankly staring at the computer screen, occasionally clicking around the internet as a distraction (as did Edward), only to return to the blankness that suck me in.

Through this process I have grown much more cognizant of these dissociative tendencies that remain as remnant s of my younger years. I am aware that when I am feeling overwhelmed I tend to turn inward, likely an adaptive way to reduce the stimulation from my environment. I am also aware of the spacing out feeling that feels anesthetic. In writing this study I am more aware of what Edward was experiencing, and now, more aware of what I experience. He and I, and so many others, share this common
escape. My personal transformation has been a process of creative action, putting these experiences to paper, sharing this common experience with others.

**Impact of the Learnings on My Understanding of the Topic**

As we have discussed my initial understand of dissociation was pretty limited. I was aware that dissociation was something that the brain would due under overwhelming circumstances and I knew that if repeated, he could become a relatively enduring trait. But I had very little training and understanding of how to work with dissociation. Through this process I have developed my understanding of the process of dissociation, how this process occurs, how it takes hold, and how to struggle to get out of this adaptive black hole. I have also learned how impactful the environment around the client is, not just in being the likely source of dissociative phenomena (vis-à-vis compromised attachment and trauma) but also a reinforcer of dissociative phenomena. In reflecting on this journey with Edward I am aware of the dissociative trends in our Western culture-the increasing involvement with electronic communication, the internet, and television. Eye to eye contact, the virtual conduit of attachment interactions, is decreasing. Communication is becoming increasingly “disembodied,” with much of the nuances of face-to-face communication being de-emphasized. These social trends create a culture that supports and reinforces detachment, as one can now communicate without connection.
Mythic Implications of the Learnings

Returning to the myth of Pan, where the symbol of man’s animalistic nature was isolated (wandering the forest) due to its/his ugliness, I see many parallels to the dissociative process. In many conceptualizations of dissociation, the sheer ugliness of trauma is segregated from consciousness, however, this traumatic material continues to “roam” the psyche, showing up as intrusive thoughts, feelings, and images (symptoms of PTSD). Just as Pan would explode in anger when aroused from his slumber, the repressed volatility of traumatic memories will often manifest in traumatic re-enactments when “awoken.”

Over the course of this journey, both the case and the case study, it has become clear to me the lasting effects of losing one’s attachment figure at a young age. From a biological perspective, an insensitive or absent caregiver will result in a delay or deficit in the development of an infant’s self-regulatory capacities, predisposing them to unmanageable arousal and ultimately, dissociation. Edward’s early years were marred by an abusive father, an oppressed and dysregulated mother who was taken from him at age eight, and a grandmother whose own wounding got in the way of her ability to nurture. And so he isolated, both physically and emotionally, occasionally returning as his dissociated, traumatic counterpart. Again, I see parallels to Pan, whose mother abandoned him at birth. Pan, the only Greek god who was said to have died, spent his life alone, chasing carnal pleasure and ultimately being rejected due to his ugliness.

Azazel, the Hebrew archetype analogous to the Greek Pan, evolved from a fallen angel to the archetype of the scapegoat. I propose that we can think of the process of dissociation as a “scapegoating” of parts of the psyche, a process by which the psyche
segregates dark, overwhelming experience for the sake of the whole. In doing so, the associated feelings and sensations are split-off and psyche pays the price for atonement-disconnectedness. A part of the person is just not (consciously) there.

In examining the historical images of dissociation, we find many references and representations of ghosts or evil spirits. The sufferer has either left their body and/or had their body possessed by an evil spirit. In fact, one of Pierre Janet’s most celebrated patients was a business man in his thirties (“Achille”) who was admitted to Salpêtrière for symptoms of “demonic possession.”

Achille had returned from a business trip depressed and detached, then reportedly fell into a coma for two days. When he awoke he began displaying convulsive, satanic laughter. At Salpêtrière Janet’s hypnotic explorations revealed that the man was really suffering from overwhelming, split-off feelings of guilt for having been unfaithful to his wife. Hypnotic suggestion “cured” Achille of his symptoms, which Janet attributed to his dissociated “fixed ideas.”

We could think of dissociated thoughts and feelings as “haunting” the psyche, perhaps the essence of PTSD (intrusions). In the dissociative personality, in Edward’s case especially, we could also say that parts of the person’s psyche are dead to them, leaving them feeling disjointed and detached. A primary learning from treating Edward was that to truly engage him I was going to have “resuscitate” his split-off parts, otherwise I was engaging only fragments of his psyche. His psyche was just not fully whole, not fully present. In applying more “body based” interventions to ground him in the present, help him feel into and track his sensations, and working to help him harness his life energy (we could say his sympathetic nervous system), I found that I was able to much better engage Edward relationally. It was like his soul (the Greek intention of the
word psyche) returned to his body. He grew able to assert, to disagree, to demand, which of course had ramifications vis-à-vis the family system. Still, the learning was clear; it’s pretty hard to engage someone who is not present, harder still to heal a psyche that is detached.

**Significance of the Learnings**

The learnings emerging from this case study demonstrate how Edward could not pull himself out of the vortex of dissociation, as the needs of the family kept pushing him back in. The family needed him to be docile and acquiescent, and every attempt at asserting himself was thwarted. Turning away from a family that could not nurture him, Edward found solace in the world of video games and the internet, which in turn, reinforced his detached, disembodied tendencies. He sought connection in an increasingly disconnected world, the only world in which he felt safe. This both reflected and reinforced the *ecology* of Edward’s dissociation. ⁸

Among the already sparse literature on dissociation, very little of it addresses the potential role of the environment in the onset and reinforcement of dissociative symptoms. True, the role of attachment is garnering increasing recognition as a major factor in the development of dissociative symptoms, yet there are numerous social factors that disrupt the formation and maintenance of attachment relationships. Social issues such as increasing economic pressures, decreasing family size, single parent homes, and decreasing social programs, all compromise the ability for caregivers to consistently be present and available for their children. That means less attuned attention, less face-to-
face communication, less eye contact. Thus, healthy attachment, both on a neurobiological and sociocultural level, is under threat.

Perhaps these social trends of disembodiment and disconnection are normalizing dissociation, perhaps much of it is being labeled and treated as attention deficit disorder (ADD) or perhaps depression.⁹ The significance of Edward’s story is that if we look at dissociation as ultimately a failure of connection (attachment), a psychic turning away from a world that is too threatening, then we need to look at the ways we connect as a culture, and the ways in which our connections are being strained by the stressors of our modern world. We also need to look at the ways in which we disconnect, drawn into the relentless black hole of the digital world where our psyches find both solace and stagnation. This is the ecology of dissociation- the reciprocal relationship between psyche and society, culture and consciousness- a connection that continues to grow ever more disconnected.

**The Application of Imaginal Psychology to Psychotherapy**

Modern psychology (at least in the West) increasingly emphasizes cognitive processes as the root of suffering and empirically based models as its cure.¹⁰ Of course, cognitions are an influential part of the human experience, though a single aspect in the kaleidoscope of human experience. The influence of the “body” (as experienced through sensation) has only recently begun to be recognized as another vital aspect.¹¹ The body is, of course, the container for all personal experience, as thus an essential consideration in health and healing, psychological or otherwise. But what this case study (i.e. Edward’s experience) clearly bears out is that the capacities and potentialities of the body and mind
are wired and reinforced by relationships, and the container for relationship is culture. Our inherent, unconscious drive to mirror one another means that the cultural will compose the personal and reciprocally, the personal composes the cultural. All this is to say that given the interrelational nature of the human experience, true transformation cannot simply take place on the personal level, as individual change must live on in a sea of status quo, resonating with old norms and old needs. True transformation must address both, the personal and the cultural, in conjunction. Looking through this interrelational lens, imaginal psychology offers an integral understanding and practice that addresses both.

While depth, humanistic, and transpersonal psychology are very “self centered,” either in the emphasis of consciousness (as in transpersonal psychology), the ego (depth psychology) or the self (humanistic psychology), imaginal psychology has a wider lens that encompasses social and cultural issues. The field expands its focus outward to issues of social accountability and reconciliation in relationships where harm has been caused, class identity and shame, and historical trauma. Imaginal psychology seeks not only to develop and articulate the soul (psyche) but to inhabit the world with soulfulness, which includes ecological respect, embodied passion, and communal action. Imaginal psychology is both distinctive and inclusive, seeking to unite our mythic past with our modern present towards a more soulful future.

Bridging Imaginal Psychology

Bridging these ideas into conventional settings can be difficult, because much of the relatively high costs of psychological care are paid by either the state or federal
government or by private insurance corporations, and these entities are most invested in “efficient” care. Because cognitive behavioral models operate in language and methods that lend themselves towards empiricism, they are increasingly supported and encouraged. But are these methods, which situated problems entirely in individual, temporal psychologies, part of the solution or part of the problem?

Many of the methods of imaginal psychology have counterparts in longstanding, accepted models of psychotherapy. Carl Jung asked the question: “… what is your myth – the myth in which you live?” 12 Here Jung is trying to broaden awareness from the personal to the collective, which he tracked through the free association of images. The more contemporary field of narrative therapy similarly endeavors to move our fixation on the personal to the broader lens of the sociocultural. Like imaginal psychology, narrative therapy shifts our awareness towards common, shared issues such as ethnicity, disenablement, sexuality, and gender.13 By deconstructing the “dominant truths” embedded in cultures, we are able to co-create new meanings, new stories.14

Shifting the cultural container requires individual courage and capacities such as an interrelational awareness and the ability to communicate and connect with others in the transformational journey. We can characterize an interrelational awareness as reflexivity, what Omer calls the “the capacity to engage and be aware of those imaginal structures that shape and constitute our experience.” 15 Reflexivity manifests as a moment-to-moment awareness of how one affects and is affected by others, the capacity to describe and communicate how one is affected, and the recognition of the underlying structures that may be gating this process.16 This personal work of reflexivity can and needs to be mirrored in the outer world through collaborativity, which is defined as “the
capacity to associate with others in ways that foster individuality, autonomy, complexity, dependability, and reciprocity.” In this way, through this interrelated process of inner awareness and outer connection, true transformation can take place.

**Areas for Future Research**

This study has emphasized the interrelated nature of the dissociative process, detailing the interplay of the inner and outer world in the co-creation of the human experience. We have discussed how emotional psychological patterns mirror the sociohistorical patterns from which they arise, producing both a cure and a reinforcer for the limitations of either. While empirically and “evidence” based models are the mode de jour, they generally offer short term solutions to archetypal problems, problems that are escalating. Relatively little research is being done on group and family therapy models, orientations geared towards systemic change, and research on narrative therapy is only in its beginnings. More curiosity, vis-à-vis qualitative and quantitative research, is needed in exploring and understanding the interrelational nature of the human experience- how we affect and are affected by those around us. The growing interest and support for the field of interpersonal neurobiology is moving the field of psychology in this interrelational direction, though the research and subsequently, the funding, is lagging far behind the interest. The integrative, culturally conscious orientation of imaginal psychology could provide a much needed, enduring anchor for these other fields lacking an integrative hub.
APPENDIX 1

INFORMED CONSENT FORM

To [guardian’s name]:

Your child, [client’s name], is invited to be the subject of a Clinical Case Study I am writing on dissociation. The study’s purpose is to better understand the experience of dissociation, personally and culturally, and how the two interrelate.

For the protection of your and your child’s privacy, all of my notes will be kept confidential and your identities will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to children and families who have experienced trauma and are suffering from Post-Traumatic Stress and may benefit the understanding of Post-Traumatic Stress.

The Clinical Case Study does not directly require your own or your child’s involvement. However, it is possible that you and/or your child simply knowing that he is the subject of the study could affect him in ways which could potentially distract him and/or you from the primary focus in therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to allow [client’s name] to be the subject this Clinical Case Study, you may withdraw your consent and discontinue your and your child’s participation at any time and for any reason up until the publication of this study. Please note as well that I may need to terminate your child being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Doctoral Project Director at Meridian University, 47 Sixth Street, Petaluma, CA 94952, telephone: (707) 765-1836.

I, ______________________, understand and consent to let my child be the subject of the Clinical Case Study written by Matthew Carter, MFT, on the topic of dissociation. I
understand private and confidential information may be discussed or disclosed in this Clinical Case Study, which will also refer to other significant people in my child’s life, particularly myself, as his legal guardian. I have had this study explained to me by Matthew Carter, MFT. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. The participation of my child in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for the use of both my child’s clinical case history, as well as for disclosure of all other information about him including, but not limited to, information which may be considered private or confidential. I understand that Matthew Carter, MFT, will not disclose my child’s or my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Matthew Carter, MFT and Meridian University (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of actions whether known or unknown, arising out of the mention, use, and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. Meridian University assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this _______ day of ______________ , 20____, at __________________, ______.

Day     Month     Year     City     State

By: ________________________________________________________

Parent or Guardian’s signature

________________________________________________________

Parent or Guardian’s name
NOTES

Chapter 1


**Chapter 2**


3. According to Adam Crabtree, in *From Mesmer to Freud: Magnetic sleep and the roots of psychological healing* (New Haven: Yale University Press, 1993), German physician Eberhardt Gmelin published the first written account of dual (“exchanged”) personality in 1791, however French psychiatrist Moreau de Tours (1845) was probably the first to use the term *dissociation* in a manner consistent with a contemporary understanding of the concept.


9. Andrew Moskowitz and Ingo Schafer, *Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology* (West Sussex: John Wiley & Sons Ltd, 2008), 91.


19. Ibid., 128.


21. Ibid., 91.

22. Ibid., 115.


25. Ibid., 55.


29. Ibid., 225.


32. Ibid., 250.


39. Ibid., 277.

40. Ibid., 130.


44. Ibid., 3.
45. Ibid., 35.


68. Ibid., 308.


72. Ibid., 716.

73. Ibid., 722.


82. Freud “reproduced” these repressed memories through analysis and interpretation of symptoms and the patient’s associations, though his patients often continued to deny (“withhold belief” of)
any memory of abuse. “Only the strongest compulsion of the treatment,” Freud wrote, “(could) induce them to embark on a reproduction of them.” As cited in Peter Gay’s *Freud Reader*. (New York: W.W. Norton & Company, 1995), 103.


85. Freud shared with his friend Wilhelm Fliess four reasons why he ultimately rejected the seduction theory; 1) He had not brought a single therapy to a fully successful conclusion using the hypothesis. 2) Patient's reports of abuse had increasingly come to implicate perverse acts by their fathers. Hence, if the theory held, would entail the existence of an improbably large number of sexually abusive fathers. 3) It was difficult to tell the difference between truth and fiction in patients' emotion-laden stories of abuse. 4) Even in psychotics, hidden childhood experiences did not break through into consciousness; it was unlikely that this could happen in the treatment of patients who were less ill. As cited in Jerome Neu’s (ed.) *Cambridge Companion to Freud* (Cambridge: Cambridge University Press, 1991), 26.


90. Ibid., 82-91.


100. Ibid., 158.


102. Ibid., 31.

103. Ibid., 100.


106. Lisa Dutra et al., “Quality of Early Care and Childhood Trauma: A Prospective Study of Developmental Pathways to Dissociation,” in the *Journal of Nervous and Mental Disease* 197 (2009), 383-90.


110. Ibid., 173.

111. Ibid., 262.


Chapter 3


2. Note that at the time of our first meeting, January 2010, the current Diagnostic and Statistical Manual of Mental Disorders (DSM) was the fourth edition (DSM-IV). The DSM-IV utilized the multiaxial system for psychiatric assessment. In the fifth edition, published May of 2013, the American Psychiatric Association (APA) eliminates the multiaxial system.

Chapter 4


5. Ibid., 41.


15. Ibid., 68.

16. Ibid., 31.


21. Ibid., 375.


Chapter 5


8. Here the use of the term “ecology” refers to the reciprocal developmental relationship between the inner world and the outer. This includes the development of the soma and psyche in relation to family, culture, and society, in this case, how dissociation arises from and is reinforced by a juxtaposition of all these aspects of human experience.


10. Note that while affect and somatic based models are growing increasingly popular, the psychological and medical (including insurance) industries continue to emphasize (and in the case of insurance, reimburse for) empirically based models. B. R. Hergenhahn and Tracy Henley, *An Introduction to the History of Psychology* (Belmont CA: Wadsworth Publishing, 2014), 4.


16. Meridian University. *Seven Levels of Reflexive Participation Rubric*. Obtained from Meridian University, Petaluma, CA., Fall of 2014.


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