Chapter 1

DISSOCIATION

A patient arrives for her psychotherapy session, silently comes into the consulting room and sits for some minutes without saying a word. She does not appear to respond to the therapist's gentle invitations to speak of what is on her mind. After about 15 minutes she suddenly shifts her body posture, looks frightened and moves around as if trying to escape into the corner of her chair. The therapist enquires what she is experiencing but in reply she repeats, in a quiet and childlike voice, the word 'hide' – this being said over and over in an eerie and imperative tone. She cannot or will not say what it is that she is frightened of, except at one point to say 'get hurt'. After some minutes of this she gets up and crouches down behind the chair, where she stays silently for almost the rest of the session. As the scheduled end of the session approaches, the therapist asks if there is another part of the patient who could take over at this point as they will have to stop in a moment. The patient gathers herself together and leaves without a word. At no point have patient and therapist engaged in any conventional exchange of words.

Later that morning the therapist receives a phone call from the patient who says that she is sorry she was not able to attend her session earlier but she could not face coming into the building and that she has been troubled by some bad experiences during the week. The therapist remarks that part of her had certainly come to her session. The patient seems puzzled by this comment and appears to assume that the therapist is not understanding correctly. She goes on to explain that she had driven to the hospital but could not bring herself to go in and so had sat in her car for the duration of the session.

What is happening here? The person speaking on the phone appears to be amnesic for her behaviour earlier in the day, or at least appears to have constructed a false version of events which she apparently believes. The therapist has remembered one set of events but the patient has presented quite a different set. Either the patient or the therapist appears to be deluded. How is such a problem to be addressed in the consulting

room – and what experiences and mental processes could lie behind such a situation? Let us see what happened subsequently.

The following session the patient again apologised for missing the previous week and repeated the same explanation about sitting in the car. The therapist decided to try to confront the discrepancy and told the patient that another part of her, in her body, had indeed come in for the session the previous week. The patient appeared genuinely bemused and alarmed by this information and argued that this could not be true and that the therapist must be lying, although she could not imagine why he would want to lie. This debate went on rather fruitlessly for some minutes with the therapist trying different ways of explaining this. Suddenly the patient's demeanour shifted, her face looking directly at the therapist and appearing more self-assured; she said 'Tell her the name of the one who came last week'. The therapist asked what the name was and the reply was 'Tiny'. The patient then added that the therapist had done well with Tiny last week, especially in letting her hide behind the chair without intrusion. When the patient's demeanour changed again to the anxious head down posture, the therapist told her that the one who had come the previous week had been called Tiny. She agitatedly demanded to know how the therapist knew that name since it was a name only in her own mind, that only she should know.

So now three versions of the patient have been encountered: the designated patient; a frightened, childlike and inarticulate one called Tiny; and one who is rather calm and perceptive and seemingly helpful who does not so far have a name. This third one seems to know more than the others. Why have the patient's mind and personality become divided in this way? What is the origin of such processes of dissociation and what purpose is achieved by them? These are the problems that I set out to describe and answer in the rest of this book.

WHAT IS A DISSOCIATIVE DISORDER?

The patient described above is clearly suffering from Multiple Personality Disorder, more recently renamed Dissociative Identity Disorder. This is the most severe, complex and chronic dissociative state, although it is one which may be covert, hidden perhaps for years behind a variety of misdiagnoses. Contrary to the popular media stereotype, these patients do not usually display their dissociative phenomena flamboyantly, but carefully endeavour to conceal it. Because MPD/DID patients hear hallucinatory voices, they are often misdiagnosed as schizophrenic; however, they do not respond particularly well to neuroleptic medication in the way

that schizophrenic patients often do. In fact, MPD/DID patients often experience a variety of Schneiderian symptoms, sometimes assumed incorrectly to be indicative only of schizophrenia (Ross et al., 1990). The differences are that MPD/DID patients usually experience their voices only as internally located, whereas schizophrenic patients may also experience them externally; MPD/DID patients do not show thought disorder, or delusions about present reality, although they may be temporarily disoriented by the intrusion of flashback memories into perception of the present. Schizophrenic patients do not reveal alter personalities, amnesia, occasional visual hallucinations, and the typical history of severe trauma that usually characterises MPD/DID. The MPD/DID patient may also experience recurrent severe headaches, often thought to be associated with the process of switching personalities – which again is not characteristic of schizophrenia.

Here are the DSM-IV criteria for MPD/DID:

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. Not due to the direct effects of a substance (e.g. blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g. complex partial seizures).

There are also patients who show some degree of dissociative disorder but fall short of the full MPD/DID picture. These may be diagnosed as suffering from Dissociative Disorder Not Otherwise Specified (DDNOS).

DSM-IV also lists three other dissociative disorders: Dissociative Amnesia, Dissociative Fugue and Depersonalisation Disorder. In fact all these may be symptoms of the more inclusive MPD/DID; fugue states being like the phenomena of inter-alter amnesia, whilst depersonalisation – the experience of feeling detached from the body – is also a common feature of MPD/DID (Steinberg, 1991). (Of course, depersonalisation is also a common experience associated with phobic anxiety and panic disorder; consideration of the broader picture must precede diagnosis of a dissociative disorder.)

DSM-IV also allows for the possibility that Dissociative Identity Disorder may occur in the context of, or as a complication of, a personality disorder

such as Borderline Personality Disorder. In this way DID, as an Axis I disorder, may coexist with an Axis II disorder.

Steinberg (1993a, b), in presenting a structured diagnostic interview, postulates five core areas of primary dissociative symptoms: depersonalisation; derealisation; amnesia; identity confusion; identity alteration. All these primary symptoms are usually covert; the patient does not reveal them unless asked. There may be a large and diverse range of secondary symptoms which are more overt, such as substance misuse, eating disorder, self-harm, mood swings, alcoholism, depression, phobic anxiety and many others.

I describe below a number of other forms of dissociation, including: psychotic dissociation, that between child and adult parts of the personality, between 'true' and 'false' self, and between different stages of life.

WHY DISSOCIATE? DISSOCIATION IS ABOUT DETACHMENT FROM AN UNBEARABLE SITUATION

Dissociation involves an attempt to deny that an unbearable situation is happening, or that the person is present in that situation. Thus dissociation involves the defence of denial, but in addition requires a degree of detachment of part of the mind from what another part is experiencing. This is like the 'hidden observer' phenomenon in hypnosis, described by Hilgard (1977, 1994). In Hilgard's experiment, a hypnotic subject was put in a trance and instructed to place their hand in ice cold water, whilst being given the suggestion that they would experience no pain; the person reported no pain, but it was possible to locate hypnotically another part of the person's mind that was aware of pain – the hidden observer. In this hypnotic state the more dominant part of the person's awareness is dissociated from the part that is aware of pain. Dissociation seems to be something like a state of self-generated hypnosis, developed to deal with unbearable pain or terror (Bliss, 1986).

A patient buries her head under a pillow on the analytic couch and begins to sob loudly, like a desolate and anguished small child. She appears to be re-enacting a childhood state of mind that was associated with severe neglect and abuse. Suddenly she sits bolt upright and says to the therapist 'I've got to stop or you are going to hit me!' She then reports that she feels unreal, as if she is not present, and describes how she is now completely out of touch with the feeling she was expressing in her crying just a few seconds previously.

About a week later she repeats a similar sequence, except she lets the drama in her mind unfold a little further. This time she stops her sobbing

abruptly as before, but reports a vivid sensation of being hit repeatedly on her right side. As she thinks about this later, it occurs to her that her father was left-handed so that if he had hit her it would indeed have been on her right side.

What appears to be happening here is that as a memory (or memory-like fantasy) of abuse is approached, the patient employs the same process of dissociation in an effort to protect herself as she had in the past. She switches off from the experience and feels she is no longer present. However she later becomes able to undo the dissociation and to elaborate more of the experience through the sensations of being hit.

Children who are abused often develop dissociative mechanisms that are specifically aimed at escaping from the body which is being violated or tortured. A patient whose background apparently involved ritual abuse within a network of perverts, described how she had learnt to detach from her body during intensely painful circumstances, in such a way that she would then experience herself as positioned in a crack in the ceiling or in a lightbulb. This dissociation allowed her some relief, but led to further problems in that it could be difficult to return to her body; she described the agonising struggle to re-enter as being like a dog chasing its tail.

MEMORY, FANTASY AND PSEUDO-MEMORIES. A NEUTRAL STANCE

The much debated issue of recovered memory and pseudo-memory is discussed at length in a later chapter. However, since the study of dissociative disorders takes us directly to consideration of memories of childhood trauma – and since I have been part of the British Psychological Society working party looking at recovered memories (Morton et al., 1994) – it is appropriate that I should here make some preliminary brief comments about memory and technique.

First, I believe that detailed but false memories of childhood abuse can occur. Memory is inherently unreliable. As any analytic therapist will know, apparent memories of childhood events may be based upon real events, upon fantasy or dreams, or upon metaphorical representations, including representations of preverbal psychotic experience (Hedges, 1994). There is evidence that coercive therapeutic techniques can lead to the development of false memories. Moreover, traumatised patients tend to have a disturbed or defective sense of reality; they may be highly suggestible – especially if they are prone to dissociation, which may partly be thought of as a state of self-hypnosis. Hypnosis should not be used to

recover memories. In the examples in this book, no coercive therapeutic procedures were used. In every instance I employed my usual analytic stance of listening receptively and responding thoughtfully.

This brings me to another general point. These patients are extremely vulnerable. They may have been severely traumatised in childhood and the potential exists for them to be traumatised again in therapy. Their sense of reality and perception of reality may have been undermined in childhood and the danger is that it could be again in therapy. The therapist must stay in the position of not knowing what went on in the patient's childhood – because he/she was not there. This is important not only because it is true that the therapist does not know objectively the historical situation, but also because the patient's own account may vary, and different parts of the patient may present differing accounts; it is not uncommon for one alter personality to describe an experience of abuse and for another alter to deny it and accuse the first one of lying. MPD/DID is a trauma-based disorder, but it is also based in fantasy and pretence; distinguishing what comes from reality and what comes from fantasy is inherently problematic.

The person who was abused or traumatised in childhood often has a very fragile sense of autonomy. False compliance with a therapist's view is always a danger – which may be followed ultimately by a violent repudiation of the therapy. Another danger is that of the patient being overwhelmed by reconnecting with warded off experiences of trauma. Through listening to my patients I have learnt to tread very carefully, gently and often slowly when facing experiences of trauma. I do not hold the view that it is always necessary or appropriate for childhood trauma to be faced fully and in detail in every case.

Intrusive investigations of childhood memory are not to be advised because (a) pseudo-memories may be encouraged; (b) the process of prematurely contacting memories of trauma may destabilise the personality system; (c) the patient's sense of autonomy will be threatened; (d) if and when the patient is ready and able to access or think about memories of trauma, then he/she will do so. On the other hand, a receptiveness and readiness, on the part of the therapist, to hear what the patient is consciously and unconsciously communicating of their early experiences is essential. The only responsible stance is to take seriously what are presented as memories and to consider these carefully with the patient, without rushing to a premature conclusion about their origin. I might add here that there is nothing essentially mysterious about amnesia for traumatic childhood experiences; to a large extent it is simply a matter of not thinking about a memory that is disturbing – and who has not done that?

One further point worth emphasising here is that there is a difference between a history and a clinical diagnosis. 'Childhood sexual abuse' is not a diagnosis of a mental state, nor a description of the adult patient's behaviour. Moreover, diagnosing a dissociative disorder does not rely upon knowing anything about a person's history. Whilst gradually coming to know a person's history may be important in understanding how he/she came to be in a particular mental state, the *goal* of therapy is the healing of a mental or behavioural disorder, not the unearthing of a traumatic history.

DISSOCIATION AND REPRESSION

The process of repression, the first mental defence described by Freud, refers to a state in which frightening mental contents are kept out of awareness on a relatively permanent basis, until such time as the 'return of the repressed' perhaps in the form of symptoms. What is implied here is that there is one main dumping ground, the unconscious, where unwanted mental contents are disposed of; this unconscious may speak, but only in the 'language of the unconscious', dreams, symptoms, parapraxes, etc. Dissociation, by contrast, suggests a fluctuating state of consciousness, wherein one part of the mind can know about and speak about, in ordinary language, matters which another part of the mind does not know about. In dissociation there can be many consciousnesses. Repression usually seems to be applied to internally generated mental contents, whereas dissociation is applied to externally generated trauma.

Davies and Frawley (1994) describe dissociation thus:

> dissociation is defined as a process by which a piece of traumatic experience, because it is too overstimulating to be processed and repressed along the usual channels, is cordoned off and established as a separate psychic state within the personality, creating two (or more) ego states that alternate in consciousness and, under different internal and external circumstances, emerge to think, behave, remember and feel. (p. 63)

Contrasting dissociation with repression, they state:

> Repression is an active process through which the ego attains mastery over conflictual material. Dissociation is a last ditch effort of an overwhelmed ego to salvage some semblance of adequate mental functioning . . . Repression brings about the forgetting of once familiar mental contents. Dissociation leads to severing of the connection between one set of mental contents and another.

Often dissociation and repression may be combined. A woman in her early twenties had begun to experience increasing flashback memories of sexual abuse, especially triggered during sexual activity with her husband. Part of the context for the intrusive re-emergence of the memories seemed to be the experience of having her own children, which was tending to put her back in touch with her own childhood. As she talked about this sexual abuse, she appeared emotionally somewhat detached, although her body was shaking. The interviewer had the impression that she was dissociated from her body, her head movements seeming quite lively but as if disconnected from the rest of her body which was relatively still albeit shaking. When asked how she felt about talking of these experiences, she replied that her attitude was one of trying to get the talking over and done with, which she said was like the way she used to try to get the abusive sex over and done with as quickly as possible. She was asked if there had been periods when she had been amnesic for the sexual abuse. She said that for a few years after leaving home she had put the abuse out of her mind. What if she had been asked at that time whether she had ever been sexually abused? She explained: 'I would have said no – and I would have believed that. I thought nothing had happened to me. I didn't want anything to have happened to me and so I thought that it hadn't.'

In this example there was clear repression, for a period of years, of the memories of abuse, the intentional forgetting of what was once known. The repression is also accompanied by the defence of denial: 'I did not want anything to have happened and so I thought that it hadn't.' This denial and repression of memories of abuse at the point of leaving home may be quite common. It is as if the abused adolescent decides at this point that he/she will put the past behind and will build a new identity on the basis of this repudiation of their past. The repression, in this example, follows the earlier defence of dissociation, the detachment from the experience of abuse and from the body that was abused. When asked about her childhood use of dissociation she said: 'It was as if there were two of me – the one that was abused and another one that it had not happened to.'

PSYCHOTIC DISSOCIATION

Dissociation is a central feature of psychotic processes, as Bleuler (1950) originally emphasised.

A schizophrenic patient complained of 'black lightning' emanating from her vagina, which she regarded as a 'septic sore', a source of pollution in her body. She wanted to cut her vulva away or else seal it up with a hot

iron. She also described waking up with pains in her vagina. When the therapist suggested that these feelings might have something to do with unwanted sexual excitements, the patient replied that she did not consider that she had sexual feelings because she was not human but 'an alien'. Eventually it was possible to link these experiences to dissociation in the context of episodes of sexual abuse in her childhood, one of which had been by an alcoholic friend of the family. She wrote about this, stating starkly: 'I was molested by a drunk and I left my body.' It was as if she had reacted to her defiled body as people sometimes do on returning to find their house has been burgled who feel that they do not want to live there any more.

This patient had experienced sexual violation as exceptionally traumatic because of the schizophrenic fragility of the boundaries of her self and her sense of being easily invaded by other people. She had reacted by dissociating from her body and from her own sexuality, so that she thought of herself as an 'alien'. She defensively misclassified her sexual excitements as 'black lightning' and as pain.

As these experiences of abuse were explored in therapy she began to get in touch with her feelings of rage. She talked of wanting to kill the abusers and to fill them with pain and despair, just as she had felt emotionally poisoned by them. A recurrent dream vividly conveyed her wish to turn the tables on her tormentor. In the dream she and the abuser are seated at a meal table with other people. She has poisoned him and he is in agony and is dying and knows that she has done this but he cannot tell anyone. The dream captures the experience of something intensely damaging going on secretly within a seemingly innocuous scene of a social meal. In this way it can be seen that, as the dissociation that she had originally resorted to in the face of sexual trauma began to be undone through the process of therapy, she became more in touch with the feelings of rage and outrage and the wish for revenge, which were a natural accompaniment of these experiences.

Another common form of psychotic dissociation is the coexistence of sane and psychotic parts of the mind. At one moment the patient may be expressing perfectly sane or neurotic strands of thought, but at the next moment is displaying utterly delusional thinking. A schizophrenic patient represented this symbolically as follows: she hallucinated that there was a news flash on the television that half the government had fled the country. She was expressing vividly the way in which part of her mind was still being governed by sanity, whilst another part had taken flight from reality. This can also be understood as the coexistence of waking and dreaming states of mind, with the dreaming state intruding into the waking.

The fundamental dissociation in schizophrenic states often does seem to correspond to the process of 'decathexis' originally described by Freud (1911b). This is the fateful break with reality, the withdrawal of psychic interest from the world, and the subsequent creation of an alternative delusional world. The eventual psychotic break usually follows a childhood and adolescence of an increasing sense of personal failure often stemming from an inherent emotional vulnerability and sensitivity, perhaps combined with exacerbating dynamics within the family. Usually there is some 'final straw' kind of blow, perhaps seemingly mild in itself, but signalling to the person the collapse of any remaining hopes of being a viable adult person. In the face of an utterly shattered self-esteem, there is a giving up on reality. Part of the mind withdraws, leaving a much diminished garrison to deal with the external world. For the person who becomes schizophrenic the encounter with reality itself seems to be traumatic.

The 'decathexis' of reality then places part of the mind in a state akin to the withdrawal from the external world during sleep, resulting in dreams, which display thought processes that carry no respect for reality. Whilst 'dreaming' the schizophrenic person is still awake – and hence the interweaving of rational and dreamlike thought in this state of mind. This is the state which is itself represented by the patient's dream of half the government having taken flight.

The dissociation between a psychotic part of the mind, which has withdrawn from reality, and a sane part of the mind, which retains respect for reality, is described in some of Bion's writings (Bion, 1956, 1957). It is also implied in Freud's (1940b) account of splitting of the ego in his analysis of fetishism; in that state of mind, part of the ego accepts the reality that females do not possess a penis, whilst another part maintains the illusion that they do and looks to the fetish as a representation of this.

DISSOCIATION BETWEEN CHILD AND ADULT PARTS OF THE PERSONALITY

In people who have been severely traumatised or neglected, there is often a marked dissociation between child and adult parts of the personality. It is as if a precocious pseudo-adulthood had to be developed, superimposed upon, and in opposition to, an unintegrated child self. The inner child and the adult then are at war with one another, often each attempting to annihilate the other, each feeling that the other threatens their own existence.

For example, one patient had an angry child self that vigorously attempted to sabotage the adult's capacity to work; the background was that she had felt neglected and abused in childhood, her mother being out working excessive hours and the patient being left to take care of her siblings; for the angry inner child this patient's adult self that went to work was abusively abandoning her just as she had felt her mother had done. Often there was very little capacity for child and adult parts to cooperate in this patient; each was pursuing quite different agendas. Whenever the adult personality attempted to look for a job she would experience a loud and violent screaming of protest in her mind. This woman's capacity to work was indeed greatly jeopardised because although she could function as an adult and work competently for certain periods, she could not maintain this adult state and would find herself feeling, thinking and behaving like a small child with no access to her adult perspective and capacities. She would put on what she called her 'mask' in order to go to work, but would be terrified that the mask would slip and she would be revealed as a traumatised and disoriented child, lost in an adult world that made no sense to her.

A common clinical experience in working with people repeatedly traumatised in childhood is that he/she might appear in one emotional state during the session, but shift into quite a different and more disturbed state after the session. The patient may appear to be engaged in an analytic endeavour during the session, seemingly with a good working alliance with the therapist, whilst afterwards, or sometimes at the very end of the session, becoming very frightened and disoriented. This might be followed by extrasessional communications, such as letters or phone calls, which show much greater disturbance; these communications may be filled with incoherent rage or overtly psychotic material – which is then not easily addressed during the session. The problem here is that the relatively adult part of the patient that is 'out' during the session is dissociated from the traumatised child or psychotic parts. It is then as if these parts demand recognition and vehemently assert their presence later. Sometimes this phenomenon takes the form of the patient presenting to the therapist in different states of mind at different times, so that initially the therapist has the confusing experience of thinking at one point that he/she has a neurotic patient but at other times perceiving the patient as psychotic.

Where there is a marked dissociation between child and adult parts of the mind, there may be a considerable therapeutic problem of how to find meaningful access to the 'children'. The small child in the patient may not be able to make use of the adult oriented analytic session, which relies upon words and a rather austere atmosphere. To a child the stance of the

adult analyst may appear strange and bewildering. For example, one patient complained that she simply could not follow the big words and long sentences that the therapist used. Another exclaimed angrily that there was nothing for a child in the consulting room. The availability of dolls, teddy bears or other toys may facilitate communication with the child. A classically trained analyst unwilling to modify his/her technique would have difficulty working with this kind of patient. Without some adaptation to the dissociation, on the part of the analyst, the child within the patient is likely to feel excluded, immensely angry, and will probably wreck the therapy.

DISSOCIATION BETWEEN 'TRUE' AND 'FALSE' SELF

Winnicott's (1960) description of a division between true and false self is not an account of repression but of dissociation. More than merely a social self or personna, Winnicott saw the false self as arising when the adaptation from the mother to the child is so lacking that the child is predominantly adapting to the mother. The mother substitutes her own gesture for that of the child. A false self of adaptation develops and the true self is held in abeyance.

A patient presents a lively personality to most people who know her, but brings her despair only to the therapist. To him she talks of hopelessness, loneliness and anguish. As she gets in her car to come to the session she feels her pretence dissolving and a sense of heaviness emerging. However, a recurrent fear in the transference is that the therapist will tire of her depression and want to get rid of her. Part of the background was that she experienced her mother as unable to tolerate her unhappiness; whenever she attempted to communicate feelings of misery, from whatever source, her mother would express disapproval and send her away. She learnt to be charming and cheerful, but this facade concealed despair – despair about ever being known and understood.

What evoked most anxiety in this patient's childhood was the wish to communicate to her mother the distress that her mother caused her. She perceived that her mother needed to be seen as glamourous and successful and worked to preserve her mother's self-image. Stolorow, Atwood and Brandchaft (1994), writing from a self-psychological point of view, describe this kind of situation as follows:

> One of the most noxious early pathogenic situations occurs when a child's attempts to communicate an experience of psychological injury by a caregiver result in a prolonged disruption of a vitally needed tie. When the

> child consistently cannot communicate such experiences without perceiving that he or she is damaging or unwelcome to the caregiver, an invariant principle becomes structuralised that organises all subsequent experiences – the conviction that the subjugation of one's own distinctive affective experience is an absolute requirement for maintaining needed ties. (p. 125)

Thus this kind of quite common dissociation between true and false self is based not on gross trauma or abuse but on repeated painful interactions with a primary caregiver, involving partial rejection of crucial affective communications. Although serious, it represents a less severe dissociation than that which derives from gross and repeated trauma.

DISSOCIATION BETWEEN DIFFERENT STAGES OF LIFE

Most people's lives show some continuity and development through the progressive stages and tasks of the life cycle. The following is an example of someone whose life was constructed, by contrast, as a series of dissociative shifts.

A man sought help in mid life, presenting with depression and a general sense of turmoil. He had taken to dressing in army fatigues, had developed an interest in martial arts, and expressed desires to spend time living alone in a tent on isolated moorland or forestry. Prior to this he had worked for 20 years as a respected civil servant, wearing a conventional dark suit every day. He was married with three grown-up children. The shift in his mental state and life style had been preceded by a period in which he had been pursued by a rather predatory woman, with whom he eventually had an affair. Having initially strongly resisted the advances of this woman he subsequently became intensely attached to her and was devastated when she ultimately rejected him in a rather cruel way.

As he talked of his preference for living alone, his distrust of people generally, his hypervigilance and his new image of himself as a 'lone wolf', the therapist commented that he was sounding like somebody traumatised by war – like a Vietnam war veteran. He immediately responded to this analogy, agreeing that it was very apt. This led him to liken the way he felt now to an earlier period of his life, in his adolescence, when he had been sent abroad to a harsh military-style boarding school.

It was then possible to reconstruct the developmental sequence. His adolescence had been a period of trauma, involving loneliness, bullying and violence, with a sense of being essentially alone and having to fend for himself. He had developed character defences to deal with this, walling

himself off emotionally, and developing a tough 'false self'. After leaving school he entered a period of heavy drinking, gambling and promiscuity which lasted about five years. Suddenly he stopped this way of life, embarked upon a respectable profession and made a conventional marriage, in which he assumed himself to be happy enough. In mid life he was insistently pursued by an attractive and predatory woman, offering a romantic, highly sexualised and exciting relationship. Whilst initially he rebuffed her in a manner consistent with his general view that it was not safe to let anyone get too close emotionally, the woman did eventually break through his defences, eliciting then an intense and needy attachment. Having gained his vulnerability, the woman triumphantly and seemingly sadistically rejected him, leaving him full of pain and shame. He was then left back in the same state of mind as the traumatised young adolescent at the military boarding school. As he and the therapist reviewed his life, he began to see that it had consisted of a series of discrete shifts rather than the more normal pattern of development with strands of continuity.

CHRONIC BUT SUBTLE DISSOCIATION

Sometimes dissociative states may be very pervasive but subtle and not immediately obvious to the clinician who is not attuned to these processes. Gradually a therapist may become aware that the patient seems to present in quite different moods and attitudes at different times, yet with enough continuity for the suspicion of gross dissociation to be dismissed. Analytic work may seem to be done, but resulting change is slow or non-existent; the patient may acquire important insight during one session, but in another session may talk as if this insight had not been achieved. The impression may be of a kind of stupefaction which prevents thinking and the linking of one piece of knowledge with another.

A patient would sometimes allude to terrible experiences that she may have had in childhood and appear very shocked by her own revelations, yet at other times talk as if her life had been quite uneventful. For the therapist it was rather as it might be if someone who had been in a Nazi concentration camp sometimes spoke in detail of the experience whilst at other times talked and behaved as if nothing like that had ever happened. Frequently she had dreams which represented idealisation of a situation, behind which was awful dereliction.

One day she reported a dream in which she was living in a log cabin in the woods and was looking forward to the winter, thinking how beautiful it would look when covered with snow. The therapist was somewhere

in the picture and the patient gradually realised that the therapist was mad and had murdered someone. There were bunkbeds and the patient was underneath. She felt dampness and realised that blood was dripping on her and that the therapist had murdered a woman with a knife. She looked at the woman all cut up, with old stitches.

In her associations to the dream, she thought that her proximity to the murdered woman might be expressing the realisation that it was she herself who had in some sense been murdered; this represented some undoing of the original dissociation in which she had detached herself from the abused body. She recognised the idealisation and denial implicit in the musing about the beauty of the snow and how this gives way to a scene of utter horror. She also could see clearly expressed her terror of the therapist as a madman, not just in his transference role as a crazy father, but also as a lunatic who was attempting to return her to her ghastly and ghoulish memories. In the context of the content of recent sessions which had been concerned with considering her traumatic past, it was as if the dream was saying that anyone would be mad to want to go back to what she had been escaping from.

SUMMARY

Dissociation is the process whereby normally integrated streams of thought or consciousness are kept apart and communication between them restricted. This last ditch defence takes place in the face of repeated and overwhelming trauma. It begins with the child's self-hypnotic assertion 'I am not here; this is not happening to me; I am not in this body.' This pretence then becomes a structuring dynamic within the personality.

In its very nature, dissociation tends to be covert and easily overlooked. Some forms may be quite startling and dramatic when they do emerge, whilst others may be much more subtle. There may be stark dissociation between child and adult parts of the personality, between true and false self, and between sane and psychotic parts of the mind, and between different phases of life.

The defence of repression tends to apply to internally generated danger, whilst dissociation is brought into play against externally derived trauma, especially repeated trauma of sexual abuse. The notion of repression implies a single area of warded off mental contents, the 'unconscious', whilst dissociation implies multiple consciousnesses.