

# Undoing dissociation. Affective neuroscience: a contemporary Jungian clinical perspective

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*Abstract:* In the last ten years both analysts and neuroscientists have begun to challenge the analytic world to explore the analytic view of the mind in relation to knowledge emerging from the field of neuroscience. I find that ‘in many ways it is Jung’s understanding of the mind, the human condition, and the self, that is most compatible with the insights that are emerging from neuroscience today’ (Wilkinson 2004, p. 84). In this paper I consider the insights that neuroscience has to offer us as we seek to work with those patients whose early experience has diminished their capacity to be ‘in mind’ and with it their capacity for reflective self-function, whose defences are dissociative, whose need has been to keep unbearable experience at bay, out of mind. I look first at dissociationist theory and its development, then focus on the insights to be gained from neuroscience with regard to early trauma and its effect on the encoding and recall of memory. Finally, I turn to the nature of cure and argue that hemispheric integration is the key to undoing dissociation and the prelude to individuation.

*Key words:* affective neuroscience, dissociation, implicit, individuation, relational, subjectivities.

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## Introduction

In the last ten years both analysts and neuroscientists have begun to challenge the analytic world to explore the analytic view of the mind in relation to knowledge emerging from the field of neuroscience. Janet and later Charcot in Paris towards the end of the 19<sup>th</sup> century were the first to propose that traumatic memories may become split off. Janet stressed that extreme emotional arousal might result in effects of trauma lingering on in an unintegrated way because it had never been able to be processed adequately. Both Freud and Jung studied in Paris, embraced dissociationist theory and wrote convincingly in support of it. Jung commented:

As a result of some psychic upheaval whole tracts of our being can plunge back into the unconscious and vanish from the surface for years and decades . . . disturbances caused by affects are known technically as phenomena of dissociation, and are indicative of a psychic split.

(Jung 1934, para. 286)

He warned that the real emotional significance of a childhood traumatic experience ‘remains hidden all along from the patient, so that not reaching consciousness, the emotion never wears itself out, it is never used up’ (Jung 1912, para. 222). He elucidated, ‘A traumatic complex brings about the dissociation of the psyche. The complex is not under the control of the will and for this reason it possesses the quality of psychic autonomy’ (1928, para. 266). He described such complexes as ‘autonomous splinter psyches’, fragments, which became split off because of traumatic experience (1934, para. 203). Jung warned how the traumatic complex may suddenly return to consciousness commenting, ‘it forces itself tyrannically upon the conscious mind. The explosion of affect is a complete invasion of the individual. It pounces upon him like an enemy or a wild animal’ (1928, para. 267). Later both Freud and Jung were to move away from this inter-psycho view of development and rather came to stress the intra-psycho world. The effects of adverse external experience lost ground to fantasy as analysts sought to understand the roots of internal object relations within the psyche. However, work with soldiers from World War I, studies of Vietnam veterans and research with those who had been sexually abused in childhood led to renewed emphasis on Jung’s earlier perspective that real, overwhelmingly traumatic, events might disappear from the mind and be held only in the unconscious, in implicit memory, in the forms of complexes.

Today DSM IV identifies dissociation as ‘a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment’ (American Psychiatric Association 1994). Schore notes that the *International Classification of Diseases* (ICD 10) also makes reference to ‘immediate sensations and control of body movements’ and that Spiegel and Cardena’s widely used definition of dissociation also includes the emotions (Spiegel & Cardena 1991, p. 7, cited in Schore 2005, chapter 9). Chefetz describes the fluctuating states of self-awareness that occur in the experience of the dissociative patient as alternating subjectivities that may exist without dissonance because of the particular effects of the dissociative defence (Chefetz 2000, p. 290). The multiplicity of definitions reflects the complexity of what analysts may experience as they seek to work with patients who dissociate. Chefetz notes that material from patients with this defence tends to have more non-verbal content (*ibid.*, p. 289); I understand this non-verbal content to be content originating predominantly from the activity of the right brain. Chefetz asserts that awareness of the differing states of subjectivity experienced by these patients will allow work to take place through which affect can be contained and explored (*ibid.*, p. 289). I find his definition of alternating or varied states of subjectivity helpful in that it allows for the whole spectrum of experience of self and other. It allows for the differing states of subjectivity that we all experience as we function in relation to loved ones, to colleagues or to friends, and the differing ways in which we will relate to any of these, depending on our external or internal transient experience, right through to the pathological states encountered in work with patients in severe dissociative states.

## Undoing dissociation

In recent years huge interest has developed in the relevance of contemporary neuroscience and attachment theory to clinical practice; the un-doing of dissociation is an area where such insights are of particular value to us in our clinical work. From the beginning, the development of mind is dependent on experience of relating to others, the initial development of mind arising from intimate interactions with the mother and also the father. Knox comments that ‘mind and meaning emerge out of developmental processes and the experience of interpersonal relationships rather than existing *a priori*’ (2004, p. 16). Earliest experiences of emotional states arise out of bodily experiences in relation to the primary caregiver. Panksepp, Schore and many others emphasize an experience-dependent understanding of the development of the self from an inner core self. They stress the relational, intersubjective nature of the development of the individual self. Thus we may think of the individual as a mind-brain-body being that has emerged from the experience of the earliest and most fundamental experiences of relating. Both nature and nurture have had a part to play in the growth and development of the neuronal connections that go to make up the individual mind. Siegel comments ‘Relationships may not only be encoded in memory but may also shape the very circuits that enable memory to be processed and self-regulation to be achieved’ (2003, p. 14).

Early brain development is adversely affected by traumatic experiences in the earliest relationships. Teicher’s research has shown the impaired connections between the right and left hemispheres, that the fibre tract known as the *corpus callosum*, that is the major highway between the two hemispheres, may be reduced through the effects of trauma in those who have experienced childhood sexual abuse (Teicher 2000). Schore has brought together evidence from a substantial body of research, including research using EEG and neuro-imaging (fMRI) data and positron emission topography (PET), that demonstrates that unconscious processing of emotion is associated with the right rather than the left hemisphere and that the right hemisphere is densely interconnected with limbic regions and therefore contains the major circuitry of emotion regulation. In his most recent paper Schore stresses the importance of the ‘hierarchical vertical cortico-subcortical functions’ of the right brain and argues that dissociation is best understood, not in terms of disconnection of left and right brain, but in terms of a loss of connectivity within the right hemisphere (2005, chapter 9). Schore has cautioned against the lopsidedness of a theory that has for too long been left brain dominated and which has naturally used a left brain tool, that is interpretation, as the main agent of change. I conclude that verbal, cognitive left-brain communication between patient and analyst is not on its own sufficient cure for right-brain, affective dissociative distress. For our dissociative patients it is important that we engage the right brain in an empathic mode of working towards relational change but whilst crucially remaining able to think. Cozolino stresses that it is

‘the blending of the strengths of the right and left hemisphere [that] allows for the maximum integration of our cognitive and emotional experience with our inner and outer worlds’ (Cozolino 2002, p. 115). I believe such integration may be facilitated as, through the experience of the transference, past is linked with present and emotional experience revisited and reworked. Siegel comments: ‘when one achieves neural integration across the hemispheres one achieves coherent narratives (2003, p. 15).

Jung stressed the profound effects of the early experiences in life. Fordham, drawing on the work of Stein (1967), understood that ‘the self has defence systems designed to preserve individual identity and establish and maintain the difference between self and not-self’ (1976, p. 90). Fordham described the healthy processes of deintegration and integration by which the infant begins to develop a sense of self in the world and emphasized that, when the infant self is threatened by overwhelming experiences it cannot process, the threat of disintegration occurs and the infant self protects itself by a retreat from the world into an autistic state (1976, pp. 88–93). Solomon emphasized that ‘when early trauma has taught a young self that searching for experiences that could lead to growth and relation to another is . . . psychologically dangerous, leaving the self open to damage and exploitation, the self has no other recourse but to withdraw back into itself (Solomon 1998, p. 236). Fordham argued that ‘if a baby is subjected to noxious stimuli of a pathogenic nature . . . a persistent over-reaction of the defence system may start to take place’ (1976, p. 91). Such a process may now be understood as the defensive development of neural pathways in order to protect the self. Schore stresses that as the limbic system myelinates in the first 18 months of life at the time when the right hemisphere is in a growth spurt and before the left hemisphere has come on line so attachment experiences inevitably affect the limbic and cortical areas of the developing right hemisphere. He reminds us that when trauma (with its associated fight, flight and freeze responses) has been experienced in the context of the earliest attachment relationship, then it becomes ‘burned into the developing limbic and autonomic systems of the early maturing right brain . . . [it becomes] part of implicit memory, and [leads to] enduring structural changes that produce inefficient stress-coping mechanisms’ (Schore 2002, p. 9).

A baby allowed to reach a state of frantic distress will, if it remains unresolved, switched off, staring into space with a glazed look. Schore suggests that if the baby continually experiences states of unbearable fear-terror or aggression emanating from the mother’s face, then dissociation will become the primary regulatory process that will be resorted to throughout the life span. He concludes that attachment trauma ‘induces an enduring impairment of . . . the primordial central integrating structure of the nascent self’ (Schore 2005, chapter 9). Chefetz (2005) comments that dissociation aims to protect the self, yet in its attempts to triumph over the self it actually injures the self and leads to enduring changes in subjectivity.

I will now summarize briefly what neuroscience has contributed to our understanding of the processing of experience, of the encoding and retrieval systems of the mind-brain. Two separate memory systems co-exist in the brain. It is the asymmetries in two hemispheres of the brain, observable in utero, that give rise to two very different systems for processing and recording different types of experience. Devinsky comments ‘The right cerebral hemisphere dominates our awareness of physical and emotional self...and a primordial sense of self...in contrast to the linguistic consciousness of the left hemisphere’ (Devinsky 2000, p. 69). The earliest memory form is implicit, unconscious, emotional and inaccessible, arising out of right hemisphere processing of information, and is on line from birth. It stores acquired skills, conditioned responses, and emotional responses that at an unconscious level manifest themselves in the person’s most fundamental ways of being and behaving. This early form of memory is most dependent on the amygdala and comes into play when processing of sensory information concerning arousal or the emotional content of experience is involved. Later memory is explicit, conscious, informational and accessible, arising from predominantly left hemispheric processing; it comes on line by the time a child is about three years of age. It is dependent on the activity of the hippocampus and the prefrontal cortex. Understanding of the nature of these two systems and the need for their integration is fundamental to our appreciation of the nature of cure for patients who suffer from the dissociative effects of traumatic experience.

Traumatic experience affects both the encoding and recall of the memories associated with it. ‘As danger threatens the brain’s initial response is acted upon in the brain stem, midbrain and thalamus milliseconds before it gets to the cortex where it can be thought about’ (Perry 1999, p. 18). Part of the brain’s response to severe trauma is to reduce function across the *corpus callosum*, the major fibre tract that connects the right and left hemispheres (Teicher 2000). Peter Levine has described how in extreme situations feeling, sensation, behaviour, image and meaning become dissociated from one another (cited in Rothschild 2000, p. 67). When the different elements of an unbearable experience get dissociated or split off from one another there can be no proper memory of the event. It will not be processed by the hippocampus, which tags time and place to memories, and so it cannot be stored as explicit or narrative memory. It cannot be recalled in the ordinary way because it has not been remembered in the ordinary way. Instead it will be encoded implicitly in the emotional brain and in the body to remind and warn when similar danger should threaten again.

Many for whom trauma has been sustained over time lose memory of it. If the trauma is pre-three then the processing capacity that leads to the ability for explicit recall associated with the left hemisphere is not yet available. The processing of early traumatic memory is very much limited to the right brain as the left brain development, with its capacity for verbal processing and hippocampal processing of memory, is not yet completely on line. Some degree

of emotional stimulation makes encoding and retrieval easier; however if arousal is over strong and stressful then explicit memory formation is likely to be impaired (LeDoux 2002, p. 222).

Terr's paper 'True memories of childhood: trauma, flaws, absences and returns' (1994) seeks to grapple with the problem that confronts all of us who struggle with the uncertainties that arise in both patient and therapist, not to mention the general public at large, as one struggles with that not remembered, half remembered, remembered only in patches, retained only in body memory yet portrayed in the transference and experienced by the therapist in the countertransference. Here I think the child therapist has the advantage: they are closer to the trauma and often the child has very clear ways of portraying it to the therapist. Terr cites five studies of 'true' trauma experience in children and from these studies makes the following points. In those who had memory of their trauma while the gist of the experience was remembered accurately, there were flaws of memory; both visual perception and perception of time were subject to distortion. In those where there was absence of memory in the face of true documented traumas, it was clear that children who were under 28 to 36 months of age could not verbally remember their trauma but might have body memories or a vague sense of foreboding when in a context which reminded of the trauma. Those older children who experienced abuse demonstrated that 'prolonged or recurring traumatic events would be less available to recall than a single short traumatic event' (Terr 1994, p. 74). Children who lacked trauma memory nevertheless demonstrated trauma symptoms (the most common of which were post-traumatic, repetitive play, personality change, and trauma-related fears), 'the only factor linked to having no trauma symptoms turned out to be harbouring a false memory' (p. 75). Terr comments on the absence of memory in those who experienced sustained and long-term trauma in terms of defence, suggesting that these children 'have mustered up their defences to hold their horrors in check'. She summarizes:

Children old enough to remember their traumas may defend themselves from prolonged or repeated trauma by putting their traumas out of mind, deliberately 'suppressing' or unconsciously and undeliberately 'repressing' them. Traumatized children may also dissociate, teaching themselves to self-hypnotize and to enter planes of consciousness in which they fail to take in and register full memories of their traumas. Children may split, creating good sides to themselves that know nothing about the awful experiences their cut off bad selves know. They may displace, concentrating deliberately on something similar but less cathected than the trauma, and, thus making their memories slip away. I have found that in my evaluations of adults who have lost parts or all of their memories of childhood traumas that all five of these defences can work against memory.

(Terr 1994)

Terr comments on children or adults who can describe their ways of removing themselves from traumatic scenes as the exception. Terr comments that usually 'the techniques, more than even the memories themselves, defy retrieval' (p. 76).

Nijenhuis and Van der Hart define dissociative defence mechanisms as primary if the individual is distanced from the experience which is available only in flashbacks, secondary if the different aspects of experience become dissociated from one another, (affect from meaning for example), and tertiary if several dissociated identities with different schemas emerge during the analysis (Nijenhuis & Van der Hart 1999). A patient who suffers from the complexities of severe dissociative identity disorder and in whom there are many vertical splits, with many sub personalities, that Jung termed 'splinter psyches' (Jung 1934, para. 203), or Chefetz refers to as 'alternative subjectivities' (2000) does not have a coherent inner core that would allow her or him to move seamlessly between the different aspects of personality which emerge in different contexts.

In my clinical work I find dissociative defences protect against painful, even unbearable memory. They lie symbolically between 'in mind' and 'out of mind', protecting the patient from overwhelming affect at a time when it would be truly unbearable yet hinting at the truth ready for the moment when the patient has sufficient ego strength to begin to confront it. The achieving of this, particularly in relation to fear and aggression, forms a major part of the work with these patients.

### Clinical illustration

Miranda Davies, a Jungian child analyst, saw a 13-year-old boy who both physically and psychologically presented as a much younger child (Davies 2002). Jay painted a graphic picture of the defences occasioned by trauma when for many sessions he played and replayed a football game with toy wild animals. His analyst experienced dissociation in the form of mindless boredom at the endless repetition, and an inability to think about the meaning of the play that overcame her. I was struck by the neuropsychobiological significance underlying the symbolism of the figures Jay had chosen; in conversation his analyst and I were able to explore the significance of the football game in a way that allowed meaning-making to occur. On the wing was the cheetah, named by Jay after a player called 'Rush' because he could run as fast as the wind to get out of danger (flight). As forwards were a pig and a bull, named by the child after English footballers notoriously associated with aggression (fight). If all else failed the large polar bear from the land of ice occupied the goal (freeze). Hope, but also the internal struggle, was carried by the little boy kangaroo. He could break all the rules, carry the ball and run where he liked. I understood these images as attempts of the mind to represent those experiences that had remained encapsulated in the emotional brain, as yet not available to conscious mind, not yet stored in explicit memory but rather held in implicit memory. Through this metaphorical play Jay sought to explore his defences, yet in such a way that for his analyst also they remained out of mind. Terr (1991) writes of the monotonous repetitive play that is the product of

traumatic experience and the difficulty that the analyst experiences in helping the child to make the links that enable the processing of the experience, thus allowing the child to move from the concrete to the symbolic. This is because the first countertransference response in the therapist is of necessity dissociative. Jay, who wanted his pain to remain out of mind, played out his anxiety in a way that kept it both in mind but out of the mind of his analyst and in himself. Jay in his repetitive play trusted his therapist enough to reveal the bare bones of his trauma. She concluded that 'he could convey meaning in a way that seems astonishing in a child with such early and severe deprivation' (Davies 2002, p. 427). She noted that, in play such as the football game, Jay's archetypal fantasy of the baby kangaroo who could take a free kick and score from the other end of the field, who could run faster than all the other players, and who did not even need other players to back him up, was an amazingly accurate depiction of 'the defensive, do-it-yourself, heroic psychology of the deprived infant, who has not got the emotional resources to acknowledge his dependency on a mother figure, but sustains himself with the omnipotent fantasy that he can overcome all odds and supply his own needs by his own efforts' (ibid., p. 431). Davies comments:

I found the play to be defensive and self-compensatory, cutting him off from reality and building a massive protective wall around the frightened, vulnerable, desperately wounded infant at the core of his personality.

(ibid., p. 431)

Can treatment of such early trauma work? Jay's school reported that by the end of his therapy he was producing four times as much written work and the behavioural difficulties experienced in school before the therapy began had ceased. He was able to move successfully into ordinary state schooling for the last phase of his education.

### **Integration**

Perhaps as yet speculative, nevertheless it may be inferred that the analytic process, and the evolving symbolizations associated with it, can develop new neural pathways in the brain, and in particular can develop the fibre tract known as the *corpus callosum* that is the major highway between the two hemispheres, shown to be reduced through the effects of trauma (Teicher 2000). Such integration is facilitated as, through the experience of the transference, past is linked with present and emotional experience revisited and reworked. Through the analytic process, new entities are added to pre-existing connections, in the transformative way that is the outcome of appropriate and well-timed interpretation. Schore comments that affectively focused treatment can 'literally alter the orbito-frontal system of the brain' and suggests that 'non-verbal transference-countertransference interactions that take place at



preconscious-unconscious levels represent right hemisphere to right hemisphere communications of...emotional states between patient and therapist' (Schoore 2001b, p. 315).

At the beginning of therapy the greatest need may be for containment with the therapist as the container of uncontainable affect of unbearable experience, and also as the one who can process the rapidly changing dynamics of the transference and countertransference in order that what feels like 'now' may settle into 'then'. There will be a need for meaning making, for naming that which was previously known only in the body, unavailable to the mind. Early relational trauma may give rise to vertical splits within the personality, experienced as alternating subjectivities, at the very least there will be the frightened, angry child whose development was stopped by the experience of overwhelming trauma and whose emergence in the consulting room will mark the first tentative steps towards trust. One might say that part of successful therapy will be the recognition of the threesome in the consulting room, that is the analyst, the patient who manages the day to day more or less successfully whether adult or child, and the inner hurt part of the patient that is often characterized as 'the traumatized child within'. The skill of the analyst is to relate to both without favouring one or the other so that the two may become more able to interact in a caring way one with the other, eventually becoming more wholly integrated into one, allowing a new experience of the self.

The questions surrounding the recall of memory and accuracy of memories that surface in the consulting-room have been widely discussed; however we should also be aware of the way in which the changing of emotional memory may actually be a benign aspect of analytic work, in that the re-telling (from explicit) or re-experiencing (from implicit) of memories in the presence of the therapist may lead to a modulation in the quality of the affect associated with the memory, thus modifying the memory. Siegel notes that 'recent studies of flashback conditions suggest an intense activation of the right hemisphere visual cortex and an inhibition of left hemisphere speech areas' (2003, p. 15). At such moments much will depend on the calm that the therapist is able to sustain within in the face of much that urges consciously and unconsciously towards just the opposite. A lowering of tone and slowing of speech, speaking in what Williams (2004) has termed 'pastel rather than primary colours' may help to counteract the responses triggered in the patient. It may be possible to help the patient to modify their experience by use of a simple phrase such as 'it was then, not now'. Cozolino (2002) suggests that this is effective because it stimulates Broca's area and encourages the functioning of right and left hemispheres in a more integrated way.

This process of cure is not only that of making unconscious conscious, with interpretation, but also the interactive experiencing within the therapeutic dyad. It is the combination of the two that enables change. The development of regulated affect within the patient brings with it the capacity to reflect, that then makes more possible the interpretative moment, in turn bringing

with it the possibility of more integrated hemispheric functioning and the development of coherent narrative. Fonagy argues that ‘the ability to represent the idea of an affect is crucial in the achievement of control over overwhelming affect’ (Fonagy 1991, p. 641). For this to occur successfully interpretations must be grounded in the emotional experiencing that occurs within the therapeutic dyad rather than being merely cognitive engaging primarily the left hemisphere alone. Beebe and Lachmann describe the analytic process as ‘a co-constructed interactive process’ in which ‘the narrative dynamic issues and the moment by moment negotiation of relatedness fluctuate between foreground and background’ (Beebe & Lachmann 2002, p. 17).

The work in the consulting room, with its focus on the transference, calls forth emotional responses that come from implicit, emotional, amygdaloidal memory traces that affect profoundly the individual’s way of experiencing and relating to others. The more traumatic the early experience of the patient, the more necessary it is for the analyst to keep this firmly in mind. The therapist’s way of working, of containing and moderating the affect evoked, will determine whether an experience ‘kindles’, that is, activates an emergency response where no emergency is, releasing a toxic soup of chemicals in the brain and retraumatizing the patient, or whether it facilitates the ‘quenching’ process which then permits analysis of the transference. Such work enables the later left brain analytic processing, that ‘allows for the structural expansion of the patient’s orbito-frontal system and its cortical and subcortical connections’ (Schoore 2001a, p. 72) and strengthens cortical control over the amygdala (LeDoux 2002).

### Individuation

Analysis is essentially a symbolic activity with the use of metaphor at its heart. Levin and Modell’s work has emphasized the value of metaphor because of its capacity to facilitate integrated working of the two hemispheres of the brain as the patient seeks to recover from traumatic experience (Pally 2000, p. 132). Knox reminds us that Jung understood that ‘mental imagery always has its origin in external experience which is then internalized and modified by innate or archetypal expectation, and that as therapists much of our skill lies in being attuned to these transforming symbols which our patients unconsciously communicate to us’ (Knox 2001). This seems to have been the case for Sophie with a series of paintings.

In the following clinical material I seek to illustrate the process of the symbolic emergence of self as traumatic memory emerged and was transformed through experience in the analytic dyad. Sophie’s pictures were produced at home during the analysis and brought occasionally to a session. The first picture vividly described the patient’s defended self at the beginning of the analysis. It showed an androgynous form, deeply buried in a sarcophagus-like structure. The outer wall or case of the sarcophagus-like structure that

represented the defences of the undefined, undifferentiated self, was made of many images of her mother's pointing fingers, hitting hands and clenched fists. The next layer of the sarcophagus was of wood and the third of stones, indicating a hardening of the defences against the trauma, experienced in the earliest relation to her mother. This was the first of a series of five pictures brought to analysis over a period of the next four years. The second and the third pictures illustrated the way that defended state had come about and accompanied the gradual emergence of memory of the quality of her earliest relationships through the experience in the transference. The fourth and fifth pictures illustrated the emergence of the self as the analysis enabled the defences to be relinquished and released a new energy for living.

Sophie, an artist, who I saw four times weekly for five years, was in her late thirties when she sought help because she had suddenly become unable to work or take care of her family, wishing only to retreat to bed. By the time she came to see me she had been off work for three months. She was depressed, unable to sleep and frightened by what was happening to her. She had two children, a daughter aged 9 and son who was 14 years old when she came into analysis. In her early twenties her first child, a son, had been stillborn. His funeral had been held without her knowledge while she was still in hospital. She felt she had never been able to complete her grieving for him. She came to analysis because she was frightened by her illness but inevitably started the analysis with a strong negative transference; I was an uncomfortably close reminder of her denying and depriving mother.

Sophie was the third girl in a family where a son was longed for. Her history is that of early relational trauma, followed by a seemingly isolated incident of childhood sexual abuse. Her mother had felt the third child was bound to be a boy. It was not until Sophie was twelve that a boy was born. Her mother had a difficult labour with her and when Sophie was born she would not even look at her. A nanny looked after her and her father named her. Her mother was unable to breastfeed Sophie. At two weeks old she was hospitalized without her mother. She is uncertain for how long. When she was a child her mother often said, 'You were the worst, you were ill and you should have been a boy'. She felt she could never please her mother because she was neither interested in feminine things like her eldest sister nor very attractive like her other sister, rather she liked to get out into the countryside or paint. Her mother considered both a waste of time for a girl. Sophie's paintings made during the analysis have documented shifts in her inner world as they have taken place. Not surprisingly she brought none for the first six months and then brought the first. She produced it very hesitantly.

In the analysis Sophie's mother came across as unhappy and bitter. Sophie experienced her as cold, blaming and uncaring. When as a child Sophie was admitted to hospital after a bad fall from her cycle, her mother did not come to visit her for several days and when she came Sophie remembered her first words as 'Well, what have you managed to do now?', a refrain repeated

throughout her childhood. Early in the analysis Sophie brought two pictures that showed her internalized relationships as a series of cogs interacting with one another. In telling me about these paintings Sophie described her mother as the bad steel cog mother and we acknowledged that it was how she sometimes experienced me in the transference, although she sought to keep me as an idealized good mother. She felt her mother's cog had damaged her cogs, her ways of relating to others, and had thus made it difficult for her to get along with others. Indeed she became increasingly aware that her experience of her mother as the tearing, hurting, destroying mother was lodged inside her, affecting the way she encountered and reacted both to me and to others.

The next phase of the work was dominated by Sophie's experience of me as the hostile, persecuting, destructive mother analyst. In a moment it seemed she would change, her face would for a moment show fear, and then would become hard as she closed off completely from me. Almost a whole session would pass, as she would struggle with her experience of me as the bad mother. Wordlessness was the most striking feature of her state of being at these times as she became dominated by right brain functioning, by deeply held ways of being and behaving arising out of the traumatic quality of her earliest relational experience, lodged deep in implicit (right brain) memory. Patients who have been traumatized are hyper vigilant and subject to flashbacks. They may be triggered by a stimulus that in some way matches past bad experience and because the brain pattern matches to protect from a repetition of trauma, the patient becomes overwhelmed by an experience that has a 'here and now' rather than a 'there and then' quality to it. A turning point came when Sophie went home and painted these pictures of the steel cog mother. They filled her with fear, but she was able to bring them to the session and to engage the left hemisphere of the brain as she thought about the images emerging from the right. In her third picture the mother's cog is seen as a wheel with spikes whirling round and tearing into the flesh of Sophie's hand. Haltingly she became able to discuss her uncertainty about whether I was the bad steel cog mother attacking her, or whether she was the bad one tearing me to shreds. We became able to talk about how aggression becomes internalized, how experience both of being abused and being the abuser made up her internal world.

Sophie had turned to her father for closeness and until his son was born he treated her as the son he longed for and took her around the estate with him. She longed to be a boy so that she might inherit the estate that she loved so much; indeed until her brother was born, she enjoyed a special relationship with her father and secretly cherished a dream that somehow it might be possible for her to inherit the land. In her early teens his attitude to her changed: her brother became old enough to walk the farm with him and there was now no place for the girl he had once treated as the longed for son and heir.

With negative feelings so firmly and understandably experienced in relation first to her mother and then to her father, an ongoing aspect of the work has

been to help Sophie to understand her own destructive impulses. It has been difficult to approach the fantasies of her own destructiveness which were apparent in her feelings about the death of her son and were manifest in her inability to care for her own children at the time of her breakdown, which occurred when her daughter reached the age she had been when she experienced a sexually abusive encounter. In her professional life she is strongly identified with the rescuer working skilfully with and on behalf of vulnerable children.

About a year into the analysis Sophie briefly recounted abuse by the twenty-year-old gardener on the estate when she was eight years old. Sophie never entirely forgot the abuse she experienced, but nevertheless managed to put it out of mind until her daughter became the age that she was when the abuse occurred. It was then that she became ill and sought treatment for depression. The memory of the abuse only came more fully into mind in the consulting room when, in a session some three years into the analysis, somewhere outside, a door suddenly banged shut at a tense moment in the transference and reminded her of the clanging shut of the garden shed door when the abuse took place. The gardener had enticed her into the garden-shed telling her he had a surprise, a new pet for her. He had shut the door. She remembered the dense quality of the darkness. She described how he had begun to touch her and had tried to force her to touch him, pretending that what she touched was the new pet. She managed to wriggle away and to escape. Afterwards she ran away and hid; she did not feel able to tell anyone.

Prior to this Sophie's happy times as a child had been wandering around the estate, and helping with the animals; later, particularly after the rejection by her father, she turned more to drawing and painting. Her mother disapproved of all of these activities. Gradually she turned to more solitary ways to feed her inner world, ways that indicated the extreme need of the self for the kind of protective shield that dissociation affords. She had a special walk along a lane that was part of their land. Once she imagined that as she walked there alone she met an ET type character from outer space. He saw inside her and said 'We are the same you and I, we look one way on the outside but our real self inside is very different'. However, although Sophie had to conform outwardly, it seems that she never entirely lost awareness of her inner truth. Her adaptive self appears to have been just that, rather than an entirely false self that left no room for awareness of inner truth.

One might ask how her inner self survived as well as it did. An uncle and aunt seem to have been warm and caring, supportive of her, encouraging her art and inviting her to stay in their home almost every holiday from when she was very young. They had two boys but no daughter, so it was a home where she had a place as a girl. In her later teens a local family had her to live in during the holidays to help to care for their young children. She remembers both these families as warm, happy, supportive, nurturing environments in which she thrived.

As the analysis continued, so gradually her paintings began to show a softening of the protective shell to allow the gradual emergence of the true self. Four years into the analysis Sophie painted the two pictures in this series that I had come to understand as revealing the gradual emergence of the true self. They show a woman, rather than an androgynous figure: she is gradually emerging from a bubble of rather amoebic like protection rather than the multi-layered sarcophagus of the earliest picture. Sophie spent another four years consolidating the experience portrayed in the pictures. She continues to work with vulnerable children but her approach to the task is less heroic.

### Treating the dissociative mind

A trauma patient's early experience causes the self to retreat, hidden from the world by protective defences. The analyst who seeks to engage in work with those who dissociate may feel that they are working at the frontier, in no-man's land, at the edges of analytic understanding and practice. Lanyado stresses that until the analyst has experienced the patient's trauma in the countertransference and been genuinely shocked by it, the patient cannot begin to work on the problem of their own traumatizing behaviour (Lanyado 1999). Hopkins notes that to help a patient to 'recover from trauma is liable to involve the therapist not only in sharing the pain but in suffering grave doubts about whether facing pain so starkly is necessary, and whether the self-protection of turning a blind eye may be preferable (Hopkins 1996, p. 63). Solomon cautions 'the analyst will inevitably be open to suffusion by the patient's terror of the appalling potential for retraumatization, given the inevitable failures that occur within the context of human relatedness' (Solomon 1998, p. 237). Ehrlich comments that 'the frontier is also the "no-man's land" where enemies are created and come into being' (Ehrlich 2003, p. 237). He cites Bion's comment that 'in every consulting-room there should be two rather frightened people: the patient and the psychoanalyst' (1990, p. 5). He suggests that 'to enable others to relate to us really and fully, that is including aggressiveness and destructiveness, what we must be capable of is not placation or masochistic surrender, or retaliatory aggression, but rather life-affirming survival' (Ehrlich 2003, p. 245). Solomon explains:

Because the substantive reality of the existence of the patient's self was eschewed by their important others, the self was experienced as extremely poisonous to the self, or as a bizarre object that was liable to appropriate a part of the self and render it alien or mad.

(Solomon 2004, p. 644)

She suggests that both empathic understanding and focused thinking are vital components in processing what might otherwise be experienced as unbearably toxic and repelling (*ibid.*, p. 650).

Gerhard makes links from her knowledge of early development into her experience with her damaged adult patients, noting in particular that many of her clients are very protective of their mothers. She notes that

They idealize them because they long for their love and approval and have never felt secure in it. They are reluctant to criticize. The progress of the therapy often depends on their ability to face their parents' human weaknesses and failings and let go of the hope that one day they will receive the loving care that they missed out on early in life.

(2004, p. 205)

She stresses the importance in therapy of having strong feelings tolerated by another person, and emphasizes that most important of all is that when 'the therapist and client fail to understand each other, or disagree about something important and there is a "rupture" in the relationship, the therapist demonstrates that relationships can be "repaired"' (2004, p. 205). She describes the cycle of rupture and repair as the key to secure relationships, thus putting reparation at the heart of relating. She suggests that through these types of experience emotional states can be shared, both verbally and non-verbally. Reparation thus leads inevitably to tolerance, to reconciliation, to warmth and to love.

Ehrlich (2003) suggests that yesterday's danger zone may become today's sphere of creative innovation, and indeed it maybe so with the consulting room and the analytic dyad, but not without the capacity for repair and for reconciliation. It is often just that experience of rupture, repair and reconciliation that builds new confidence in relationship and that enables our dissociative patients gradually to drop the defence that, although originally life-saving, has become life-denying.

## Conclusion

It is the plasticity of the brain throughout life that enables change. The mirroring of healthy early relational experience by the therapeutic dyad permits new entities to be added to pre-existing connections in both brain-minds. The past is revisited at the level of the implicit, changing deeply founded ways of being and behaving by means of transformative interpretation. Such process involves the integration of hemispheric function within the context of actual relational experience, leading to change in the nature of attachment. Interpretations without relational grounding are merely cognitive, engaging primarily the left hemisphere. However, well timed interpretations, especially those that involve putting feelings into words, encourage healthy and integrated functioning of both hemispheres of the brain and are an intrinsic part of the process of the coming into mind. Analytic work must encompass relational as well as interpretive agents of change to bring about the integration of the activity of both

hemispheres of the mind-brain that will then permit the self to emerge more fully through the process of individuation.

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#### TRANSLATIONS OF ABSTRACT

Dans les dix dernières années les analystes comme les scientifiques des neurosciences ont commencé à demander au monde analytique d'interroger sa conception de l'esprit à partir des connaissances qui ont émergées du champ des neurosciences. Je trouve que 'de bien des façons c'est la conception de Jung de l'esprit, de la condition humaine, et du soi qui est la plus compatible avec les points de vues qui émergent des neurosciences de nos jours' (2004, p. 84). Dans cet article je considère les points de vues que les neurosciences nous offrent qui nous sont utiles pour le travail que nous cherchons à faire avec les patients ayant des vécus primaires difficiles. Ces vécus primaires ont diminué la capacité de ces patients d'être en relation avec l'esprit et ce faisant leur capacité à être relié à la fonction reflexive de soi, du fait de leurs défenses par la dissociation, et du besoin qu'ils ont eu de garder les vécus insoutenables à distance, loin de leur esprit. Dans cet article je regarde d'abord la théorie de la dissociabilité et son développement, puis je me concentre sur les points de vues que nous pouvons prendre des neurosciences quant aux traumatismes précoces et leurs effets sur l'inscription dans la mémoire et sur le souvenir. Pour finir je me tourne vers la question de la nature de la cure et j'avance que l'intégration hémisphérique est la clé pour défaire la dissociation et le prélude à l'individuation.

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In den letzten zehn Jahren haben sowohl Analytiker als auch Neurowissenschaftler begonnen, die Analytische Welt herauszufordern, den analytischen Blick auf Geist und Seele in Beziehung zu dem Wissen zu erforschen, das sich aus dem Feld der Neurowissenschaft entwickelt hat. Ich habe festgestellt, dass "in vieler Hinsicht Jungs Verständnis von Geist und Seele, der menschlichen Beschaffenheit und des Selbst sehr gut vereinbar ist, mit den Erkenntnissen, die sich gegenwärtig aus der Neurowissenschaft entwickeln" (2004, S. 84). In der vorliegenden Arbeit denke ich darüber nach, was die Neurowissenschaft uns anbieten kann, wenn wir versuchen mit den Patienten und Patientinnen zu arbeiten, deren frühe Erfahrung ihre Fähigkeit, "im Bewusstsein" zu sein, vermindert hat, und damit einhergehend auch ihre Fähigkeit zur reflexiven Selbstfunktion, deren Abwehr dissoziativ ist, und die es nötig haben, unerträgliche Erfahrungen auf Abstand zu halten, außerhalb des Bewusstseins. Zunächst betrachte ich die dissociationist theory ("Theorie der Dissoziationisten") und ihre Entwicklung, dann fokussiere ich auf die Erkenntnisse, die aus der Neurowissenschaft gewonnen werden können, im Hinblick auf Frühe Traumata und ihre Auswirkungen auf die Enkodierung und die Fähigkeit, sich etwas ins Gedächtnis zurückzurufen. Schließlich widme ich mich der Art und Weise der Heilung und vertrete die Auffassung, dass hemisphärische Integration (Vernetzung) der Schlüssel ist, Dissoziationen aufzuheben und die Einleitung zur Individuation darstellt.

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Negli ultimi dieci anni sia gli analisti che i neuroscienziati hanno iniziato a sfidare il mondo analitico per esplorare il punto di vista analitico della mente in relazione alla



conoscenza che emergeva dal mondo delle neuroscienze. Io trovo che in molti modi è la comprensione junghiana della mente, della condizione umana e del sé ad essere la più compatibile con le intuizioni che emergono oggi dalle neuroscienze (2004, p. 84). In questo lavoro prendo in considerazione le intuizioni che ci possono offrire le neuroscienze quando noi cerchiamo di lavorare con quei pazienti le cui esperienze precoci hanno diminuito la capacità di essere 'nella mente' e con essa la capacità di una funzione autoriflessiva, le cui difese sono dissociative, il cui bisogno è stato quello di mantenere le esperienze insopportabili ai margini, fuori dalla mente. Mi sono dapprima accostato alla teoria dissociativa e alla sua evoluzione, poi ho concentrato il mio interesse sulle intuizioni che si possono guadagnare dalle neuroscienze, in particolare per quanto riguarda il trauma precoce e i suoi effetti sul codificare e sul richiamare alla memoria. Infine mi sono occupato della natura della cura e ne ho dedotto che l'integrazione degli emisferi è la chiave per sciogliere la dissociazione e il preludio all'individuazione.

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En los últimos diez años tanto los analistas como los neurocientíficos han comenzado a retar el mundo analítico para explorar la visión analítica de la mente en relación a la sabiduría surgiendo del campo de la neurociencia. Encuentro que en muchas formas es el entendimiento de Jung sobre la mente, la condición humana, y el self, que es más compatible con los descubrimientos que estan surgiendo de la neurociencia hoy en día' (2004, p. 84). En este ensayo considero que los descubrimientos que la neurociencia nos ofrece mientras buscamos trabajar con esos pacientes quienes sus tempranas experiencias han disminuido su capacidad de estar 'en mente' y con eso su capacidad de auto-función reflexiva, los cuales sus defensas son disociativas, los cuales su necesidad ha sido mantener experiencias insoportables AT BAY, fuera de mente. Primero veo la teoría disociativa y su desarrollo, luego me enfoco en los descubrimientos que pueden ser absorbidos por la neurociencia con respecto a tempranos traumas y su efecto en la codificación y reconocimiento de la memoria. Finalmente, me vuelco hacia la naturaleza de la cura y discuto que la integración hemisférica es la llave para deshacer la disociación y el preludio a la individualización.

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