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# Reply to Reviews of *Awakening the Dreamer: Clinical Journeys* by Philip M. Bromberg

Philip M. Bromberg, Ph.D.

I reply here to reviews by three inspiring thinkers, Ethel Person, Susan Sands, and Allan Schore who, though uniquely different from one another in their conceptual frames of reference, share a sensibility as clinicians and creative scholars that has led them to engage and appreciate my work in depth while enriching it with their individual perspectives. Ethel Person's review is meaningful to me for many reasons, not the least of which is the fact that we think very much alike about "how we are" with patients despite the diversity in our families of origin. Her thinking, which extends the boundaries established by any one school of thought, transcends doctrine, especially that of "technique." I am equally grateful to Susan Sands, whose review stimulated a dialogue between us about the similarities and differences in our views of the analyst's personal role in enactments with severe trauma survivors and whether there is reason to distinguish between life-threatening and developmental trauma. My reply to Allan Schore's review satisfies a long-standing wish to engage with him in dialogue about what he refers to in his review as "a remarkable overlap between Bromberg's work in clinical psychoanalysis and my work in developmental neuropsychoanalysis, a deep resonance between his treatment model and my regulation theory" (this issue, p. 755). In my reply I comment from my own vantage point on how our shared commitment to an interpersonal and intersubjective perspective—my interpersonal/relational treatment model and his "Interpersonal Neurobiology" led us to arrive at overlapping views on developmental trauma, attachment, the dyadic regulation of states of consciousness, and dissociation.

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I never learned to spell,
At least not well.

I never learned to count,
A great amount.

But my busy mind is burning to use what learning I've got,
I won't waste any time,
I'll strike while the iron is hot.

From "I Could Write a Book," from the show *Pal Joey* (1940)
Lyric by Lorenz Hart

"If they asked me, I could write a book" is a line that could be a more or less fitting epigraph, but I selected instead some relatively unfamiliar lines from the same lyric. The lines I chose might possibly strike a reader as a disingenuous way to begin a reply to three such positive reviews of the book I *did* write, but my choice is neither disingenuous nor an attempt to minimize the reviewers' praise. It is in fact the opposite, because it allows me to publicly acknowledge an aspect of my writer-self that makes my gratitude for their appreciation of my work even more deeply felt. Lorenz Hart's rather breezy attitude toward the "formalities" is not a bad analog for a long-standing attitude of my own. Perhaps it is not quite as basic as a disregard for spelling and counting, but for psychoanalysts who write about theory, the time-honored obligation to historicize one's theoretical contribution has never been my cup of tea and I have never *fully* done it.

I have never enjoyed thinking about theory in the abstract, and for the most part I have conceptualized my perspective by framing it in the context of illustrative examples. I have included a detailed history of its antecedents mainly when I felt it would enrich the understanding of *clinical* issues. Not surprisingly, my references have been dominated by authors who have advanced *clinical theory* by advancing clinical praxis and who seemed to have had as little interest as I in placing their contributions within the broader context of abstract theory. In my treatment of theory qua theory as a "formality" I realize I am being somewhat defensive because I am simply not good at it. In fact, I admire authors who write "the other way," and I envy even more those who are able to write *both* ways at the same time without compromising either clinical evocativeness or theoretical contextualization, but I am not such a writer. So I find it especially gratifying that three inspiring thinkers, uniquely different from one another in their frames of

reference but blending deep clinical sensibility with creative scholarship, have engaged my work in depth.

A final note before I reply to each reviewer in turn: My use of the line from Lorenz Hart's lyric, "I'll strike while the iron is hot," does not actually refer to the fact that I am fortunate enough to be writing as part of a receptive psychoanalytic zeitgeist. The line emblemizes my belief that the deepest analytic growth takes place by working in the *heat* of the present moment—engaging interpersonally and intersubjectively as the context that most transformatively engages what is within the mind/brain of the patient.

Some psychoanalysts have recently suggested that it may be better to "strike when the iron is cold," which addresses a valid argument related to the difficulty in cognitively processing hyperaroused traumatic affect. Although I agree with this in principle, I also believe that what is of paramount importance is that the analyst does not assume it is his job, unilaterally, to decide what temperature is therapeutically optimal. As I wrote in *Awakening the Dreamer*,

> The wisdom of the recent psychoanalytic admonition to "strike while the iron is cold" is no more valid, prescriptively, than "strike while the iron is hot"; more often than not, it is only by *failing* to know when the temperature is right that the analyst learns when the iron is too hot. And it is only through this dialectic that the patient comes to know that the analyst is learning from *her* and, most important, cares about what he is learning. Simply put, by recognizing the nonlinearity of what we call mutative change, we also accept that it takes place not through thinking, "If I do this correctly, then that will happen," but, rather, through an ineffable coming together of two minds in an unpredictable way [p. 147].

I'm going to reply to only a few points in each review and ask the authors to please accept that my appetite for more extended engagement is suppressed, not absent.

## Ethel Person

Ethel Person's review of my new book is especially meaningful to me for many reasons, not the least of which is the fact that we think so much alike about what we do despite the disparity in our families of origin. Her work,

which has contributed to the evolution of psychoanalytic theory and practice in unparalleled ways, reflects a clinical sensibility that has always transcended doctrine, especially the doctrine of "technique." The fact that she is a *Freudian* psychoanalyst has never defined her either as a clinician or a writer. Perhaps her being part of Columbia's Psychoanalytic Institute has facilitated this, but I suspect that whatever her affiliation had been she would have inevitably framed her contribution beyond the boundaries established by any one school of thought.

This latter quality is evident throughout her review of *Awakening the Dreamer* despite the fact that every so often I found myself hungry for a bit more challenge, one instance of which I touch on shortly. The central importance of relational affective engagement with our patients, which is the most salient feature of her commentary, is best captured in the ease with which she points out that my perspective is not an *abandonment* of Freud's contribution, but resonant with it. She writes,

> He is not so far from Freud when he says that "my approach to working with dreams is a reflection of my overarching self-state perspective on the human mind and represents my belief that, no matter what one's theoretical perspectives or loyalty, a clinical stance derived from this perspective optimally facilitates enduring personal growth within a psychoanalytic relationship" [this issue, p. 736].

Her commitment to human relatedness (*both internal and external*) as the foundation of the analyst's technical stance is made clear in her comments about my clinical and conceptual distinction between repression and dissociation.

Bromberg makes clear the distinction between dissociation and repression. What he is proposing is that for psychoanalysis to remain relevant to understanding the mind, certain concepts need to be retheorized in relationship to how we now understand self-states and dissociation. *He focuses not only on interpersonal perspectives but also on the inwardness of the self.* In particular, what he brings to the table in stunning fashion is not only the impact of trauma on the patient but also how the exploration of the transference and countertransference and the relevance of the patients' dreams are essential to the process. *He brings an exploration of the patient/psychoanalyst dyad to the fore, that is, the outcome of a therapy is not just about the patient.*

Person makes her agreement with this most explicit in her declaration that "Bromberg provides profound insight in his understanding of how to approach the subject of trauma with patients" (this issue, p. 738). She writes,

> For Bromberg, psychological trauma takes place in an interpersonal atmosphere in which the protagonist has no way of assessing validation from without. It is at this juncture that the individual invokes dissociation as a means of self defense. For Bromberg, "the meaning of the struggle between patient and analyst that we call enactment entails an externalization of the war within the patient's internal object world" (p. 33). He suggests that this behavior on the part of the patient leads to a dissociated response in the analyst; one that is linked to or reciprocal to that of the patient. As a consequence, the capacity for intersubjectivity is put on hold. Here Bromberg is making an important observation, emphasizing how the therapist can be drawn into what I would call a form of parallel process with the patient. Ideally, however, the analyst will become aware of his part in a stalemate, and will eventually address what is going on in terms of a "here-and-now experience." Bromberg emphasizes that when the therapist "dissociates his awareness of the parts of the patient he is loathe to deal with," he is closing down the prospects of a viable analytic intervention [this issue, pp. 736–737].

How does my point of view on dreams and dreaming enter into Person's perspective? She puts it that "Bromberg's emphasis here is definitely on dreams," and she then accurately clarifies the reason:

> He proposes that 'dreaming,' a term that he expands to include more than its traditional meaning, is one of the most enlightening accesses to understanding the more general phenomenon of dissociation. He sees the dream as it occurs during sleep as "the most familiar special case of the more general phenomenon of dissociation, the normal self-hypnotic capacity of the human mind—its nocturnal function being an adaptational effort to cope with minimal levels of affectively disruptive not-me experience without interfering with the waking illusion of central consciousness" (pp. 29–30). Consequently he views the use of the dream in analysis "as a gradual development between the waking self-state of the patient as patient and the sleeping

> self-state of the patient-as-dreamer" (p. 30), hence the title of his book [this issue, p. 737].

But although Person is clearly comfortable with allowing dreaming to include "more than its traditional meaning," she *engages* my clinical use of the dream only with respect to the narrower definition of it as a nocturnal event. In other words, although she warmly acknowledges my expansion of the term *dream*, she unfortunately does not directly engage the fact that I see the "sleeping-dream," as a special, albeit centrally important case of the more general phenomenon of the self-state organized by what I call the "dreamer." I wish she had taken that next step, because I think she has much to offer in helping me develop it further, especially because my expansion is at least as close to Bion's view as to either Freud's or Sullivan's and could have led to an interesting dialogue between us.

Finally, I want to acknowledge my gratitude for Person's comments about the epilogue to my final chapter, which was not just a piece of writing in the usual sense. It was based on my processing of a piece of unfinished business between "Adolf the cat" and me—a piece of my "not-me" experience that I was unaware of when I published my original version of that chapter. It was not until I returned to the manuscript to rewrite it as a book chapter that I, astonishingly, could re-engage my memory of Adolf beyond the meaning that had held me captive for so many years. I had thought I already had processed it all when I wrote the original paper, but I was wrong. When I sat down to encounter it once more, the original manuscript became a helpful "other" that prodded me to symbolize something personal that still remained. This "other" insisted that I access my childhood fear of helplessness so as to finally understand why my hatred of Adolf was so cherished by me for so many years and was so frozen in time. By my doing so, forgiveness of Adolf became possible, and Ethel Person grasped the importance of this when she read the epilogue. She wrote,

> He knows what it is like to be a blue jay, but he also knows what it is like to forgive and not forever be entangled in fear or hate. That is the gracious gift he offers to us and a clue about understanding the ramifications of trauma [this issue, p. 740].

Here is Ethel Person at her magnificent best, fully in her element—the clinician's clinician, who has offered *me* the gracious gift of feeling totally recognized and understood.

## Susan Sands

Susan Sands and I share a deep commitment to exploring the central role of trauma and dissociation in shaping normal and pathological mental functioning and in facilitating the deepest and most enduring personality growth. We are each involved with articulating the process through which dissociation transforms the analytic relationship into a therapeutic medium through which a patient's "not-me" self experience is communicated through enactment, offering the potential for its relational symbolization as "me."

It was in fact our common interest in a *subcategory* of this focus, the psychodynamics and treatment of eating-disordered patients, that brought each of us to the other's attention originally and is a topic to which Sands returns in the section of her review titled "Dissociative/Addictive Uses of the Body."

In her review of *Awakening the Dreamer* Susan Sands writes, "quite frankly, I find little with which to disagree" (this issue, p. 742), but I am happy to say that this did not keep her from offering some wonderful food for thought. She has taken up three broad themes that particularly interested her and that she felt could be fruitfully elaborated or clarified further: (a) the analyst's personal role in enactments with severe trauma survivors, (b) dissociative/addictive uses of the body, and (c) the distinction between life-threatening and developmental trauma.

I am going to start by replying very briefly to Sands's second theme because there is not much I can contribute to it beyond what Sands has written. She states, accurately, that I do not sufficiently discuss "the specific ways in which these patients make use of the *body and bodily processes* to further dissociation"—a focus of attention that, in her view, "accounts for much of the difficulty in their treatment" (this issue, p. 746). As she cogently puts it,

> the patient must first come to understand her 'transference' (positive) to the substance or addictive activity and her 'transference' (negative) to her body; then, only secondarily, can the transference be gradually 'shifted' onto the therapist where it can become intersubjectively elaborated [this issue, p. 749].

I, too, work with this very much in mind, but in my writing I recognize that I do not pay sufficient attention to its importance and I am grateful to her for highlighting this vital element.

In the rest of my reply I address her first and third themes by synthesizing what I see as their unifying essentials, and I hope that my synthesis will not fail to convey my appreciation of Sands's fuller development of each theme in its own right.

## The Analyst's Personal Role in Enactment, and the Distinction Between Life-Threatening and Developmental Trauma

According to Sands, I do not adequately depict what she calls "the *actual traumatization* of the analyst" and "the intensely personal nature of it" (this issue, p. 743). In situations where the analyst "temporarily loses her ability to function," Sands argues that "*the analyst is actually traumatized*" (this issue, p. 743). Here I disagree, and it is here that my self-state perspective comes into highest relief. It is my position that during enactments, including enactments where self-destabilization is especially intense, neither the patient nor the analyst is *actually* traumatized. The exceptions to this are *very rare,* and the only instances of it that I know about occur when unaddressed aspects of a therapist's own traumatic history are reactivated so unexpectedly and concretely that he is *permanently* unable to access his own dissociative processes during an enactment regardless of his patient's continuing efforts to call them to his attention.

This is not to deny that an analyst's experience of self-destabilization can *feel* traumatic even in the absence of actual trauma, but in almost all instances of what Sands accurately describes as an analyst's "significant disruption of her sense of self" (this issue, p. 743), the "traumatic" experience during an enactment is part of a communication process that does not in fact threaten "self-annihilation." This communication process, which Bucci (1997, 2007a, b) has shown to be a complex interaction between the symbolic and the subsymbolic, frees working memory while activation of unprocessed dissociated experience is taking place. As Kihlstrom (1987; quoted from LeDoux, 1989, p. 281) succinctly stated, for what is dissociated to become symbolized in conscious awareness, "a link must be made between the mental representation of the event and a mental representation of the *self* as the agent or experiencer." When the amygdala is providing working memory with the affective input of *fear,* it does so implicitly, which is to say unconsciously, and the more intense the unsymbolized affect, the more destabilizing is the enactment both for analyst and patient before episodic or "working" memory can represent, perceptually, what is taking

place in the here-and-now. But the dissociative process that keeps the affect unconscious is above all else a process that has a life of its own—a relational life that is interpersonal as well as intrapsychic—and is played out between patient and analyst in a communication system that experientially *simulates* actual trauma.

I fully agree with Sands point that "the analyst, during such periods, not only comes close to the abyss of traumatic self-annihilation; she must in some way enter it" (this issue, p. 743) (and I have in fact championed this view), but I agree only in the following way: *Actual* trauma is defined by its unexpectedness, and in *Awakening the Dreamer* I wrote that

> The reason an actual fall into the abyss seldom takes place is that a dissociative mental structure is designed to prevent trauma from occurring by always anticipating it. The felt danger to sanity is if the trauma fails to be anticipated and hits unexpectedly—by "surprise." So the scenario of escape from potential trauma is played out over and over with the therapist, as if the patient were back in the original trauma, which one part of the self, indeed, is. But *this time there are other parts of the self "on call," watching to make sure they know what is going on so that no surprises occur* and ready to deal with the betrayal they know will happen. Through this enacted scenario of escape from potential trauma, the patient relives miniversions of the original trauma with a hidden vigilance that protects her from having it hit without warning. Its effectiveness as an early warning system is dependent on the preservation of her dissociative mental structure, which is designed to preempt any potential for lasting trust, hope, or spontaneity. Thus, these patients seldom, if ever, actually fall into an abyss (*nor does their therapist*), but for a seriously traumatized patient the experience is frequently one of being dangerously "on the edge.
>
> For the patient, the abyss is really real. The analyst, to the extent that his theory gives him a place to anchor his sense of professional competency (and, of course, we all need such a place to stand), will not allow the abyss to seem really real until he absolutely has to. Thus, until the analyst is forced to deal with the patient's experience as something that gradually permeates its way into his soul in spite of his theories and his logic, the iatrogenic threat of potential retraumatization escalates. It is not for the analyst to say to the patient that the abyss is false. Because the abyss is subjectively an abyss to an aspect of the patient's self that feels it as "really real," if we are personally to live

> with and know that part of who our patient is, *the abyss must become a really real experience for the analyst too* [pp. 92–93].

This being said, I am nonetheless grateful to Susan Sands for underlining an issue that merits further development in my own work—an issue she articulates persuasively by so openly describing how it took place while working with her patient, Linda—"that analytic patients 'know' the analyst deeply and will actively, albeit unconsciously, through a process of trial and error, search for some unresolved aspect of the analyst's subjectivity to 'hook onto'" (this issue, p. 744). This, as she says

> can function as a kind of internal contact point, which opens up a process of unconscious empathy with the patient. Then, during the rapid sequence of reciprocal interactions that take place during enactment, the unconscious affective communications become amplified within the intersubjective field [this issue, p. 744].

I have increasingly come to share this view, and I believe that to one degree or another every analyst is *always* a "wounded healer" (R. Bosnak, personal communication, June 2007), and if this "wounded" self-state of the analyst is not defensively blocked, then for the patient, the wound and the healing are unified as an intersubjective experience because shame is less present and the processing of unsymbolized traumatic affect is facilitated. *However, I do not see this as leading to the need to distinguish between severe trauma and developmental trauma.* In fact, I believe that supporting the necessity for diagnostic categories such as PTSD may contribute more to the problem than to its solution. Why do I feel this way? Because it perpetuates the belief in treating the "disorder." I fully recognize that I am entering a domain of argument that goes far beyond a reply to a review of my book, but I feel it merits at least a few words. The therapeutic processing of past trauma by means of cognitive techniques does not address the dissociative mental structure—a basic aspect of personality that stays in place as an "early warning system." I believe that this structure is what shapes personality disorders of *all* types and cannot justifiably be squeezed into a diagnostic entity such as PTSD. Character structure and its pathology demands attention and cannot receive what it deserves within a treatment system that perpetuates the validity of diagnostic categories that ignore the person in favor of the symptoms.

The concept around which our viewpoints most diverge is Sands's belief that for the dissociative patient to know that we have somehow "'lived' what

she went through, not just cognitively but, most crucially, viscerally—to know that *we* know her experience ourselves" (this issue, p. 745)—the analyst must be *actually* traumatized. My argument is that the analyst's "living" what the patient went through does not define his experience as *actually* traumatic, and here is where our divergence in viewpoints becomes linked to Sands's distinction between the outcome of Life-threatening Trauma (what she and others call PTSD) and the outcome of Developmental (or Relational) Trauma. Sands argues that "many neuropsychoanalysts think that it is no longer justifiable to group these two different forms of trauma together" (this issue, p. 749). I disagree with her, and I believe that my position is supported by clinical psychoanalytis and neuropsychoanalysts other than those cited by Sands. I *do* agree with her, however, that when the *major* affect is terror, it makes the enactment *feel* more like real trauma.

Sands's belief that *grossly assaultive* impingement on selfhood is a different category of trauma than *relational* impingement is at the heart of why she suggests that I have not gone far enough in portraying the full intensity of the analyst's personal experience during enactments, at least with patients she places in the category of having suffered grossly assaultive impingement. To respond to her argument fairly and within the limited space available, I have synthesized Sands's first and third themes (the analyst's personal role in enactments with severe trauma survivors, and the distinction between life-threatening and developmental trauma) into a single reply and direct my comments to this synthesis.

Sands writes, "Unlike Bromberg, I think that we need more differentiated language to distinguish a relatively more physiologically devastating brain event from a relatively less devastating, more psychological one" (this issue, p. 750). I understand why she holds this view (and there are days when I even support it), but when I have recovered my stability I return to my belief that Sands's categorization of trauma along the dimension of intensity is problematic. I hold that trauma is best understood as the precipitous disruption of self-continuity through invalidation of the internalized self–other patterns of meaning that constitute the experience of "me-ness," and I have found that the clinical evidence for this is highly persuasive.

According to Freud (1926), the essence and meaning of the traumatic situation is not the *source* of the danger that is primary but whether the affect is subjectively experienced as overwhelming. Whether something is traumatic "*consists in the subject's estimation of his own strength compared to the magnitude of the danger and in his admission of helplessness in the face of it*" (p. 166). Schecter (1973) defined trauma in infancy as occurring when an infant's sense of continuity of being is traumatically disrupted because the mothering

person fails to help render the strange into what is engagingly novel or even familiar. Schecter's is a particularly important formulation insofar as *it accurately defines trauma not according to its specific content, form, or objective magnitude but by the degree to which it cannot be held or contained by a person without a flooding of unintegratable affect*. He observed that, to cope with oncoming psychological disorganization, the infant "freezes" (one of the hallmarks of a dissociative response to trauma), leading to what he called dys-recognition of me-ness and disruption of the subjective continuity of "I."

In other words, dissociation as a proactive defense indeed operates especially intensely when massive trauma has occurred, but it operates equally and sometimes even *more* intensely when early *developmental* trauma has created areas of dissociative mental structure *with or without intense terror.* Whether trauma is massive or developmental, its nature is relational, and the relational healing process in psychoanalysis depends on what the analyst and patient do together by creating what I have called "safe surprises" in the space between what is perceived as *potentially* traumatic and what is perceived as *safe but on the "edge*." I agree with Sands's point that when the major affect of the trauma has been terror, there is "a cascading of neurophysiological effects" (this issue, p. 749), but I differ with her that this makes a *qualitative* difference. In my experience it makes the work more strenuous but does not demand a "distinction between massive and developmental trauma" (this issue, p. 750).

From my perspective the essence of the work is to help rebuild faith in self–other experience *regardless* of how it came to be lost or compromised and that even during the most intense enactments, *actual* trauma is virtually never lived or relived by either analyst or patient. This being said, I know that Susan Sands and I each respond to our patients in ways that lead to authentic affective engagement; how we each get there is what makes us want to write about it.

## Allan Schore

My long-standing admiration of Allan Schore's contribution to what he felicitously calls "the interpersonal neurobiology of attachment" (this issue, p. 754) would require a full-length paper to convey and a second paper to adequately express my appreciation of his extraordinarily close reading of my book and his perceptive and generous review of it. But even beyond this I have discovered another bond between us, our commonality as *clinicians*, that makes his review even more personal to me. It is a bond that I had al-

ways suspected might exist and that was discernable, implicitly, throughout his review, but explicitly near its conclusion, where he states, "I must admit a personal bias, since his style of working with such patients is very similar to my own" (this issue, pp. 762–763). Allan, I couldn't be more delighted. But now to the review itself. Schore writes,

> Within the structure as well as the content of the book Bromberg continuously weaves together concepts and data from developmental psychoanalysis (discoveries in the interpersonal neurobiology of attachment), neuropsychoanalysis (current models of the impact of relational trauma on the structural organization of the implicit self), and clinical psychoanalysis (the essential roles of affect dysregulation and dissociation in psychopathogenesis and treatment). Indeed, this developmental perspective appears in every chapter, in which he links various clinical phenomena to the seminal events at the beginning of human life, the critical period of development of the human unconscious, the implicit self (Schore, 2005) [this issue, p. 754].

Let me begin my reply with Schore's acknowledgment of what he sees as "a remarkable overlap between Bromberg's work in clinical psychoanalysis and my work in developmental neuropsychoanalysis, a deep resonance between his treatment model and my regulation theory" (this issue, p. 755). I too have felt this resonance and I am deeply gratified as well as honored by his acknowledgement of it. One thing that especially gratifies me is the neurobiolgical support he provides for what is most foundational to my writings on dissociation—my self-state perspective and my argument that dissociation is fundamentally a *normal* brain process.

Although, as Schore states, the focus of his "neuropsychoanalytic perspective, as in Bromberg's book, is on early trauma and *pathological* [italics added] dissociation and their enduring impact on the right brain system" (this issue, p. 755), he echoes my own description of the interconnection between the self-state organization of the mind and the evolutionary function of *normal* dissociation. Schore, too, as is evident in the following quotation, sees normal dissociation as a mind–brain mechanism that is intrinsic to everyday mental functioning through selecting the self-state configuration that is most immediately adaptive in the context of moment-to-moment changes in the environment. Schore writes,

> In a number of works I have offered interdisciplinary evidence that indicates that the implicit self, equated with Freud's system *Ucs*, is lo-

> cated in the right brain (Schore, 1994, 2003a, b, 2005)… . On the other hand, higher orbitofrontal-limbic levels of the right hemisphere generate a conscious emotional state that expresses the affective output of these motivational systems. This right lateralized hierarchical prefrontal system, the system *Pcs*, *performs an essential adaptive motivational function - the relatively fluid switching of internal bodily-based states (Bromberg's self-states) in response to changes in the external environment that are nonconsciously appraised to be personally meaningful* [italics added] [this issue, p. 761].

## Self-Continuity, Self-Coherence, and Psychic Energy

Schore writes, drawing on Janet's (1889) speculation, "that dissociation was the result of a deficiency of psychological energy ('la misere psychologique')," that "individuals with characterological dissociation are deficient in binding together all their mental functions into an organized unity under the control of the self" (this issue, p. 756). He thus departs from Janet by seeing this deficiency of psychological energy as a deficiency in organized unity (self-coherence) that "is manifest in a maladaptive highly defensive rigid, closed system" that I term a dissociative mental structure. Schore sees this structure (as do I) as "an enduring outcome of early relational trauma" (this issue, p. 761). He then goes on to describe, neurobiologically, how, "this fragile unconscious system is susceptible to mind-body metabolic collapse, Janetian energy failure, and thereby a loss of energy-dependent synaptic connectivity within the right brain" (this issue, p. 761). "Stressful affects," states Schore, "especially those associated with emotional pain are thus not experienced in consciousness (Bromberg's 'not-me' self-states)" (this issue, p. 761).

Schore's use of the phrase "Janetian energy failure" is especially interesting because it suggests that he and I hold a profound skepticism about Janet's speculation that "dissociation was the *result* [italics added] of a deficiency of psychological energy" while still valuing his basic position about dissociation as fundamental to mental functioning (this issue, p. 756). I believe that although Janet's *correlation* between dissociation and diminished psychic energy is clearly accurate, Janet misunderstood the direction of causality. Goldberg (1995), for example, argued that in a personality organization where dissociation is present to a significant degree, there is a disturbance in psychosomatic unity that leads to psychic deadness. This dead-

ness is in turn countered by a lifelong search for enlivenment through various forms of stimulation—a solution that results in what he calls "pseudovitality." From this perspective, Janet's speculation about "a deficiency in psychological energy" has misunderstood dissociation to be the *effect* when it is more probably the cause. One of the consequences of Janet's error was that his theory has been undervalued by generations of psychoanalysts, *in part* because it was held to explain dissociation as the result of "hereditary weakness" or "hereditary degeneration." It is now clear that, in Shore's words, the "dissociative metabolic shutdown state is … [an] *energy-conserving parasympathetic (vagal) mechanism* [italics added] that mediates the 'profound detachment' of dissociation" (this issue, p. 757).

I would add to this, following Goldberg (1995), that the "energy conservation" Schore describes has the effect of making the restoration of vitality the goal of life rather than vitality being the means of living life. As Shore puts it,

> It is now established that there are in fact *two* parasympathetic vagal systems in the brainstem medulla. The *ventral vagal* complex regulates … all aspects of a *secure* attachment bond of emotional communication. On the other hand, activity of the *dorsal vagal* complex is associated with intense emotional states and immobilization and is responsible for the severe hypoarousal and pain blunting of dissociation. The traumatized infant's sudden state switch from sympathetic hyperarousal into parasympathetic dissociation is described by Porges (1997) as 'the sudden and rapid transition from *an unsuccessful strategy of struggling requiring massive sympathetic activation* to the metabolically conservative immobilized state … associated with the dorsal vagal complex [all italics added; this issue, p. 758].

## Trauma and Attachment

For the purpose of his review, Schore summarizes modern attachment theory as follows:

> The essential task of the first year of human life is the creation of a secure attachment bond of emotional communication between the infant and the primary caregiver, and the subsequent expanded capacity for affect regulation. To enter into this communication, the mother

> must be psychobiologically attuned to the dynamic crescendos and decrescendos of the infant's bodily-based internal states of arousal.
>
> In contrast to this optimal attachment scenario, in a relational growth-inhibiting early environment the primary caregiver induces traumatic states of enduring negative affect in the child [this issue, p. 757].

I would add that the context in which this takes place creates a threat to self-continuity during self-state *transitions*, because when the child's state transitions to one that is beyond a parent's capacity to contain in her own subjectivity, the parent invalidates the existence of the new state as something that is connected to her perception of the child *before* the shift took place. It is as though the new state does not exist for her as belonging to *her* child, a trauma of nonrecognition that is often accompanied by whatever fear is being created by any manifest abuse that may be taking place simultaneously. About the significance of self-state transitions, Shore notes, validating the similarity of the aforementioned conception to his own studies in right brain interpersonal neurobiology, that "the core of the self lies in *patterns of affect regulation that integrate a sense of self across state transitions, thereby allowing for a continuity of inner experience* [italics added]" (Schore, 1994, p. 33; this issue, p. 764).

Schore beautifully articulates the view that instead of modulating, the parent "induces extreme levels of stimulation and arousal, very high in abuse and/or very low in neglect" (this issue, p. 757), and goes on to add that "*because she provides no interactive repair the infant's intense negative affective states last for long periods of time* [italics added]" (this issue, p. 757). This latter point emphasizes what was also the main finding by Tronick and Weinberg (1997) that it is not affective synchrony between infant and caretaker that is the salient factor leading to sturdy personality development. Rather, "*reparation of interactive errors is the critical process of normal interactions that is related to developmental outcome rather than synchrony or positive affect per se* [italics added]" (Tronick and Weinberg, 1997, p. 65).

## Attachment, Affect Dyregulation, and Dissociation

Because of its direct relevance to attachment theory as previously discussed, I want to comment here on Porges's (1997) point about the "sudden and rapid transition from *an unsuccessful strategy of struggling* [italics added]" (this issue, p. 758). As I view it, the brain is adapted to switch when

it is forced to hold two mentally incompatible relational experiences simultaneously, one of which is *attachment related*. The struggle to process them both within a single mental state is *inherently* overwhelming to the mind because no successful strategy of struggling *exists* when intrapsychic conflict is impossible both neurobiologically and experientially. The futility of the struggle itself creates "massive sympathetic activation" that is so affectively destabilizing that it threatens psychological self-continuity (this issue, p. 758). The destabilization then triggers what Porges describes, in *neurobiological* terms, as the rapid transition to a "metabolically conservative immobilized state … associated with the dorsal vagal complex" (this issue, p. 758). Of particular significance is the fact that, in Schore's view,

> a prolonged state of dorsal vagal parasympathetic activation accounts for the extensive duration of "void" states associated with pathological dissociative detachment and for what Bromberg calls dissociative "gaps" in subjective reality, "spaces" that surround self-states and thereby disrupt coherence among highly affectively charged states [this issue, p. 758].

In my own language, a dissociative *mental structure* takes shape as an evolutionary function of the mind-brain that is designed to anticipate and thereby prevent uncontrollable affect-dysregulation by proactively preventing the return of self-state coherence. Paradoxically, self-continuity is *preserved* by making each dissociated self-state an island of selfhood within which reality can never be challenged. Each state is hypnoidally isolated from those incompatible with what is experienced as "me" at that moment. Other self-states that threaten its "truth" are felt as "not-me." The potential restoration of self-state coherence is a threat to self-continuity because it is a threat to the dissociative structure.

The capacity for intersubjectivity is now compromised or shut down totally. Interpersonally, the person becomes unable to hold disjunctive ways of seeing himself vis-à-vis his objects within a single experiential state long enough to feel the subjective pull of opposing affects and dissonant self-perceptions as a state of mind that can be taken as an object of self-reflection and allow the experience of internal conflict. I have argued in my writing that for *every* patient there are areas of dissociative mental structure that must be addressed for internal conflict to become possible, but that for some patients more than others it is the central focus of treatment. Therapeutically, the incompatible elements must be negotiated both externally—between therapist and patient—and internally—between the pa-

tients dissociated self-states—but the restoration of intersubjectivity is possible only when each element can surrender some of its own "truth" and recognize the "other" as more than "not-me" (see also Stern et al., 1986).

Schore ends his review with a statement that *Awakening the Dreamer* is "the most important work on the topic since Henry Krystal's (1988) pioneering volume" (this issue, p. 765) and that it "represents a valuable contribution of psychoanalysis, the science of unconscious processes, to the ongoing interdisciplinary effort to formulate a clinically applicable model of trauma on mind and body" (this issue, p. 765). I can say only that I will be more than happy if my contribution ultimately represents even a small fraction of what he attributes to it. Thank you, Allan Schore, for your comradeship and for your wonderful elucidation of my work and synthesis of it with your own.

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