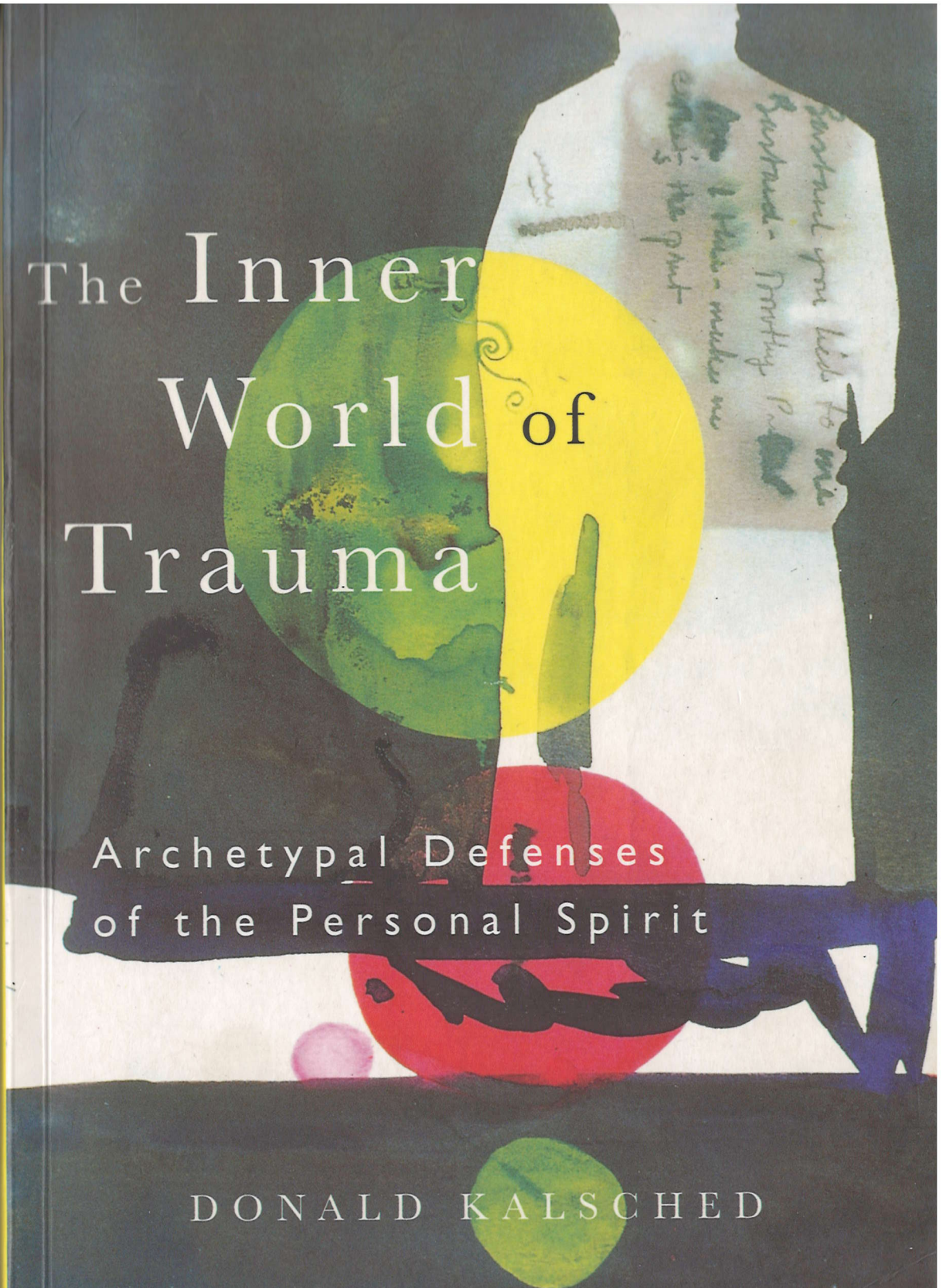
The Inner World of Trauma

Archetypal Defenses of the Personal Spirit



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INTRODUCTION

This is a book about the inner world of trauma as it has been revealed to me in the dreams, fantasies, and interpersonal struggles of patients involved in the psychoanalytic process. By focusing on the "inner world" of trauma I hope to illustrate how the psyche responds *inwardly* to overwhelming life events. What happens in the inner world, for example, when life in the outer world becomes unbearable? What do dreams tell us about the inner "object-images" of the psyche? And how do these "inner objects" compensate for the catastrophic experience with "outer objects"? What patterns of unconscious fantasy provide an inner meaning to the trauma victim when life-shattering events destroy outer meaning altogether? Finally, what do these inner images and fantasy structures tell us about the miraculous life-saving *defenses* that assure the survival of the human spirit when it is threatened by the annihilating blow of trauma? These are some of the questions I will attempt to answer in the following pages.

Throughout the discussion that follows, I will be using the word "trauma" to mean any experience that causes the child unbearable psychic pain or anxiety. For an experience to be "unbearable" means that it overwhelms the usual defensive measures which Freud (1920b: 27) described as a "protective shield against stimuli." Trauma of this magnitude varies from the acute, shattering experiences of child abuse so prominent in the literature today to the more "cumulative traumas" of unmet dependency-needs that mount up to devastating effect in some children's development (Khan, 1963), including the more acute deprivations of infancy described by Winnicott as "primitive agonies," the experience of which is "unthinkable" (1963: 90). The distinguishing feature of such trauma is what Heinz Kohut (1977: 104) called "disintegration anxiety," an unnameable dread associated with the threatened dissolution of a coherent self.

To experience such anxiety threatens the total annihilation of the human personality, the destruction of the personal spirit. This must be avoided at all costs and so, because such trauma often occurs in early infancy before a coherent ego (and its defenses) is formed, *a second line of defenses* comes into play to prevent the "unthinkable" from being *experienced*. These defenses and their elaboration in unconscious fantasy will be the focus of my investigation. In psychoanalytic language, they are variously known as the "primitive" or "dissociative"

defenses; for example, splitting, projective identification, idealization or diabolization, trance-states, switching among multiple centers of identity, depersonalization, psychic numbing, etc. Psychoanalysis has long understood that these primitive defenses both *characterize* severe psychopathology and also (once in place) *cause* it. But rarely in our contemporary literature do these defenses get any "credit," so to speak, for having accomplished anything in the preservation of life for the person whose heart is broken by trauma. And while everyone agrees how maladaptive these defenses are in the later life of the patient, few writers have acknowledged the miraculous nature of these defenses – their life-saving sophistication or their archetypal nature and meaning.

For insights into these matters we turn to C. G. Jung and to dreams – but not to Jung as he has classically been interpreted, and not to dream images as they are understood by many clinicians today. Instead, in Chapter 3 we go back to the early dialogue between Freud and Jung where both were struggling to understand the "mythopoetic"[1] fantasy images that were thrown up by the psyche as the sequelae of trauma. During this fruitful time, and before their tragic split and the subsequent reification of their theories, they each brought an experimental openness to the psyche's mysteries – an openness we must try to recover if we are to understand trauma and its meaning. In Chapter 3 we follow their dialogue to the point where it came apart, and we discover that it did so around the question of how to understand the "daimonic" and "uncanny" images of trauma-linked dream and fantasy.

If we study the impact of trauma on the psyche with one eye on traumatic outer events and one eye on dreams and other spontaneous fantasy-products that occur *in response* to outer trauma, we discover the remarkable mythopoetic imagery that makes up the "inner world of trauma" and that proved to be so exciting to both Freud and Jung. And yet neither Freud's nor Jung's *interpretations* of this imagery have proven entirely satisfactory to many clinicians today, including the present author. For this reason, a new interpretation of trauma-linked fantasy follows in the ensuing pages – one that combines elements from both Freud and Jung. This "new" interpretation relies a great deal on dreams that immediately follow some traumatic moment in the patient's life. Careful study of such dreams in the clinical situation leads to our main hypothesis that the archaic defenses associated with trauma are *personified as archetypal daimonic images*. In other words, trauma-linked dream imagery represents *the psyche's self-portrait of its own archaic defensive operations*.

In the clinical material to follow we will find examples of this imagery in the dreams of contemporary patients, all of whom have struggled with the devastating impact of trauma on their lives. We will see how, at certain critical times in the working through of trauma, dreams give us a spontaneous picture of the psyche's "second line of defenses" against the annihilation of the personal spirit. In providing these "self-portraits" of the psyche's own defensive operations, dreams aid in the healing process by symbolizing affects and fragments of personal experience that have been heretofore unrepresentable to consciousness. The idea

that dreams should be capable, in this way, of representing the psyche's dissociative activities and holding its fragmented pieces together in one dramatic story is a kind of miracle of psychological life which we may too easily take for granted. Usually, when dreams do this, no-one is listening. In depth psychotherapy, we try to listen.

What dreams reveal and what recent clinical research has shown are that when trauma strikes the developing psyche of a child, a fragmentation of consciousness occurs in which the different "pieces" (Jung called them splinter-psyches or complexes) organize themselves according to certain archaic and typical (archetypal) patterns, most commonly dyads or syzygies made up of personified "beings." Typically, one part of the ego *regresses* to the infantile period, and another part *progresses*, i.e., grows up too fast and becomes precociously adapted to the outer world, often as a "false self" (Winnicott, 1960a). The *progressed part* of the personality then caretakes the *regressed part*. This dyadic structure has been independently discovered by clinicians of many different theoretical persuasions – a fact that indirectly supports its archetypal basis. We explore the writings of these clinicians in more detail in Chapters 5 and 6.

In dreams, the regressed part of the personality is usually represented as a vulnerable, young, innocent (often feminine) *child- or animal-self* who remains shamefully hidden. Occasionally it appears as a special animal – a favorite pet, a kitten, puppy, or bird. Whatever its particular incarnation, this "innocent" remainder of the whole self seems to represent a core of the individual's imperishable personal spirit – what the ancient Egyptians called the "Ba-soul," or Alchemy, the winged animating spirit of the transformation process, i.e., Hermes/Mercurius. This spirit has always been a mystery – an essence of selfhood never to be fully comprehended. It is the imperishable essence of the personality – that which Winnicott referred to as the "True Self" (Winnicott, 1960a) and which Jung, seeking a construct that would honor its transpersonal origins, called the *Self*.[2] The violation of this inner core of the personality is *unthinkable*. When other defenses fail, archetypal defenses will go to any length to protect the Self – even to the point of killing the host personality in which this personal spirit is housed (suicide).

Meanwhile, the progressed part of the personality is represented in dreams by a powerful *benevolent or malevolent great being* who protects or persecutes its vulnerable partner, sometimes keeping it imprisoned within. Occasionally, in its protective guise, the benevolent/malevolent being appears as an angel or a miraculous wild animal such as a special horse or a dolphin. More often the "caretaking" figure is daimonic and terrifying to the dream-ego. In the clinical material of Chapters 1 and 2 we will explore cases in which it presents itself as a diabolical axeman, a murderer with a shotgun, a mad doctor, a menacing "cloud," a seductive "food demon," or as the Devil himself. Sometimes the malevolent inner tormenter turns another face and presents a more benevolent aspect, thereby identifying himself as a "duplex" figure, a protector and persecutor in one. Examples of this are found in Chapter 2.

Together, the "mythologized" images of the "progressed vs. regressed" parts of the self make up what I call *the psyche's archetypal self-care system*. The "system" is archetypal because it is both archaic and typical of the psyche's self-preservative operations, and because it is developmentally earlier and more primitive than normal ego-defenses. Because these defenses seem to be "co-ordinated" by a deeper center in the personality than the ego, they have been referred to as "defenses of the Self" (Stein, 1967). We will see that this is an apt theoretical designation because it underscores the "numinous,"[3] awesome character of this "mythopoetic" structure and because the malevolent figure in the self-care system presents a compelling image of what Jung called *the dark side of the ambivalent Self*. In exploring this imagery in dream, transference, and myth, we will see that Jung's original idea of the Self as the central regulatory and ordering principle of the unconscious psyche requires revision under conditions of severe trauma.

The self-care system performs the self-regulatory and inner/outer mediational functions that, under normal conditions, are performed by the person's functioning ego. Here is where a problem arises. Once the trauma defense is organized, all relations with the outer world are "screened" by the self-care system. What was intended to be a defense against further trauma becomes a major resistance to all unguarded spontaneous expressions of self in the world. The person survives but cannot live creatively. Psychotherapy becomes necessary.

However, psychotherapy with the victims of early trauma is not easy, either for the patient or the therapist. The resistance thrown up by the self-care system in the treatment of trauma victims is legendary. As early as 1920, Freud was shaken by the extent to which a "daimonic" force in some patients resisted change and made the usual work of analysis impossible (Freud 1920b: 35). So pessimistic was he about this "repetition compulsion" that he attributed its origin to an instinctive aim in all life towards death (Freud, 1920b: 38–41) Subsequently, clinicians working with the victims of trauma or abuse have readily recognized the "daimonic" figure or forces to which Freud alludes. Fairbairn (1981) described it as an "Internal Saboteur" and Guntrip (1969) as the "anti-libidinal ego" attacking the "libidinal ego." Melanie Klein (1934) described the child's fantasies of a cruel, attacking, "bad breast;" Jung (1951) described the "negative Animus," and more recently, Jeffrey Seinfeld (1990) has written about an internal structure called simply the "Bad Object."

Most contemporary analytic writers are inclined to see this attacking figure as an internalized version of the actual perpetrator of the trauma, who has "possessed" the inner world of the trauma victim. But this popularized view is only half correct. The diabolical inner figure is often far more sadistic and brutal than any outer perpetrator, indicating that we are dealing here with a *psychological* factor set loose in the inner world by trauma – an archetypal traumatogenic agency within the psyche itself.

No matter how frightening his or her brutality, the function of this ambivalent caretaker always seems to be the protection of the traumatized remainder of the

personal spirit and its *isolation from reality*. It functions, if we can imagine its inner rationale, as a kind of inner "Jewish Defense League" (whose slogan, after the Holocaust, reads "Never Again!"). "Never again," says our tyrannical caretaker, "will the traumatized personal spirit of this child suffer this badly! Never again will it be this helpless in the face of cruel reality. . . . before this happens I will disperse it into fragments [dissociation], or encapsulate it and soothe it with fantasy [schizoid withdrawal], or numb it with intoxicating substances [addiction], or persecute it to keep it from hoping for life in this world [depression]. . . . In this way I will preserve what is left of this prematurely amputated childhood – of an innocence that has suffered too much too soon!"

Despite the otherwise well-intentioned nature of our Protector/Persecutor, there is a tragedy lurking in these archetypal defenses. And here we come to the crux of the problem for the traumatized individual and simultaneously the crux of the problem for the psychotherapist trying to help. This incipient tragedy results from the fact that the Protector/Persecutor is not educable. The primitive defense does not learn anything about realistic danger as the child grows up. It functions on the magical level of consciousness with the same level of awareness it had when the original trauma or traumas occurred. Each new life opportunity is mistakenly seen as a dangerous threat of re-traumatization and is therefore attacked. In this way, the archaic defenses become anti-life forces which Freud understandably thought of as part of the death instinct.

These discoveries made by exploring the inner world help us to explain two of the most disturbing findings in the literature about trauma. The first of these findings is that *the traumatized psyche is self-traumatizing*. Trauma doesn't end with the cessation of outer violation, but continues unabated in the inner world of the trauma victim, whose dreams are often haunted by persecutory inner figures. The second finding is the seemingly perverse fact that *the victim of psychological trauma continually finds himself or herself in life situations where he or she is re-traumatized*. As much as he or she wants to change, as hard as he or she tries to improve life or relationships, something more powerful than the ego continually undermines progress and destroys hope. It is as though the persecutory inner world somehow finds its outer mirror in repeated self-defeating "re-enactments" – almost as if the individual were *possessed* by some diabolical power or pursued by a malignant fate.

In the first chapter of the book we will anchor these preliminary ideas in three clinical cases and several important dreams which illustrate the diabolical side of the Self in early trauma. In Chapter 2 further examples enrich the picture by showing the self-soothing aspects of the self-care system in addition to its diabolical aspects. In Chapter 3 we will trace Freud and Jung's initial explorations of trauma's inner world and show that Jung had independently "discovered" our dyadic defensive structure as early as 1910, although he did not label it as such. In Chapter 4 we provide a compilation of Jung's views as they relate to trauma, beginning with Jung's personal boyhood trauma and how it informed his later theory. Chapter 5 reviews and critiques additional Jungian contributors to a

clinical theory of trauma, and Chapter 6 surveys psychoanalytic theorists, focusing on those who describe a structure similar to our trauma defense.

By the end of Part I, the reader should have a good sense of how the dyadic defense functions in the inner world as seen from a variety of theoretical perspectives, and also an awareness of its recurrent, universal features. Given the mythopoetic features described in Part I, it will come as no surprise that these primordial defenses of the Self frequently appear in mythological material, and the demonstration of this fact is the purpose of Part II of the book. In these chapters, we will interpret several fairy tales and a short myth, the tale of Eros and Psyche (Chapter 8), in order to show how the personified imagery of the self-care system appears in mythological material. Readers unacquainted with Jung's approach may find such attention to folklore and mythology somewhat strange in a psychological work, but we must remember, as Jung has repeatedly pointed out, that *mythology is where the psyche "was" before psychology made it an object of scientific investigation*. By drawing attention to the parallels between the findings of clinical psychoanalysis and ancient religious ideation we demonstrate how the psychological struggle of contemporary patients (and those of us trying to help them) runs rather deeper into the symbolic phenomenology of the human soul than recent psychoanalytic discussions of trauma or the "dissociative disorders" are inclined to acknowledge. Not everyone is helped by an understanding of these parallels, but some people are, and for them, this "binocular" way of viewing, simultaneously, the psychological and religious phenomena is equivalent to finding a deeper meaning to their suffering, and this in itself can be healing. It is not an accident that our discipline is called "depth psychology," but for psychology to remain deep, it must keep one "eye," so to speak, on the life of man's spirit, and the vicissitudes of the spirit (including its dark manifestations) are nowhere so well documented as in the great symbol-systems of religion, mythology, and folklore. In this way, psychology and religion share, as it were, a common concern with the dynamics of human interiority.

In Chapter 7, we find our self-care system personified in the Grimms' fairy tale of the innocent Rapunzel under the protective but persecutory guardianship of the witch, and we explore some of the clinical implications of how to get this psychical "child" out of her tower. Chapter 8 describes a similar "captivity story," i.e., that of Eros and Psyche: and in Chapter 9, we explore an especially violent rendition of the Self's dark aspect in the fairy tale of Fitcher's Bird, one of the popular Bluebeard cycle of tales. Chapter Ten concludes the book with an analysis of a Scandinavian tale of Prince Lindworm, and emphasizes the role of sacrifice and choice in the resolution of the trauma defense. Throughout there latter chapters, implications for the treatment of trauma victims are interspersed in the mythic material.

By focusing the following investigation on the *inner* world of trauma, especially on unconscious fantasy as illustrated in dreams, transference, and mythology, we will be attempting to honor the *reality of the psyche* in ways that much current literature about trauma fails to do, or does only secondarily. By the reality of the

psyche, I mean an intermediate realm of experience which serves as a ligament connecting the inner self and the outer world by means of symbolic processes which communicate a sense of "meaning." In my experience, a sense of the reality of the psyche is extremely elusive and hard to maintain, even for the experienced psychotherapist, because it means staying open to the unknown – to a mystery at the center of our work – and this is very difficult, especially in the area of trauma, where moral outrage is so easily aroused and with it the need for simple answers.

In an effort to place the present study in context, we should note that psychoanalysis began in a study of trauma almost one 100 years ago, but it then suffered a kind of professional amnesia on the subject. In recent years there is some indication that the profession is returning to a "trauma paradigm" once again. This renaissance of interest in trauma has been motivated by the cultural "rediscovery" of childhood physical and sexual abuse, and psychiatry's revived interest in the dissociative disorders, especially Multiple Personality Disorder and Post-traumatic Stress Disorder. Unfortunately, with very few exceptions, this literature has escaped comment by Jungian writers.[4] This fact is all the more peculiar given Jung's relevant model of the psyche's dissociability and his emphasis on ego–Self "indivisibility" (individuation). I believe that Jung's insights into the *inner* world of the traumatized psyche are especially important for contemporary psychoanalysis while, at the same time, contemporary work on trauma requires a revision of Jungian theory. The present work is an effort, on the one hand, to illustrate the value of Jung's contributions, while attempting, on the other hand, to offer certain theoretical revisions made necessary in my judgment by the findings of trauma researchers and clinicians, especially those of contemporary object-relations and self-psychologists.

The reader should be forewarned that at least two different psychoanalytic "dialects" define the language of the present investigation and the argument moves freely back and forth between them. On the one side is British object-relations – especially Winnicott – together with some of Heinz Kohut's self-psychology and, on the other, is the mythopoetic language of C. G. Jung and his followers. I consider both of these idioms essential for an understanding of trauma and its treatment.

Some of the observations in these chapters have appeared elsewhere in print (Kalsched, 1980, 1981, 1985, 1991) and others have been the subject of extended lectures at the C. G. Jung Institute in Zurich and at the Center for Depth Psychology and Jungian Studies in Katonah, New York. But the full implications of my earlier ideas for a theory of trauma and its treatment were not clear until recently. Even so, the present volume should be considered as little more than provisional – a preliminary effort to cast some light into that dark background of unconscious imagery making up the "inner world of trauma."

1

THE INNER WORLD OF TRAUMA IN ITS DIABOLICAL FORM

> When innocence has been deprived of its entitlement, it becomes a diabolical spirit.
>
> (Grotstein, 1984: 211)

In this and the following chapter, I will offer a series of clinical vignetttes and theoretical commentary in order to explore the phenomenology of a "daimonic" figure whose appearance I have encountered repeatedly in the unconscious material of patients with a history of early childhood trauma. The word "daimonic" comes from *daiomai*, which means to divide, and originally referred to moments of divided consciousness such as occur in slips of the tongue, failures in attention, or other breakthroughs from another realm of existence which we would call "the unconscious" (see von Franz, 1980a). Indeed, dividing up the inner world seems to be the intention of our figure. Jung's word for this was "dissociation," and our daimon *appears to personify the psyche's dissociative defenses in those cases where early trauma has made psychic integration impossible.*

I can best approach this topic by sharing with the reader how I became interested in it. Over the last twenty-five years of clinical work I have had a number of individuals in analysis who, after an initial period of growth and improvement, reached a kind of plateau where they seemed to stagnate in therapy and, instead of getting better as a result of the treatment, seemed instead to get stuck in a "repetition compulsion" of earlier behavior, which left them feeling defeated and hopeless. These were individuals who might be described as "schizoid" in the sense that they had suffered traumatic experiences in childhood which had overwhelmed their often unusual sensitivities and driven them inward. Often, the interior worlds into which they retreated were childlike worlds, rich in fantasy but with a very wistful, melancholy cast. In this museum-like "sanctuary of innocence" these patients clung to a remnant of their childhood experience which had been magical and sustaining at one time, but which did not grow along with the rest of them. Although they had come to therapy out of need, they did not really want to grow or change in ways that would truly satisfy that need. To be more precise, one part of them wanted to change and a stronger part *resisted* this change. They were divided within themselves.

In most cases these patients were extremely bright, sensitive individuals who

had suffered, on account of this very sensitivity, some acute or cumulative emotional trauma in early life. All of them had become prematurely self-sufficient in their childhoods, cutting off genuine relations with their parents during their developing years and caretaking themselves in a cocoon of fantasy instead. They tended to see themselves as the victims of others' aggression and could not mobilize effective self-assertion when it was needed to defend themselves or to individuate. Their outward facade of toughness and self-sufficiency often concealed a secret dependency they were ashamed of, so in psychotherapy they found it very difficult to relinquish their own self-care protection and allow themselves to depend on a real person.

What gradually became clear to me through the analysis of these patients' dreams, was that they were in the grip of an internal figure who jealously cut them off from the outer world, while at the same time attacking them with merciless self-criticism and abuse. Moreover, this inner figure was such a powerful "force" that the term *daimonic* seemed an apt characterization. Sometimes in the dreams of my patients, this inner daimonic figure violently dissociated the inner world by actively attacking the dream-ego or some "innocent" part of the self with which the dream-ego was identified. At other times its goal seemed to be the encapsulation of some fragile, vulnerable part of the patient which it ruthlessly "divided off" from reality, as if to prevent it from ever being violated again. At still other times, the daimonic being was a kind of guardian angel, soothing and protecting a childlike part of the self inwardly while at the same time hiding it shamefully from the world. It could play a protective or a persecutory role – sometimes alternating back and forth between them. And to further complicate matters, this duplex image usually made its appearance in what James Hillman has called a "tandem" (Hillman, 1983). It usually did not appear alone, but was paired with an inner child or with some other more helpless or vulnerable "partner." In turn, this innocent "child" had a duplex aspect – sometimes it was "bad" and "deserved" persecution, so to speak; at other times it was "good" and received protection.

In summary, these duplex imagos, yoked together as an internal "structure," make up what I call the *archetypal self-care system*. As I hope to demonstrate in the ensuing pages, we have reason to believe this structure is a universal inner "system" in the psyche, whose role seems to be the defense and preservation of an inviolable personal spirit at the core of an individual's true self.

The question I began to ask myself, then, was: "How did the internal guardian figures of this 'system' and their vulnerable child 'clients' get organized in the unconscious, and from whence did they derive their awesome power over the patient's well-intentioned ego?"

JUNG AND DISSOCIATION

The psyche's normal reaction to a traumatic experience is to withdraw from the scene of the injury. If withdrawal is not possible, then a part of the self must be

withdrawn, and for this to happen the otherwise integrated ego must split into fragments or *dissociate*. Dissociation is a normal part of the psyche's defenses against trauma's potentially damaging impact – as Jung demonstrated many years ago with his word association test (Jung, 1904). Dissociation is a trick the psyche plays on itself. It allows life to go on by dividing up the unbearable experience and distributing it to different compartments of the mind and body, especially the "unconscious" aspects of the mind and body. This means that the normally unified elements of consciousness (i.e., cognitive awareness, affect, sensation, imagery) are not allowed to integrate. Experience itself becomes discontinuous. Mental imagery may be split from affect, or both affect and image may be dissociated from conscious knowledge. Flashbacks of sensation seemingly disconnected from a behavioral context occur. The memory of one's life has holes in it – a full narrative history cannot be told by the person whose life has been interrupted by trauma.

For the person who has experienced unbearable pain, the psychological defense of dissociation allows external life to go on but at a great internal cost. The outer trauma ends and its effects may be largely "forgotten," but the psychological sequelae of the trauma continue to haunt the inner world, and they do this, Jung discovered, in the form of certain images which cluster around a strong affect – what Jung called the "feeling-toned complexes." These complexes tend to behave autonomously as frightening inner "beings," and are represented in dreams as attacking "enemies," vicious animals, etc. In his only essay explicitly about trauma, Jung wrote:

> a traumatic complex brings about 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. Its autonomy consists in its power to manifest itself independently of the will and even in direct opposition to conscious tendencies: 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. I have frequently observed that the typical traumatic affect is represented in dreams as a wild and dangerous animal – a striking illustration of its autonomous nature when split off from consciousness.
>
> (Jung, 1928a: paras 266–7)

The nature and functioning of those dissociative mechanisms responsible for complex-formation were not clear to Jung in his early experiments, but subsequent research with patients suffering from the so-called "dissociative disorders" showed that it is not a passive, benign process whereby different parts of the mind become disconnected and "drift apart." Instead, dissociation appears to involve a good deal of aggression – apparently it involves an active attack by one part of the psyche on other parts. It is as though the normally integrative tendencies in the psyche must be interrupted by force. Splitting is a violent affair – like the splitting of an atom. This is a fact that strangely eluded Jung. Despite his awareness

that traumatic affect may appear in dreams as a "wild animal," he did not include violent affect in his understanding of the psyche's primitive defenses themselves. Contemporary psychoanalysis recognizes that where the inner world is filled with violent aggression, primitive defenses are present also. More specifically, we now know that *the energy for dissociation comes from this aggression*.

In the dream material of the cases below, the violent nature of these self-attacking dissociative processes is illustrated. In psychotherapy with trauma victims, it seems that as the unbearable (traumatic) childhood experience, or something resembling it in the transference, begins to emerge into consciousness, an intra-psychic figure or "force," witnessed in the patient's dreams, violently intervenes and dissociates the psyche. This figure's diabolical "purpose" seems to be to prevent the dream-ego from experiencing the "unthinkable" affect associated with the trauma. For example, in the cases below "he" cuts off the dreamer's head with an axe, shoots a helpless woman in the face with a shotgun, feeds crushed glass to a helpless animal, and "tricks" the helpless ego into captivity in a diabolical "hospital." These actions appear to fragment the patient's affective experience in such a way as to disperse the awareness of pain that has emerged or is about to emerge. In effect, the diabolical figure traumatizes the inner object world in order to prevent re-traumatization in the outer one. If this impression is correct, it means that a traumatogenic imago haunts these patient's psyches, supervising dissociative activities, reminding one of Jung's early suspicion that "fantasies can be just as traumatic in their effects as real traumata" (Jung, 1912a: para. 217). In other words, the full pathological effect of trauma requires an outer event *and a psychological factor*. Outer trauma alone doesn't split the psyche. *An inner psychological agency – occasioned by the trauma – does the splitting*.

CLINICAL EXAMPLE: THE AXEMAN

I will not soon forget the first case where these possibilities began to dawn on me. The patient was a young female artist who, later treatment revealed, had suffered repeated physical and sexual abuse by her alcoholic father, who was her only living parent and someone who, as a little girl, she had loved deeply. When this woman came to her first therapy appointment she arrived on a motorcycle, dressed in black leather, and spent the entire hour in cynical condemnation of her roommate who had recently gotten married and had a child. She was tough, contemptuous toward others, cynical about life in general, and extremely armored against any acknowledgement of her own pain. As close as she could get to acknowledging any difficulties of her own was to mention a whole bundle of psychosomatic complaints – chronic back pain, incapacitating pre-menstrual cramps, episodic asthma, and recurrent epileptic-like symptoms where she would "go blank" for several minutes. This had frightened her enough for her to seek help. Her inner life was haunted by morbid feelings of being a living dead-person and was full of overwhelming rage, portrayed in horrifying images of mutilation

and dismemberment. These images of amputees, of chopped-off hands, arms, and heads, kept spontaneously appearing in her artwork, and everyone but the patient was appalled by them.

The following dream occurred about one year into her treatment immediately after a session in which, for the first time, this very self-sufficient patient had allowed herself to feel small and vulnerable in response to my departure for a summer vacation. In an unguarded moment and with the coquettish smile of an adolescent girl, she had grudgingly acknowledged she would miss me and her therapy hour. That night, after writing a long letter to me about how she could not continue her treatment (!) because she was becoming "too dependent," she had this dream.

> I am in my room, in bed. I suddenly realize I have forgotten to lock the doors to my apartment. I hear someone come into the building downstairs, walk to my apartment door – then walk in. I hear the footsteps approach the door of my room . . . then open it. A very tall man with a white ghost-like face and black holes for eyes walks in with an axe. He raises it over my neck and brings it down!. . . I wake up in terror.

Interpretation and theoretical commentary

Here we have an image of a violent decapitation – an intended split between mind and body. The neck, as an integrating and connecting link between the two, is about to be severed. The room in which the dream took place was her current bedroom in an apartment she shared with a roommate. Usually afraid of the dark, she always double-locked the door to this room before retiring. The unlocked outer door was the door to her apartment, and this door she also compulsively checked whenever she was home alone. In the dream, the ghost-like man apparently has access to both doors, just as her father had had unrestricted access to the bedroom where she slept and also to her body. Often my patient – when only 8 years old – had heard his footsteps approach her room before his regular sexual violations of her.

Clearly her "unguarded" moment of neediness within the transference during the previous hour was equivalent to her "forgetting" to lock the door in her dream and constituted a breach in her usual ego-defenses. Through this breach comes a kind of "death spirit," an image of unmitigated horror – the ghost-like man with black holes for his eyes. The patient recognized this dream as one version of a repetitive nightmare from her childhood in which she would be attacked by threatening figures. But why, I wondered, had she dreamed about such a horrific image the very night she felt emotionally open and vulnerable in relation to me and her therapy?

In keeping with our prior hypotheses about the function of the self-care system, the explanation seems clear enough. Apparently, the vulnerable admission of feelings of dependency in the previous hour was experienced by some part of the

patient's psyche (the ghost-like man) as a dire threat – the threat of re-experiencing the unbearable pain of needing an outer object (her father) and having this need traumatically rejected. In other words, the patient's emergent feeling for me in the transference was linked associatively with her childhood devastation – the unbearable suffering she had experienced in desperately loving a man who then beat her and sexually abused her. As this "love" and neediness came into consciousness, associated with *unthinkable* despair from her unremembered childhood, it triggered overwhelming anxiety, which in turn triggered her dissociative defenses. And so she was going to "split" this off and leave her therapy! This splitting behavior was further represented in her dream as the axe with which the murderous figure prepared to sever the connections (links) between her body (where many of her traumatic memories were stored) and her mind. This figure, then, represents the patient's *resistance* to re-experiencing feelings of dependency and probably to vulnerable feelings in general. He represents a "second line" of defense, when the usual ego-defenses have been penetrated and unacceptable levels of anxiety have been constellated. As a truly daimonic figure, he would cut her off from her embodied, feeling self – in the world – in order to keep her in her persecutory "mind," where he would have total control over her unrealized personal spirit. Such is the perverse "goal" of the self-care system when early trauma has simply broken the heart too many times.

The self-care system and the psyche's auto-immune reaction

In the intervening years since my experience with this patient, I have come to see it as almost axiomatic that in the inner world of the trauma victim we will find such diabolized personifications of self-attack and abuse. In the dreams of trauma patients I have analyzed over the years, the diabolical Trickster has performed the following acts: he or she has tried to cut the dreamer's head off with an axe, has brutally raped the dreamer, petrified the dreamer's pet animals, buried a child alive, seduced the patient into performing sado-masochistic sexual favors, trapped the dream-ego in a concentration camp, tortured the patient by breaking his knees in three places, shot a beautiful woman in the face with a shotgun, and performed a variety of other destructive acts, the purpose of which seems to be nothing less than driving the patient's terrified dream-ego into a state of horror, anxiety, and despair.

How do we understand this? It is bad enough that our hapless patient suffered unbearable outer trauma in early childhood. Now the psyche seems to perpetuate this trauma in unconscious fantasy, flooding the patient with continued anxiety, tension and dread – even in sleep. What could possibly be the purpose or telos of such diabolical self-torture?

One hint at a possible understanding comes from the derivation of the word "diabolical," from the Greek *dia* (across) and *ballein* (to throw) (*OED*), hence, "to throw across or apart." From this derives the common meaning of "diabolos"

as the Devil, i.e., he who crosses, thwarts, or dis-integrates (dissociation). The antonym of diabolic is "symbolic," from *sym-ballein*, meaning "to throw together." We know that both processes – throwing apart and throwing together – are essential to psychological life and that in their apparently antagonistic activities we have a pair of opposites which, when optimally balanced, characterize the homeostatic processes of the psyche's self-regulation. Without "throwing apart" we would have no differentiation, and without "throwing together" there would be no synthetic integration into larger wholes. These regulatory processes are especially active at the transitional interface between the psyche and outer reality – precisely the threshold at which defense is necessary. We might imagine this self-regulatory activity, then, as the *psyche's self-care system, analagous to the body's immune system.*

Like the body's immune system, these complementary dynamisms of dis-integration/re-integration are involved in complicated gatekeeping functions at the thresholds between inner and outer worlds and between the conscious and unconscious inner systems. Strong currents of affect reaching the psyche from the outside world or from the body must be metabolized by symbolic processes, rendered into language, and integrated into the narrative "identity" of the developing child. "Not-me" elements of experience must be distinguished from "me" elements and must be rejected aggressively (outwardly) and repressed firmly (inwardly).

In the trauma response, we might imagine that something goes wrong in these naturally protective "immune responses." It is an almost universal finding in the trauma literature that children who have been abused cannot mobilize aggression to expel noxious, "bad", or "not-me" elements of experience, such as our young artist's hatred of the abusive father. The child is unable to hate the loved parent – and instead identifies with the father as "good" and, through a process which Sandor Ferenczi (1933) called "identification with the aggressor," the child takes the father's aggression into the inner world and *comes to hate itself and its own need.*

If we apply this analysis to our case, we can see that as her vulnerable need within the transference began to emerge, the patient's introjected hatred (now amplified by archetypal energy) attacked the links between body and mind in an effort to cut the affective connections. The white-faced, black-eyed "terminator" in her psyche is, however, much more than the introjected father. He is a primitive, archaic, archetypal figure, personifying the terrifying dismembering rage of the collective psyche and, as such, represents *the dark side of the Self.* The outer catalyst for this inner figure may be the personal father, but the damage to the inner world is done by the psyche's Yahweh-like rage, directed back upon the self. It was for this reason that neither Freud nor Jung were convinced that outer trauma alone was responsible for splitting the psyche. It was rather an interior, psychological factor that ultimately did the worst damage – witness the diabolical axeman.

Developmental hypotheses on the origin of the Dark Self

Why, then, does the primordial ambivalent Self, both light and dark, good and evil, appear with such regularity in the inner world – even for patients who have not suffered outright physical or sexual abuse? The following is a brief description of how I understand this issue developmentally, in light of clinical experience with patients like our young artist with her horrifying inner world.

We must assume that the inner world of the very young infant is one in which painful, agitated, or uncomfortable feeling-states oscillate with feelings of comfort, satisfaction, and safety in such a way that gradually two images of the self and the object gradually build up. These early self- and object-representations tend to be structured in opposites and to embody opposing affects. One is "good," the other "bad;" one is loving, the other hateful, and so on. In their original condition, affects are primal and archaic like volcanic storms, quickly dissipating or giving way to their opposite, depending on the nature of environmental provision. Negative, aggressive affects tend to fragment the psyche (dissociation), whereas positive, soothing affects accompanying adequate mediation by the mother, have the effect of integrating these fragments and restoring homeostatic balance.

The mediational capacities that later become the ego are, at the beginning of life, totally vested in the maternal self-object who serves as a kind of external metabolizing organ for the infant's experience. Through her empathy, the mother senses the infant's agitation, picks up and comforts her infant, helps to name and give form to its feeling-states, and restores homeostatic balance. As this happens repeatedly over time, the infant psyche gradually differentiates and he or she begins to contain his or her affects, i.e., to develop an ego capable of experiencing strong emotion and tolerating conflict among emotions. Until this occurs, the infant's inner self- and object-representations are split, archaic and typical (archetypal). Archetypal inner objects are numinous, overwhelming, and mythological. They exist in the psyche as antinomies or opposites, which gradually come together in the unconscious as dual unities which are alternately blissful or terrifying, such as the Good Mother and her "tandem," the Terrible Mother. Among the many such *coincidenta oppositora* in the deep unconscious is one central archetype which seems to stand for the very principle of unity among all the opposing elements of the psyche and which participates in their volcanic dynamism. This central organizing agency in the collective psyche is what Jung called the archetype of the Self, both light and dark. It is characterized by extraordinary numinosity, and an encounter with it can involve either salvation or dismemberment, depending upon which side of the Self's numinosity is experienced by the ego. As the "unity of unities," the Self stands for the image of God in the human psyche, although the God embodied in the Self is primitive, a *mysterium tremendum*, combining both love and hate, like the Old Testament Yahweh. Until the ego develops, the unified Self cannot actualize – but once constellated, it becomes the "ground" of the ego and its "guide" in the rhythmic unfolding of the individual's inborn personality potential. Michael Fordham (1976) described this as the de-integration/re-integration cycle of the Self.

In healthy psychological development, everything depends upon a gradual humanization and integration of the archetypal opposites inherent in the Self as the infant and young child wrestles with tolerable experiences of frustration (hate) in the context of a good-enough (not perfect) primary relationship. The child's ruthless aggression does not destroy his object and he can work through to guilt, reparation, and what Klein called the "depressive position." However, inasmuch as the traumatized child has *intolerable* experiences in the object world, the negative side of the Self does not personalize, remaining archaic. The internal world continues to be menaced by a diabolical, inhuman figure. Aggressive, destructive energies – ordinarily available for reality-adaptation and for healthy defense against toxic not-self objects – are directed back into the inner world. This leads to a continuation of trauma and abuse by inner objects long after the outer persecutory activity has stopped. We turn now to a second case in which such inner persecution is starkly illustrated.

MRS. Y. AND THE SHOTGUNNER

Mrs. Y, an attractive, likeable, professionally accomplished divorced woman in her early 60s, sought analysis because of generalized depression and an awareness that some part of her was withheld in all her relationships – leaving her with an underlying sense of loneliness. From previous therapy, she knew that the roots of this "schizoid" problem lay deeply buried somewhere in a childhood of which she had almost no happy memories. Her history revealed an early family situation of emotional poverty in the midst of material luxury. Her narcissistic mother, already symbiotically attached to the first-born 3-year-old brain-damaged son, paid the patient little or no attention – never physically touching her except for rigidly routinized feedings and toilet training. A younger sister was born when the patient was 2 years old. Whatever emotional life Mrs. Y. could eke out as the middle child in this family came from a succession of nurses and nannies. With them she remembered crying, raging, spitting, and rebelling. Nothing of this ever happened with her mother. Instead, the mother was "untouchable" – remote – tied to the other two siblings or to the father. A repeated childhood nightmare showed the mother watching indifferently from the porch while the patient was run down by the laundry truck in the driveway of her house.

The patient's father, whom she adored, was preoccupied with business. He seemed to prefer her younger sister (also the mother's favorite) and was otherwise in orbit around the narcissistic, controlling mother. Although he took care of the patient when she was sick, and spent time alone with her, he was also subject to attacks of rage which were terrifying. When Mrs. Y. was 8 years old, her father developed a chronic illness and was home in bed for six years until he died. During these years the patient was afraid to disturb him. All emotion around his death – indeed, even the reality of the illness itself – was denied. The result was that the patient could never make her needs or feelings known to either parent for her entire childhood. To have a childhood in which needs cannot be expressed to

primary caretakers is tantamount to losing one's childhood altogether, and such was Mrs. Y.'s experience. She retreated into an inner world of unconscious fantasy, convinced that some unfathomable "badness" had condemned her to despair in this world. For reasons unknown to her, she felt chronically ashamed and, despite her constant efforts to please people through her considerable school achievements, she never felt that she made anyone very happy.

The psyche's natural anesthesia for the "cumulative trauma" in a childhood such as this renders most patients incapable of remembering specific traumatic events, much less experiencing them on an emotional level in analysis. Such was the case for Mrs. Y. We talked *about* the deprivation in her early life, but we could not recover it *experientially*. Often, in my experience, it is not until some aspect of the early traumatic situation emerges in the *transference* that analyst and patient are given emotional access to the real problem, and it is just such an incident I wish to report.

While at her mother's home one day, Mrs. Y. found some old home movies taken when she was 2 years old. In one of the films, taken at a family party, she saw her knee-high, 2-year-old, skinny self, crying and desperately running from one pair of legs to another, looking up imploringly for help, being ignored and then rushing to another pair of legs where she pleaded again, until finally, overcome by grief and rage, the nanny came and dragged her off kicking and screaming. At her analytic session the next day, Mrs. Y. reported all this in her usual dispassionate way, covering her sadness with humor and sarcasm. Inwardly, she seemed very upset.

To capitalize on this fortuitous access to strong feeling about her childhood self, I suggested that we schedule a special session and watch the film together. Obviously pleased but embarrassed by this offer (she had never heard of such a thing in therapy) and protesting that she could never presume upon my time like that, offering various reasons why this would be too much to ask, etc., she nevertheless accepted the idea and we set up an extra "movie-session."

As expected, this new situation was somewhat awkward for both the patient and myself, but after some joking and laughter around our mutual awkwardness with this new experience, she relaxed as we talked about the various people in the film leading up to the moment she had described. And then together we witnessed the horrific despairing trauma captured some 55 years earlier on film. We watched this part a second time and during this second review, Mrs. Y. started to cry. I too found my eyes full of tears which, as far as I could tell, the patient didn't notice. Mrs. Y. quickly recovered her composure but then broke down again and we struggled together with her mixture of genuine grief and empathy for her despairing childhood self, and her efforts to recover her composure with self-demeaning remarks about her "weakness" and "hysteria" together with awkward efforts to reassure me that she was all right and would soon leave.

The following session, through many awkward silences, we processed what had happened. "You became a human being last time," she said:

> "I had neutralized you until you offered to see that movie with me and then I saw your tears. My first reaction was 'Oh God, I didn't mean to do that . . . to upset you. Please, I'll never do it again!' – As though affecting you in any way was a terrible, thing. But secretly I was pleased and deeply moved inside. You were so human. I couldn't get over it," she continued. "I kept saying over and over 'you affected him! you affected him! He cares about you!' It was very moving. I'll never forget that session! It felt like the beginning of something new. All my armor fell away. I was up late into the night writing about it in my journal."

But that same night Mrs. Y. also reported an alarming dream. In this dream, an ominous male figure we had both come to know from previous dreams, made his dark appearance again. Here is the dream she reported:

> The scene is somber, with many dim male figures lurking in the shadows. The colors are muted, sepia tones. There was going to be a joyful reunion between two women. Perhaps they are sisters, long separated. I am in a happy, anticipatory mood, and am waiting in a hall overlooking a double staircase and balcony. The first woman appears on the ground floor. She's wearing an incredibly bright kelly-green suit. Suddenly a dim figure, a man, jumps out from behind a curtain and shoots her in the face with a shotgun! She falls, the colors are startling: bright green and blood red. The other woman, eager to see her friend, appears entering from the left onto the balcony. She is dressed in bright bright red. She leans over the balcony to see the green/red body. Her shock is great. She vomits great gushes of red blood in her grief and falls over backwards.

The patient's main reaction to this dream was horror and revulsion. She could not understand this dream in light of her experience in the session, although she knew it was linked somehow. In working with the dream, I started with the anticipated joyful reunion between the sisters and asked her to associate to that feeling. She came up with nothing. Suspecting, then, that she was avoiding the transferential "union" of the previous hour, I wondered out loud whether perhaps she was in great conflict about allowing the feelings for me that had come up the previous hour to surface again, or to even entertain them within an inner space inside herself. She blushed and agreed that this might be so. She then began to get in touch with the part of her that minimized and contemptuously dismissed this feeling (the shotgunner). Its negative and frightening voice sometimes spoke to her with phrases like: "That's all bullshit – his feelings weren't real – it was just a technique – it's all just a business relationship anyway – he shows you out and then the next one comes in for the same treatment."

Further associations emerged. The shotgunner's cruelty in response to a hoped-for connection reminded her of earlier male figure from a dream the previous year who had ruthlessly killed a primitive octopus-like creature that was also trying to make contact. She thought the double staircase and balcony created a shape like

a uterus, while the red and green reminded her of Christmas, which in turn reminded her of Rubens' painting *The Slaughter of the Innocents*, depicting King Herod's envious attempt to murder the Christ-child by having his soldiers kill all male children under two years of age. This biblical event had always partially spoiled the Christmas story for her and filled her with dread whenever she heard it or saw Rubens' painting. She also mentioned that red and green are complementary colors – if you close your eyes after seeing one of them, the inner after-image is its complement. Finally, she was reminded that she had had bright red hair as a girl and that her mother had never let her wear red.

I had forgotten her previous dream, so I looked it up. It was from a period six months earlier in her analysis at a time when she had just met an interesting man and become emotionally and sexually involved with him. We had not worked on this dream, but my notes indicated that she was very hopeful about this new relationship and excited about the rekindled sexual feelings she was having. The night after her first rendezvous with this man she had the octopus dream as follows:

> I'm lying in that childhood bed of mine. I'm screaming in fear, having some nightmare. I hear this very faint whisper saying that I've been heard by somebody. I feel terribly guilty because I've woken up the person or interrupted them. Then, somehow related to this scene, a big trash-can has spilled. In its there's a slug-like octopus creature. At first I am disgusted with this thing, but then I begin to play with it. I tap the floor in front of the can and this tentacle reaches out playfully – kitten-like – and touches a pencil I'm holding. At this point two men come in. One is wearing dark glasses with mirrored lenses. He takes them off, grinds up the lenses and feeds the crushed glass to this animal so it'll die a long slow death. I'm appalled at the cruelty. I turn my back on it.

Interpretation and theoretical commentary

So here we have two important affect-laden relational events in Mrs. Y.'s life – one in the transference, another with her new male friend – followed by dramatic "statements" from the unconscious in response: a shotgun blast in the face of the green-dressed woman seeking reunion with her long-lost sister, on the one hand, and the cruel man who feeds crushed glass to the octopus on the other. The patient notes that the shotgunner dream so horrified her that she was numb and could hardly remember the events from the previous session. In other words, the dream itself was a trauma and had the same effect as a real-life trauma, i.e., dissociation from affect. This seemed like re-traumatization by fantasy. Why, I wondered. would her dream do this?

Developmental considerations

To understand this we have to go back to her childhood situation. From observing the film and exploring her memories, the patient and I were already aware that all

dependency-needs in her childhood had been denied. Given that childhood is by definition a dependent period of life, this meant my patient had been made ashamed of her own needs repeatedly and was repeatedly frustrated to the point of raging temper tantrums. These also could not be tolerated, so the result was a split in her inner world where the rage she felt toward her neglectful parents was used to repress the neediness about which now even she had grown intolerant. So the aggressive energies of the psyche are turned back upon the dependent aspects and we have an internal environment where self-attack for neediness is a constant occurrence. This internal attack becomes what Bion (1959) called an "attack against linking," and so the archetypal aggressive energies that rage through the psyche dismember it *in order to keep the ego from feeling its own pain*.

When the linkages are attacked within the inner world, the natural processes of symbolic integration cannot occur. The psyche cannot metabolize its own experience and render it meaningful. This is what Winnicott meant when he said that severe trauma could not be encompassed within the area of symbolic illusion or the child's omnipotence (Winnicott, 1965: 145). We see this problem illustrated in the dreams of soldiers who suffer an acute trauma in wartime – such as a soldier who lights his buddy's cigarette in a foxhole and sees his head blown off by sniper fire. These soldiers' nightmares are pure repetition of the unbearable event (see Wilmer, 1986). The psyche cannot symbolize something this unbearable until much later. Slowly, if such a traumatic event can be told and retold, the dreams start to symbolize the experience until eventually it is metabolized. But for sustained, unbearable childhood trauma, the archaic defensive system must come into play, and this system annihilates the architecture of the inner psychological world. Experience is rendered meaningless. Thoughts and images are disconnected from affect. The resulting state is what Joyce McDougall (1985) calls "alexithymia," or having no words for feelings.

This process might be imagined as analogous to the circuit-breaker in a house. If too much electricity comes in, i.e., more than the wires of the house can carry without burning up, then the circuit blows and the connection to the outside world is annihilated. But in the psyche the process is more complicated because there are two sources of energy – both the outside world and inner world, the unconscious. So when the psychological circuit-breaker trips, it shuts off both. The person must be defended against dangerous stimulation from the outer world, but also from those needs and longings which arise from deep within.

Shame and self-attack

As I interpreted this material, it seemed that my offer of the special session, as well as my empathic tears in response to the movie we watched, had opened up a level of need or longing in the transference, and had also opened up my patient's unconscious *feeling of shame about this need,* (i.e., she felt the need was "bad," "weak," etc.) which had heretofore been unavailable in the analysis. She was at

first terribly ashamed at having "upset me" with her "bad" (because needy) tearful feelings. (The extent of the patient's feeling of shame appears in the octopus dream as the guilt for having been heard and awakened someone with her screaming.) Yet my own unintended self-disclosure of feeling (tears) reduced her shame and made it easier for her to experience her own "bad" vulnerability.

There was a price to be paid for this, however, and here is where the dreams present a fuller picture of her intra-psychic state. It seems that a very important inner figure connected to her shame did not like this exposure of vulnerability and possibly mistook it as a signal for immanent re-traumatization. In other words, vulnerable longings presumably preceded earlier traumatic ruptures and now, fifty-five years later, a recurrence of such vulnerability serves as a warning to the guardian shotgunner that the trauma may occur again. This would be unbearable, so the diablical introject dissociates the ego from its emerging affect (shotgun blast).

If we understand "killing" in dreams as an obliteration of awareness or profound dissociation, then we see that the psyche of the traumatized person cannot countenance re-exposure of the same vulnerable part-self representation as (apparently) occurred in the original traumatic situation. The original humiliating shame must be avoided at all costs. The price, however, is severance from the potentially "corrective" influence of reality. Here we have the psyche's self-care system gone mad.

Like the immune system of the body, the self-care system carries out its functions by actively attacking what it takes to be "foreign" or "dangerous" elements. Vulnerable parts of the self's experience in reality are seen as just such "dangerous" elements and are attacked accordingly. These attacks serve to undermine the hope in real object-relations and to drive the patient more deeply into fantasy. And just as the immune system can be tricked into attacking the very life it is trying to protect (auto-immune disease), so the self-care system can turn into a "self-destruct system" which turns the inner world into a nightmare of persecution and self-attack.

Both the "shotgunner" dream and the "octopus" dream associated with it give eloquent testimony to the annihilating self-attack suffered by the patient as she tried to reach out for a real object in the world in the hope of meeting a need. Many analysts would interpret these figures as "introjections of the perpetrator" (although there was no single perpetrator here) or perhaps as introjections of the mother's sadism or "negative animus." It would be more correct to say that these malicious killers *captured rather the mythological level of the patient's childhood experience of shame*. The resulting image is an *archetypal inner object,* a feature of the inner world of trauma that only an archetypal understanding can encompass adequately.

In the dream featuring the shotgunner, Mrs. Y.'s nascent renewed hope for connection within the transference was symbolized by the long-awaited reunion between two women, which I would interpret as complementary aspects of her feminine self-identity (green, the color of vegetative life, and red, the color of

blood, are both symbols of life-energy[illegible] *resist* integration of the together" but which had been separated prev[illegible] the point of dividing up the ego's mother in infancy?). This reunion, says the dream, w[illegible]hem, therefore, must involve structure (the two stairways and balcony), indicating a [illegible]nstructions we consider containing environment, presumably in the transference. The[illegible]creation of a safe unconscious to this anticipated connection is shocking – a traumath[illegible] dreams and the vulnerable figure reaching out for contact (the woman in green). [illegible] fashion

Even in her associations to the red and green of Christmas (King Hero[illegible]e-slaughter of the innocents) the same theme emerges: potential new life is snuffed out by a tyrannical masculine "ruling principle" who cannot countenance the threat to his powerful control by the miraculous child of light. Similarly, in the octopus dream (also occasioned by a new, hoped-for relationship) the undefended, archaic, "disgusting" trash-can part of the self reaches out "kitten-like" to make contact. This again is the apparent signal for the arrival of the violent, sadistic male image who emerges at the critical moment to bring death into the dream and traumatically end the "reaching out" process. It is interesting that he does this with crushed glass from a "polarized" lens – the fragmented remnants of the ocular lens which allows him to see "out" but no-one to see "in." Given that consciousness means literally "knowing with another," our octopus-killer might be thought of as a kind of anti-consciousness factor in the psyche. The dreamer "turns her back" on the scene, i.e., dissociates herself from the violence of this inner process. She cannot "look at" it.

Trauma and the repetition compulsion

With such a terrifying sadistic figure lurking in her psyche, it was of course no surprise when, following the romantic evening with her new friend, Mrs. Y. had a great deal of difficulty pursuing the relationship afterwards – despite the friend's initial interest in her. She found great resistance in herself which she could not rationally explain but which, we were able to discover, represented her resistance to being re-exposed to the potentially annihilating shame originating in her "forgotten" childhood trauma. It was as though her psyche was "remembering" an unthinkable similar event from long ago.

The reader will note that these assumptions about the dangers inherent in hoping for new life or relationship seem to be the same assumptions by which the patient's inner terminator operates. In other words, in killing off her own feeling of hope, the patient acts in "identification with the aggressor" in herself – as if she is "possessed" by him. In this way the persecutory, anxiety-ridden inner world of trauma is recapitulated in outer life and the trauma victim is "compelled to repeat" the self-defeating behavior.

Such is the devastating nature of the trauma cycle and the resistance it throws up to psychotherapy. As Mrs. Y. and I worked through the resolution of her "trauma-complex" we encountered again and again the cycle of hope, vulnerability, fear, shame, and self-attack that always led to the predictable repetition of

depression. Every moment of intimacy or personal accomplishment was an occasion for her daimon to whisper that it would all be taken from her, or that she didn't deserve it, or that she was an imposter and a fraud and would soon be humiliated. Fortunately, we were able to work on this cycle in the intimacy of the transference/counter-transference relationship and could thereby "catch" the daimon at his tricks in the moment-to-moment changes of feeling during the sessions.

Without the consciousness that can only come in such a process of working through, the inner world of trauma, with its archetypal defensive processes, duplicates itself in the patient's outer life (repetition compulsion) in a pattern which Freud justly called *daimonic*. In Jung's language, we might say that the original traumatic situation posed such danger to personality survival that it was not retained in memorable *personal* form but only in *daimonic* archetypal form. This is the collective or "magical" layer of the unconscious and cannot be assimilated by the ego until it has been "incarnated" in a human interaction. As archetypal dynamism it "exists" in a form that cannot be recovered by the ego *except as an experience of re-traumatization*. Or, to put it another way, the unconscious repetition of traumatization in the inner world which goes on incessantly must become a *real* traumatization with an object in the world if the inner system is to be "unlocked."

This is why a careful monitoring of transference/counter-transference dynamics is so important in our work with severe trauma. The patient wishes to depend upon the analyst, to "let go" of the self-care system, and get well again, but the system itself is much more powerful than the ego – at least initially, and so the patient inadvertently resists the very surrender to the process that would restore a feeling of spontaneity and aliveness. To hold these patients responsible for this resistance is a terrible mistake, not just technically but structurally and psycho-dynamically as well. The patient is already feeling blamed for some nameless "badness" inside, so interpretations which emphasize the patient's "acting out" or avoidance of responsibility merely drive home the conviction of failure. In many respects, it is not "they," the patients, who resist the process at an ego level. Rather, their psyches are battlegrounds on which the titanic forces of dissociation and integration are at war over the traumatized personal spirit. The patient must, of course, become more conscious and responsible for a relationship to his or her tyrannical defenses, but this consciousness must include the humble realization that archetypal defenses are much more powerful than the ego.

The prominence of the archetypal defense system explains why the "negative therapeutic reaction" is such a prominent feature in our work with these patients. Unlike the usual analytic patient, we must remember that for the person carrying around a dissociated trauma experience, integration or "wholeness" is initially experienced as the worst thing imaginable. These patients do not experience an increase of power or enhanced functioning when the repressed affect or traumatogenic experience first emerges into consciousness. They go numb, or split, or act out, somatize, or abuse substances. Their very survival as cohesive "selves" has

depended upon primitive dissociative operations which *resist* integration of the trauma and its associated affects – even to the point of dividing up the ego's "selves" into part-personalities. Analytic work with them, therefore, must involve "softer" techniques than the usual interpretations and reconstructions we consider mutative in analysis. Great attention must be given to the creation of a safe physical space and a safe interpersonal environment within which dreams and fantasies can emerge and be worked with in a more playful, open-ended fashion than the usual analytic interpretation allows. All forms of the so-called "creative-arts" psychotherapies are extremely helpful toward this end and often these will open up traumatic affect much faster than purely verbal exploration.

Grief and the process of working through

To return to our case, it is worth noting that instead of dissociated awareness (turning her back in the octopus dream), it is the emotion of overwhelming grief that characterizes the shotgunner dream. This grief over the lost union is felt by the woman in red (clearly an identity figure for the patient) as she witnesses the lost friend, now killed by the shotgun blast. If we consider what Masud Khan (1983: 47) means by the "space potential of the dream towards self-experience," we might speculate that this grief is the patient's previously unfelt mourning for all the lost satisfactions and unmet needs of her childhood, presented in a dream image – now that a positive transference is encouraging the opening up of her inner world and its trauma – so she can "see" it and relate to it. Her grief unites, as it were, the hope of anticipation and the violent disappointment of loss. Both sides of the archetype – the "tearing apart" and the "throwing together" – are held together in the overarching symbolic narrative of the dream. This is an important reminder of the healing efficacy of dream experience, quite apart from the interpretive meaning our analysis may give it.

The inability to mourn is the single most telling symptom of a patient's early trauma. Normal mourning requires an idealized self-object with whom the young child merges and around whom the child's omnipotence can first be experienced – then slowly given up through what Heinz Kohut called the mother's "tolerable failures in empathy" (see Kohut, 1971: 64). This process of normal mourning is, according to Kohut, how internal psychic structure is built and how the archetypal world is humanized. If this empathically attuned self-object is never experienced by the child, or is experienced inadequately, then the archaic idealized and diabolized figures we have described in this chapter haunt the child's inner world in archetypal form and substitute for the ego-structure that would otherwise have been consolidated.

In the two previous cases, the diabolical figure has appeared as a true *agent of death*, attempting to murder the dream-ego or its identificatory object. In this form he seems to represent a truly perverse factor in psychological life. His disintegrative activity constitutes a formidable resistance to psychotherapy or, for that matter, to any form of personality change, growth, or vital living. While it is

not necessary to propose a "death instinct" in the psyche, I believe it was this diabolical factor in the psyche which Freud and Klein were concerned about when they elaborated the notion of an intra-psychic anti-life force (Thanatos) and its "repetition compulsion" (see Freud, 1926).

It would not be appropriate to attribute the archaic violent energies of this figure to the "shadow" – at least not in the way Jung intended the shadow to represent the coherent ego's dark alter-personality, split off in moral development and later integrated in the interest of the "wholeness" of personality. Clearly, this figure belongs to a more primitive level of ego development and corresponds to what Jung designated as the "archetypal shadow" or the "magic demon with mysterious powers" (Jung, 1916: para. 153). If anything, this figure, whose unfeeling murderous acts assure psychic disintegration, is closer to incarnate evil in the personality – the dark side of the Godhead or Self.

In addition to killing, this diabolical figure accomplishes its purposes by encapsulating a part of the psyche and sealing it off. Our next case illustrates this role of the inner daimon. By thus imprisoning a relatively "innocent" part of the personality, it seeks to assure its protection from further abuse. In order to accomplish this, our daimon now appears as a Trickster, seducing the ego into addictive behaviors and other aberrant distractive activities which bring on a variety of "altered states." He is the true "oblivion-seeker" in the psyche, personifying the psyche's undertow toward regression. He becomes the inner voice that tempts the ego with intoxicating substances, including food or alcohol, away from any struggle with outer reality.

MARY AND THE FOOD DAIMON

Jung once said that "compulsion is the great mystery of human life" (Jung, 1955: para. 151) – an involuntary motive force in the psyche ranging all the way from mild interest to possession by a diabolical spirit. Freud was also deeply impressed by the "uncanny" aspect of what he called the "compulsion to repeat," a seemingly universal destructive tendency in the psyche of his very resistant patients (see Freud, 1919: 238). In the case of Mary we will be exploring the world of compulsive addiction and will see how the diabolical figure of our previous two cases appears again as a seductive "food daimon" and also as a diabolical "doctor," seducing the patient's ego into oblivion and anesthetizing it against feeling.

Mary, an overweight middle-aged Catholic woman came to see me for psychotherapy during the final stages of her mother's terminal illness. In addition to her grief over this impending loss, she complained of a sometimes desperate loneliness made worse by what she called "binge eating," and she was worried about the fact that she had had no sexual experience and that, indeed, she had no sexual desire that she was aware of. On the outside she presented a kind of rough and ready, no-nonsense exterior, with a keen – albeit self-deprecatory – sense of humor. I found myself liking her immediately. She was a pediatric nurse – a very

competent one – and held leadership roles in various public groups. But underneath she felt like a fragile bird without feathers. As the oldest child in a very large rural family from Pennsylvania, she had taken care of the younger siblings and become the caretaking confidante of her alcoholic, phobic mother, who spent most of her time in bed crying and bitterly complaining about their lack of money or the father's cruelty. Instead of getting solace and mirroring for her developing self, Mary had been forced to mirror and caretake the mother.

This went on until she left for the convent at the age of 16. She then embarked upon an ascetic life of prayer and service to the various mother superiors, until twenty years later when her religious order lost most of its members and she no longer felt needed – at which point she left. By the time she came to see me ten years later she was an established workaholic, and when she was not working she was caring for what was left of her extended family. The father, a benign figure, but uninvolved in her life, had died some years earlier. A positive transference soon developed and I rapidly assumed the role of the dead mother – once a week this very delightful woman with a keen sense of humor would come to her session and "take care" of me. She did this by regaling me with outrageously entertaining stories about her very disturbed family and the extraordinarily incestuous goings-on that regularly transpired on the farm among her brothers and sisters, aunts, uncles, nephews, nieces, and a menagerie of farm animals, each and everyone with their own eccentric personality. These stories were punctuated with stories from her Overeaters Anonymous meetings – always about other people – and the closest we could get to her inner life were descriptions of her struggle to lose weight.

After several months of this family gossip, I began, ever so gently, to share with Mary my impression that all this talk about other people might be avoiding the deeper personal feelings which were the reason for her having come into therapy in the first place. I recalled Winnicott's comment that patients like this, in presenting a false self, are rather like a nurse who brings a sick baby for treatment. The nurse chats with the doctor about all sorts of pleasantries, but the therapy doesn't start until the child-part is contacted and starts to play (see Winnicott, 1960a). At one point, I said that her stories seemed to me like the broken wing display of a mother bird whose nest of eggs is being approached by a dangerous intruder and that I was being "led away" from *her own* psychic pain and vulnerability by her entertaining descriptions of everyone else's. Her response to this was to feel criticized – even humiliated – and confused about what she was supposed to do. What did I want? Maybe therapy was not going to work for her after all. But despite her protests, I could tell that another part of her – her healthier part – was peeking out, curious – and that this part of her liked my comment.

Slowly, as we worked through this injury in the transference, Mary began to grope for a language with which to open up the great undifferentiated mass of psychic pain that lived in her body. At first she could not locate this as psychological pain in *herself*. The only "place" this pain was housed was in her archaic identification with the emotionally disturbed and abused children she treated in hospital. We began to talk about these children and her deep feeling for

them, and I started to treat these stories about her child-patients as if they were a dream about aspects of herself. In other words, I began to treat them as if they were parts of herself. I would say things like: "You know, your empathy for that child is obviously so powerful, so compelling, and so accurate – it's as though some part of you has experienced their suffering in your own life". This was the only way I could approach *her* pain. She would usually look at me like a stunned fish after such interpretations, having no memories of such pain, but gradually it began to dawn on her that maybe there was more to her life than she thought.

In fact, Mary had no "memories" of her life before the age of 5 or 6 – only vague feelings of anxiety whenever she tried to think about it. She had heard from a beloved Aunt that at the age of 2 she had severe excema, was subject to temper tantrums and beatings by both parents, and had often been locked in her room for hours on end when she was "bad." Reportedly, she had toilet trained herself by the age of 12 months. Before her mother died Mary asked about these rumors, but the mother denied it all and claimed Mary had had a happy childhood. I asked her to bring in pictures of herself and family members and gradually we began to get some vague memories or proto-memories of how impossible it had been for her to be the dependent child she in fact was and how, suffering what self-psychologists call the "trauma of unshared emotionality," she had grown up much too fast, sacrificing her true self's need, identifying with the caretaking adults, adopting a false facade of invulnerability and "independence."

Behind this independence there lay a fragile world in which Mary took *care of herself in fantasy.* She was a melancholy child, and spent much of her time alone, reading or on long walks. Nature was a special sanctuary for her and, as analysis progressed, she began to remember a kindergarten daydream about the Lord Jesus and the Virgin Mary who lived in heaven on a cloud and watched over her from on high. These idealized inner figures were the only support Mary had from within. Her life of prayer and devotion could sustain her only for a limited time.

A great sadness enveloped these memories as Mary slowly realized that she had been totally unable to depend on anyone in the real world, and that while cared for physically, emotionally she had been abandoned. During this period of analytic exploration, she had the following dream image:

> I see a little girl floating away from a space ship without an umbilical cord, arms outstretched in terror, eyes and mouth distorted as if by a silent scream for her mother.

When Mary allowed herself to feel this frightening image, her grief was overwhelming and typically she felt shortness of breath in the session, just like the asthma she had suffered as a child. Each time we approached this anxiety and despair, she would need to cut off her feeling, sometimes with a sarcastic remark or by "going blank." To complicate the matter, I was leaving in a month for vacation and Mary had begun to realize for the first time, and to her horror, that she was feeling very dependent on me and was already missing me! She thought this was inappropriate and "sick."

In one particular session, approaching the summer break, she was especially courageous about this new-found vulnerability, worrying out loud that her old defenses might freeze her up again and undo all the progress we had made. She asked if she might be in touch with me over the summer if she needed to be. I said yes, and for the first time, her gruff humorous facade melted and her eyes filled up with tears. We discussed the realities of how this phone contact would work, and of course, she said, she would never abuse it, and I said that I knew she wouldn't, and we parted that day with a mutual feeling of deep connection.

She appeared for her next session looking bloated, flushed and depressed. With great embarrassment and fear of my disapproval she reported that immediately upon leaving my office, she had stopped at a bakery, purchased a whole chocolate cake and a quart of ice cream, gone home in state of possession, with her heart pounding, and eaten everything in one sitting. Five hours later, upon awakening from a stuporous sleep she had gone out to the local deli, bought more food and consumed that also. She was up all night eating. Since the last session she had gained 10 pounds. She was disgusted and ashamed. She had an impulse to call me during the binge, but was afraid she'd get out of control with her neediness.

This is an experience of *resistance,* and we psychotherapists all have strong counter-transference reactions to moments like this in our work. As I reflected on my personal response to Mary's self-destructive act, I became aware of a sense of irritation – even a feeling of anger that she had just destroyed what had clearly been an important breakthrough in our work together. This interested me. I had never felt these reactions toward this patient before. The "screw you" message in her action was clearly coming from a different place than Mary's usual ingratiating ego-attitude. Underneath my irritation, I also became aware of disappointment – almost a feeling of betrayal, as though she had cheated on me and "had an affair with somebody else." As I was musing on these "mad" counter-transference reactions, Mary said something like this:

> You know, it's exactly like I'm possessed by the Devil. Food is the only sensual pleasure I have. It's the only place I can lose control. I savor each spoonful of chocolate like it's the touch of a lover. I'm compelled to do it. I search it out – there's a feeling of dark excitement just approaching the bakery! The Devil says "C'mon – you've done all this work, why don't you be 'bad' for once – you need this. There's no sense fighting it, Mary. It's hopeless to resist. I'm too strong for you. You can always lose the weight if you really want to – that'll happen when you're ready, but right now you need this comfort and you know it. You're too stressed out. I want you all to myself. Leave your world behind and come into my world. You know how good it tastes, how good it feels. C'mon, Mary. You belong to me. Good girls don't say no!"

Perhaps the reader can imagine my shock and dismay hearing this erotic language from my very asexual patient. So she *did* have an affair, I thought to myself, but with an *inner* figure. Who was this speaking through her? Certainly

not her highly "spiritual," sweet, ingratiating ego, busy pleasing people all the time. This was truly a diabolical seductive voice – a part of her inner world that neither of us had really known about. "He" was very clever, a veritable shape-shifter, a Trickster. He would use the truth about her excessive "goodness" to seduce her into being "bad" – clearly something Mary needed to risk in her life – but the result was always an even deeper sense of worthlessness and a vicious circle of trying to be extra good to atone for her compulsion. This figure's crafty seductiveness is what intrigued me. He personified a bodily sensuality, a sexuality, and an aggression that gave Mary's otherwise pale ingratiating ego much-needed color and depth. Submission to her "Daimon-lover" was the only place she could lose control, and what's more, this "surrender" was to her much-neglected body's cravings – at least this is what her inner daimon "told" her – the way she rationalized her binges.

The cost of these repeated "surrenders," however, was that Mary never got filled up in a way that gave her the "fullness" she was looking for. Quite the contrary; her midnight trysts with the food devil were tantamount to repeated rapes and violations. In the sober light of morning she felt devastated, her hopes crushed, her diet broken, her relationship to therapy and to me threatened with guilt. The pattern, she reiterated, was truly "perverse."

The next session, Mary reported an important dream (reported here in the first person). The dream tells us more about her inner daimon-lover.

> I'm checking into a hospital with my friend Patty [Patty was a much younger, very innocent new nurse on her service]. We're there for some kind of procedure, maybe a blood test or something. I'm not sure. It's all very high-tech with many machines, etc. The doctor in his white coat is very nice as he introduces us to the hospital. But as we walk down the hall to the place our blood will be drawn I begin to feel uneasy because there is something wrong with the other patients. They're all in a trance or something – like zombies. Their essence has been removed. I realize that we've been tricked! The doctor has lured us into a trap. The place is like a concentration camp! Instead of testing our blood he is going to inject us with a serum that will make us zombies too. I have this hopeless feeling that there is no way out of this. No-one can hear us. There are no phones. I think "Oh my God, Mommy will die and they won't be able to let me know!" I hear the doctor's footsteps coming down the hall and I wake up in a sweat.

Interpretation and theoretical commentary

So here we have a sequence of historical and psychological "events" that point to an early trauma and its defense. First, we have the early traumatic abandonment that Mary and I were uncovering, then the dream of the terrified motherless baby fading into space that appeared in connection with this exploration, then the "breakthrough" of forbidden dependency feelings in the transference, the violent

resistance to this implied in the acting out of the food binge (with its seductive daimonic voice), and finally the dream of the Trickster-doctor who seduces her into the zombie-hospital and the accompanying thought that "Mommy will die and . . . I won't know it." I would ask the reader to hold these themes in mind while I briefly review some literature which illuminates the nature of anxiety and splitting in cases of early trauma.

The nature of Mary's anxiety

The first thing that helps us to understand this case is the nature of Mary's anxiety. Both Winnicott and Kohut have pointed out that a certain level of "unthinkable" anxiety originates at a symbiotic stage of child development where the child is totally dependent on the mother as a kind of external metabolizing organ of psychological experience. The mother's role is to help mediate experience, and this means especially to help metabolize anxiety. It is as though the infant breathes in psychological oxygen through "lungs" supplied by the mother. What happens, then, when suddenly the mother is gone? Winnicott puts it this way:

> [for the baby] the feeling of the mother's existence lasts x minutes. If the mother is away more than x minutes, then the imago fades, and along with this the baby's capacity to use the symbol of the union ceases. The baby is distressed, but this distress is soon *mended* because the mother returns in x + y minutes. In x + y minutes the baby has not become altered. But in x + y + z minutes the baby has become *traumatized*. In x + y + z minutes the mother's return does not mend the baby's altered state. Trauma implies that the baby has experienced a break in life's continuity, so that primitive defences now become organized to defend against a repetition of 'unthinkable anxiety' or a return to the acute confusional state that belongs to disintegration of nascent ego structure.
>
> We must assume that the vast majority of babies never experience the x + y + z quantity of deprivation. This means that the majority of children do not carry around with them for life the knowledge from experience of having been mad. Madness here simply means a *breakup* of whatever may exist at the time of *a personal continuity of existence*. After 'recovery' from x + y + z deprivation a baby has to start again permanently deprived of the root which could provide *continuity with the personal beginning*.
>
> (Winnicott, 1971b: 97; emphases in original)

In the case of Mary, the dream image that emerged of what must have been her long-forgotten x + y + z deprivation was that of a little girl falling into space, with her arms outstretched in a silent scream for her mother, with no supply of oxygen – no connection to the "mother" ship. Anxiety over the lost mother-connection returns in the second dream where she is trapped in the zombie-hospital. Her central anxiety there is that her mother will die and she will not know it. Again, Winnicott has taught us that many *dreads* of this kind are really encoded *memories*

of things that have already happened before full ego-formation (see Winnicott, 1963: 87), and if we apply this insight to Mary's dream, we might surmise that her mother's "death" is *something that has already happened emotionally many times*, even though she doesn't "know it" and even though her actual mother is still alive. In other words, the zombie-hospital is a "place" where she will be anesthetized to the loss of the mother – where she will lose all psychic connection to this fact. This will be assured by the Trickster-doctor who will administer his mind-altering serum.

Translated into Jungian language, we might say that an "unthinkable" level of anxiety results when archetypal energies fail to be humanized and the child is left at the mercy of the Terrible Mother as well as the Good Mother archetype. But this language *does not capture the emotional essence of this experience for the child who is now our patient*. Heinz Kohut comes closer when he calls this anxiety "disintegration anxiety." It is, he says, the "deepest anxiety man can experience" (Kohut, 1984: 16). It threatens the total annihilation of one's very humanity – the outright destruction of the human personality. To prevent this destruction, we might say that an archetypal "force" comes to the rescue. This archetypal force represents a self-care defensive system which is far more archaic and devastating than the more common level of ego-defenses. We might think of this figure as "Mr. Dissociation" himself – an emissary from the dark world of the unconscious, a true *diabolos*. We find him in Mary's material in two places – first, as the diabolical "voice" of her food binge, and second, as the Trickster-doctor, seducing her into the zombie-hospital where she will be forever separated from her life and from the mother's "death." We will come back to these appearances in a moment.

Two levels of trauma's inner world

The disintegration anxiety which Mary carried inside her body is the kind of anxiety that we must imagine got its start in her very early life before a coherent ego was formed. So, when this anxiety starts to come up again, it threatens to *fragment* the personality, and the nature of dissociation required to prevent this is more severe and archaic than the more "benign" forms of dissociation we associate with neurotic conflict. For the neurotic, the return of dissociated shadow-material creates anxiety, but this material can be recognized and integrated, leading to an inner *coniunctio oppositorum* and greater wholeness of personality. *This is because the neurotic has a place within his psyche for repressed material.* It is different with the victim of early trauma. For these patients, disowned material is not psychically represented but *has been banished to the body* or relegated to discreet psychical fragments between which amnesia barriers have been erected. It must *never* be allowed to return to consciousness. A *coniunctio oppositorum* is the most terrifying thing of all, and the dissociation necessary to insure the patient against this catastrophe, is a deeper, archetypal split in the psyche.

Attacks on transitional space and its replacement by fantasy

In order to accomplish his necessary dismembering of experience, we might think of our diabolical imago as operating in two areas of experience. The first of these is the transitional space *between the ego and the external world of reality.* The second is the inner symbolic space *between various parts of the internal world.* When operating between ego and world, our diabolical figure tries to encapsulate the personality in a kind of counter-dependent self-sufficient bubble. He (or she) seems to function in that "transitional zone" between inner self and outer world – precisely the interface where Mary's traumatic anxiety was experienced before her ego had formed. Winnicott has helped us to understand that when "unthinkable" trauma occurs, something dreadful happens to this transitional space. Internally there is a split in the ego (the classic schizoid position) but there is a corresponding split in the "potential space" where the personality is alive between illusion and reality. This "transitional space" is the place where the child learns how to play and use symbols.

Repeated exposure to traumatic anxiety *forecloses transitional space,* kills the symbolic activity of creative imagination, and replaces it with what Winnicott calls "fantasying" (Winnicott, 1971b). Fantasying is a dissociated state, which is neither imagination nor living in external reality, but a kind of melancholic self-soothing compromise which goes on forever – a defensive use of the imagination in the service of anxiety avoidance. My patient Mary was seduced into this "limbo" many times by her wistful self-soothing daimon, sadly fantasying about and idealizing the mother she never really had – rewriting history to deny at all costs her underlying despair and fury.

Following from these considerations, psychotherapists must be very careful, with patients like Mary, to distinguish between genuine imagination and fantasy, which is the self-soothing activity of the daimon. This self-soothing really amounts to a self-hypnotic spell – an unconscious undertow into non-differentiation to escape conscious feeling. Here a retreat into "oneness" replaces the hard work of separation necessary for "wholeness."[1] This is not regression, as we like to think of it in the service of the ego, but "malignant regression"[2] – regression which suspends a part of her in an auto-hypnotic twilight state[3] in order (so our diabolical figure thinks) to assure the survival of herself as a human person.

In the dream material of the trauma victim, this preserved personal spirit is often represented as an innocent "child" or animal appearing in tandem with the caretaking side of our self-care system – like the dying baby calling out for its mother, for example, or the patient and her food daimon in their nightly trysts. Looked at from the standpoint of the patient's survival, even Mary's food daimon is a kind of guardian angel who watches out for the deprived part of herself and cares for it (feeding it with substitutes) as long as the vulnerable creature never wants to leave its comfortable prison and emerge into the world (or come down into the body). Here we have a structure in the psyche which is simultaneously infantile and very grown up, innocent and jaded at the same time.

Psychotherapists who have worked with people like Mary will confirm how utterly vulnerable, uninitiated, needy, and infantile they are, on the one hand, and how haughty, inflated, arrogant, know-it-all, and resistant they are on the other. This inflated inner defensive structure, like a "king-baby" or the "queen-baby," represents the unholy marriage between the caretaking self and its infantile object. It is extremely difficult for patients to give up these omnipotent inner self/object units in the absence of genuinely satisfying early experiences of dependency.[4]

As applied to our case, this would mean that Mary would have to give up her self-care illusions – the fantasy world in which she and her mother existed in a kind of blissful dual union, bathed in goodness and innocent "love," needing no-one else (including her therapist). Into this comforting illusion she would have to let the horrific reality of her actual abandonment by her real mother, in stark contrast to the illusory Good Mother she never had and never would have. She would also have to mourn all the unlived life that her self-care system had cut her off from. This would mean the dual sacrifice of both her God-like self-sufficiency and the innocent demands associated with it. In Melanie Klein's language, she would have to give up her manic defense and begin to mourn the loss of her objects, entering the "depressive position."

We know, however, that this process never happens without the release of much of rage and aggression – and this is exactly what I was beginning to feel in my counter-transference reaction to Mary's food binge. We might say that I was beginning to wrestle with her daimon, our diabolical figure. I could feel his grip on her and his hatred and suspicion of me. I could also "see" him in the diabolical Trickster-doctor of Mary's zombie-hospital dream. I could see how he had lured the dream-ego into an ostensible place of healing, now revealed as a concentration camp enclosure full of bloodless wraiths, their human essence removed, injected with de-humanizing "zombie-serum."[5]

Dissociation and attacks against linking in the inner world

In Mary's dream, the Trickster-doctor lured her into a hospital on the pretense of testing her blood, but his "intention" was to turn her into a zombie – to take away her "essence," to put her into a trance. This is one of the major effects of the dissociative defense and involves a temporary dismemberment of experience – an inner separation of the ego or "de-cathexis" of its reality functions in the interest of psychic numbness. This involves an attack on the very capacity for experience itself, which means "attacking the links" (Bion, 1959) between affect and image, perception and thought, sensation and knowledge. The result is that experience is rendered meaningless, coherent memory is "disintegrated," and individuation is interrupted.

The most interesting current theory about trauma's effects on the psyche takes into account how difficult it is for us humans to *process* certain aspects of our experience (see Eigen, 1995). Work by clinicians such as Henry Krystal (1988) on trauma and affect, Joyce McDougall (1989) on psychosomatic disorder, Frances

Tustin (1990) on autism, have combined to help us understand that "whole" experience is a unity of many factors and that *integrated* experience is not always easy. One researcher (Braun, 1988), for example, describes four aspects of experience along which dissociation can occur, namely *behavior, affect, sensation* and *knowledge* – otherwise known as the BASK model of dissociation. In dissociative disorder, any of these aspects can be split within itself or the usual links among them or between them can be severed.

The normally integrated components of experience include both *somatic* and *mental* elements – affects and sensations from the body, thoughts, images and cognitive mechanisms in the mind, as well as a mysterious "meaning" dimension which has to do with whether something can be integrated as a part of one's personal identity and narrative history. Related to this dimension of meaning, and rarely discussed by clinicians, is that animating *spirit* at the center of all healthy living. This spirit, which we have described as the transcendent essence of the self seems to be compromised in severe trauma. It is never annihilated completely because, presumably, this would be the literal death of the person. But it may be "killed" in the sense that it cannot continue living in the embodied ego. Or it may be put in "cold storage" in the unconscious psyche or take bizarre forms in the (mad) mind.

For experience to become *meaningful* requires that bodily excitations, including the archaic affects of infancy, be given mental representation by a transitional parental figure so that eventually they can reach verbal expression in language and be shared with another person. This process of mediation of archaic affects, their eventual symbolization and shared expression in language, is the crucial element in the personalization of all archetypal affects, including those of early trauma. Winnicott describes personalization (the opposite of de-personalization) as being related to the gradual process of "indwelling." Indwelling occurs as the mother repeatedly "introduces and re-introduces the baby's mind and psyche to each other" (Winnicott, 1970: 271). It is interesting that Winnicott does not say what part of the self "indwells" – the personal spirit perhaps?

In trauma, affect-experience is simply too much to bear. Splitting is necessary. Whole experience is dismembered. The links between the BASK elements of experience are attacked by the archaic defense. Events and their meanings are disconnected, or perhaps the diabolical inner tyrant convinces the child's ego that the unbearable events are no longer happening to "me." In severe cases, experience loses all dimensionality. The child no longer attributes meaning to his perception at all. Unbearable infantile affects and sensations from the body are not permitted to acquire symbolic mental representation. The result is an inner world in which archaic affects and their fantastically elaborated archaic objects remain unnamed and disconnected from personal meaning or significance. Primal affects have not been modulated, humanized, and personalized through the usual projective/identificatory processes so well described by Winnicott and others. The result is psychosomatic illness or what Joyce McDougall referred to as "alexithymia" – patients who have no words for feelings and who as a result are

"dis-affected" or in the language of the current discussion, "dis-spirited" (cf., McDougall, 1985).

In less severe cases, dissociation is not as severe and the inner world is not as persecutory. Archetypal fantasy takes over and replaces imaginal engagement with the outer world. A rich inner world sometimes develops and access to the positive side of the Self and its numinous energies support a fragile ego, albeit "defensively." This "schizoid" picture is prognostically more favorable for analytic therapy, because it means that the positive side of the archetypal world is embodied in infancy and early childhood. If a safe intermediate "play" space can be found, and if the *sanctum originalis* can be re-contacted in metaphor and symbol, rebuilding can begin and enough trust can be established so that the negative affects can also begin to be tolerated and worked through.

Archetypal defenses, then, allow for survival at the expense of individuation. They assure the survival of the person, but at the expense of personality development. Their "goal" as I have come to understand it, is to keep the personal spirit "safe" but disembodied, encapsulated, or otherwise driven out of the body/mind unity – foreclosed from entering time and space reality. Instead of slowly and painfully incarnating in a cohesive self, the volcanic opposing dynamisms of the inner world become organized around defensive purposes, constituting a "self-care system" for the individual. Instead of individuation and the integration of mental life, the archaic defense engineers dis-incarnation (dis-embodiment) and dis-integration in order to help a weakened anxiety-ridden ego to survive, albeit as a partially "false" self.

The Trickster and archetypal defenses of the self

As we have already seen in Mary's food addiction, her compulsion seemed to be "personalized" in the unconscious in diabolical form as the seductive food daimon, on the one hand, and in the figure of the Trickster-doctor on the other. Jung himself was interested in the psyche's Trickster energies and how they related to compulsive and addictive trends. For example, in his alchemical studies, he compared the possessing "spirit" of compulsion to the alchemical sulphur, a substance associated with hell and the Devil as well as with the poisonous, crafty, and treacherous Trickster figure of Alchemy, Hermes/Mercurius. Like all ambivalent Self-figures, Mercurius, the Trickster-god was ambivalent, a paradox, and the source of healing as well as destruction (see Jung, 1955: para. 148). This fact is symbolically demonstrated in his winged staff, the caduceus, with two opposing serpents twined around it, one containing poison, the other the antidote. So, as Alchemy says, the darkest, vilest of inner figures, the very personification of evil itself "was destined to be the medicina" (Jung, 1955: para. 148). This is the mystery of the ambivalent figure of Mercurius and of all ostensibly "evil" things in the psyche. Jung was impressed all his life by the paradoxical role of evil in delivering people from darkness and from suffering.

The Trickster is a well-known figure in primitive cultures and perhaps the most

archaic god-image known in mythology (see Hill, 1970). He is present from the primordial beginning of things and hence is often pictured as an old man. His essential nature is quixotic, ambivalent – like Hermes/Mercury (one of his personifications). On the one hand, he is a killer, amoral and evil, often identified with powerful underworld daimons or animals. He is responsible for bringing pain and death into an Eden-like paradisiacal world. But he is also capable of great good. Not uncommonly, he is a psychopomp, an intermediary between the gods and men, and often his diabolical nature is precisely what is necessary to help initiate a new beginning – like, for example, Satan as the Trickster-snake in the Garden of Eden, tempting Eve into the act of knowing which ended mankind's participation mystique and started (mythologically speaking) the history of human consciousness.

The Trickster's paradoxical nature, combining two opposing aspects, often makes him a *threshold* deity – a god, if you will, of transitional space. This was true, for example of the archaic Roman god Janus, whose name means "door" and who, by facing both ways, was the god of all gateways and passageways (see Palmer, 1970). As patron of all entrances, he is also the protector and promoter of all *beginnings* – hence also our January, the beginning of the year. But he is also the god of exits, celebrated at the year's harvest, and early cults in his name worshipped Mars, god of war. In the Roman Forum, his temple had two sets of swinging doors. When the doors were closed, Rome was at peace. When the doors were open, there was civil war. So Janus, like all Tricksters, embraces a pair of opposites.

We find this same two-facedness in the earliest ambivalent imagery of Yahweh, the Old Testament God who is also a two-faced Trickster. Yahweh's left hand is one of divine wrath, vengeance and jealousy – sending flood, disease, and death to persecute the Israelites. Conversely, his right hand is one of mercy, love and protection. But frequently Yahweh's hands don't seem to be coordinated and Israel suffers more of his wrath than his mercy. Gradually, through the suffering of the people, and especially his chosen servants, Moses, Joshua, Jacob, Noah and Job, Yahweh reaches a kind of "depressive position" and integrates his aggressive and libidinal nature. This is the meaning of the rainbow in the flood myth and of the covenant between Yahweh and the nation of Israel, secured in the Ark and "written upon the hearts" of his people.

The problem of Yahweh's right and left hands being either integrated or dissociated speaks to another interesting aspect of the Trickster figure. This is the fact that the Trickster often dissociates a part of his body which then leads a kind of independent existence. In some tales he dissociates his anus and gives it a task, which it then fails to perform whereupon he foolishly punishes it, thereby causing himself great suffering. In the Winnebago cycle, the Trickster's right arm quarrels and fights with his left and sometimes he sends his penis off to rape the daughter of a neighboring chief. In one story, he stupidly mistakes his enormous penis for a flagpole to no end of hilarity among the assembled tribespeople watching these antics.

All these mythological traditions show the Trickster as both diabolical and symbolical. As a threshold deity, he either dissociates or associates various inner images and affects. He links things together or he tears them apart. Changing his shape at will, he is either creative or destructive, transforming and protective, or negating and persecutory. He is totally amoral, like life itself, instinctual, undeveloped, a stupid blockhead, a practical joker, a hero who aids mankind and changes the world (see Radin, 1976).

In his incarnation as Mary's food daimon, he seduced her ego into addictive eating binges and other aberrant distractive activities and away from any struggle with reality. This inevitably put her into an "altered state." As her Daimon-lover he had access to the inflating archetypal energies of the inner world itself, and like a veritable Phantom of the Opera, he seduced Mary with his "music," drawing her ineluctably into a web of aggrandized, melodramatic fantasy – but out of creative living, with its struggles, frustrations, and disillusionments. In this way, we can imagine that his "intention" is to encapsulate the threatened personal spirit within a world of illusion, in order to prevent it from being dismembered in a too-harsh reality.

Needless to say, the Trickster is a formidable adversary in the working-through process with patients like Mary. Often in this process we must struggle with our own diabolical impulses, developing enough neutralized aggression to confront the Trickster's seductiveness in the patient and in ourselves, while at the same time maintaining "rapport" with the patient's genuine woundedness and need. This struggle constitutes a genuine "moment of urgency" in the therapeutic process and many treatments have been shipwrecked on the Scylla of too much confrontation or the Charybdis of too much compassion and complicity with the undertow of the patient's malignant regression. If the patient's traumatized ego is to be coaxed out of its inner sanctum and inspired to trust the world again, a middle way will have to be found between compassion and confrontation. Finding this "middle way" provides both the daunting challenge and the enormous opportunity of psychotherapeutic work with the victims of early trauma.

2

FURTHER CLINICAL ILLUSTRATIONS OF THE SELF-CARE SYSTEM

> The false God changes suffering into violence. The True God changes violence into suffering.
>
> (Simone Weil, 1987: 65)

In the vignettes that follow, other facets of the self-care system are explored, especially its role as Protector, guardian, and sometimes tyrannical imprisoner of an anxiety-ridden child-ego. After each clinical example, there is a brief interpretive comment and in the second case (Gustav) a more extended description of how traumatic memory is recovered through the unfolding of a dream series in psychotherapy. A final case (Patricia) illustrates the "return" of the personal spirit to the body during an advanced stage of grief work in analysis. The chapter concludes with some theoretical speculations about psychosomatic illness and the self-care system's role in the splitting of mind and body.

THE LITTLE GIRL AND THE ANGEL

One of the most moving stories about the spirit-preserving role of the self-care system and its guardian Self was reported by Edward Edinger in the course of his audio-taped lecture series on the Old Testament at the Los Angeles Jung Institute (see Edinger, 1986). The story apparently originated with the New York analyst Esther Harding who knew the person in England to whom it happened. It goes as follows:

> A mother sent her young daughter, aged 6 or 7, to her father's study o[illegible] the morning to deliver an important message. Shortly thereafter the da[illegible]rived on came back and said "I'm sorry mother, the angel won't let me [illegible] and a deep Whereupon the mother sent the daughter back a second time, w[illegible] fantasy world result. At this point the mother became quite annoyed at h[illegible]wicked "aunt"), a imaginative excess, so she marched the message over to [illegible]no loved to listen Upon entering, she found her husband dead in his stu[illegible]
> and sanctuary for her. I say

This story brings home to us how the psyche even her inner world had partly emotion. Certain affects simply cannot be proc[illegible]out four years while she was a