

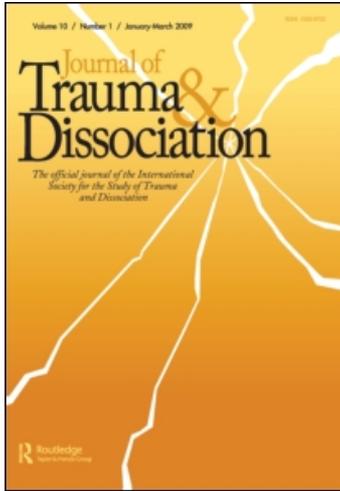
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Narcissism, a Relational Aspect of Dissociation

Elizabeth F. Howell, PhD

ABSTRACT. Pathological narcissism is an inevitable result of trauma-generated dissociation. It is also a relational aspect of dissociation, for in dissociative psychopathology the mutuality of relationships, both interpersonal and intrapsychic, has collapsed in significant ways. Dissociation of both aggression and dependency characterizes the “closed system.” While an open system allows interaction with the outside and transformation of the individual through interactive interchange with another, a closed system precludes transformation and intersubjectivity. Grandiose, domineering self-states may be understood as procedural, somatoform, dyadic enactments. These working models of attachment are at the core of much of the narcissistic entitlement, grandiosity, domination, and self-sufficiency that are so often found in dissociative disorders and in narcissism. It is possible to have a real impact on the closed system of narcissistic psychopathology by providing a safe attachment within the therapeutic relationship, and empathizing with the expression of self-protective aggression while containing its destructiveness. As a safe at-

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tachment figure with expertise, the therapist has the opportunity to facilitate positive transformation. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]

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The mythological Narcissus spurned the overtures of all who wanted to be close to him. Incapable of needing others, Narcissus's life became a closed intrapersonal system, an internal hall of mirrors. And, he drowned in his own reflection. The legend does not tell us if Narcissus suffered disorganized attachment or trauma, but, if he lived today, those would be likely antecedents for his condition. While the Greeks thought the cause of Narcissus's problem was punishment from the gods, we can see it today as the result of dissociative processes.

This article is not intended to survey or explain the vast literature on narcissism. However, much of this literature has overlooked the role of dissociation. It is the thesis of this article that pathological narcissism is an inevitable result of trauma-generated dissociation.¹ This does not mean that all persons with dissociative disorders are, as a whole, excessively narcissistic. However, parts of them are. In this article, the term "narcissism" is used to refer to pathological (1) preoccupation with the self, survival, and self-esteem; (2) lack of recognition of the other's separateness (or lack of intersubjectivity); (3) isolation, being closed off from external influence—a closed system; (4) unilaterality; (5) false self processes; (6) excessive use of other people (or other parts of the self) as narcissistic or self-objects; (7) a sense of omnipotence; and (8) excessive grandiosity. While not always manifest, the grandiosity so characteristic of narcissistic personality disorder is always an important part of a personality system in which dissociation is prominent. All of these aspects of narcissism just mentioned are linked with dissociation. Dissociation and pathological narcissism are inextricably intertwined, each reflecting aspects of the other, each implying the other. As one lessens, so does the other.

Although this article refers to dissociative identity disorder (DID), the application of the concept of dissociation will not be limited to DID. For example, Fairbairn's schizoid self (1952), with its split part-selves,

is clearly dissociative. Furthermore, Fairbairn's description of schizoid patients is also remarkably similar to Kohut's description of narcissistic patients (Grotstein & Rinsley, 2000; Sutherland, 2000; Robbins, 2000). Fairbairn observed that schizoid individuals have a sense of inner superiority (1952) and that both grandiosity and idealization increase as a function of the severity and chronicity of the dissociative processes. Not surprisingly, Fairbairn (1935/1994) worked with children who had been sexually abused.

Fairbairn's views on the schizoid self can be partially synthesized and integrated with more modern approaches to dissociation. In Fairbairn's theory, impossibly frustrating and disappointing attachment figures are internalized and split in intrapsychic structure. One way of interpreting his model is in terms of dissociated self-states. Another might be in terms of multiple, but unlinked, working models which anticipate and, in a way, make intelligible, the terrors, needs, and satisfactions generated by frightening and unpredictable attachment figures. In either case, the individual who is burdened with too much defensive dissociation is doing too much of the work in defining reality, alone. In the extreme, the individual will see the external world as isomorphic with the internal world, and one that will be understood primarily by projection and projective identification—a closed system. This is one meaning of narcissism: developmentally, there was no other to rely upon, only the self. Other meanings of the word, "narcissism," such as grandiose over-valuation of the self, may also derive partially from this inherent need for self-sufficiency.

When a child must dissociate parts of the self in order to maintain attachment to an abusive or frightening caretaker (Blizard, 1997a; Bromberg, 1994; Fairbairn, 1952; Ferenczi, 1942; Howell, 1997), this forecloses open expressiveness of the self as well as an open vulnerability to the real behaviors of the other. As this process progresses, the self becomes more and more a self-contained system. Open responsiveness to the caretaker is replaced by a set of expectations and responses that unconsciously and self-protectively allay terror and "work" interpersonally, often by placating or otherwise "managing" the frightening attachment figure (Schwartz, 2000). The true vulnerability of a real relationship has been replaced by the "internal object," which predicts, and in a way, provides a defensive buffer against the psychic impact of the behavior of the frightening attachment figure. The intense attachment to internal objects contributes to the narcissistic self-sufficiency, omnipotence, and grandiosity.

The term, “internal object” (see Ogden, 2001 for an especially sophisticated treatment of this topic), may be misleading in giving the impression of a literal transportation of something external into the intrapsychic arena. Rather, in effect, the self has modified itself, such that parts of the self now have a specifically designated function to be caretakers to the self, a function that often involves mimicry of the caretaker.

In this sense of narcissism, the self is all there is. Self-care is provided by parts of the self, not by the outside interpersonal world. This means that the behavior and intentions of others will be misinterpreted for the worst, and/or overidealized; that it will be hard to “get through” to or to make a real impact upon such a person; and, conversely, the person is often unaware of the profound effect she can have upon others. In this way, pathological narcissism is a *relational* aspect of dissociation. In dissociative psychopathology the mutuality of relationships, both interpersonal and intrapersonal, has collapsed in significant ways. Relationality, which assumes linking, puts the emphasis on relationships, on the interconnectedness of parts of the self, and of selves to each other, such as in family, and community (Schwartz, 2000). Severe dissociation severs not only internal links, but interpersonal ones as well. There is a correspondence and reciprocal relationship between the intrapsychic and the interpersonal. It is the connection to the outside, the interpersonal, which enables greater communicative and collaborative interaction of self-states, or self-reflectiveness, in the intrapsychic system. And conversely, less dissociation promotes greater interpersonal mutuality and harmony. When the acknowledgment of dependency on attachment figures is significantly undermined, a closed system develops.

CLOSED VS. OPEN SYSTEM

Fairbairn (1952) recognized the relationship between schizoid (or dissociative) processes and narcissism. He contrasted the closed system of internal objects and the parts of the self that are attached to them, to an open system that allows for the transformation of the individual through interactive interchange with an attachment figure. An open system assumes interaction with, and influence from, the outside. A whole is more than the aggregate of its parts because it is in constant interaction with, and thus continually transformed by, the environment. Fairbairn (1958) observed that

A real relationship with an external object is a relationship in an open system; but, insofar as the inner world assumes the form of a closed system, a relationship with an external object is only possible in terms of transference, viz., on condition that the external object is treated as an object within the closed system of inner reality. (p. 381)

Here “external object” refers to an attachment figure, a term originally used by Freud to refer to the “object” toward which the drive is directed. By definition, a closed system precludes interpersonal intersubjectivity, the mutual recognition of separate, self-reflective and agentic selves. Lack of awareness of one’s impact on others characterizes the closed system. For instance, Terry, a patient with DID, who was prone to fugues and who had recently been actively suicidal, failed to keep scheduled phone contacts while traveling on business. It did not occur to her that her therapist might be extremely concerned and worried about what had happened to her. Such occurrences are understandable in terms of the early life history of many traumatized patients, a history in which their responses, feelings, and wishes may not have been important to their attachment figures. However, one of the tasks of therapy is to help such patients understand how their behavior really does impact upon others in the present. The closed system also precludes interstate intersubjectivity, that is, the awareness of the contextual interdependence and interrelatedness of parts of the self, which comprise personal depth. This is because there is not an adequate, internalized, empathic standpoint from the outside that can link aspects of the self. Transformation then would involve making an attachment that breaks into the closed system, such as in good psychotherapy, healing both chronic dissociation and narcissism. Therapy needs to offer an opportunity for transformation.

THE SELF-CARE SYSTEM

The attachment system can be understood as a psychological system for combating stress and modulating stressful arousal (Lyons-Ruth, 2001). The attachment system cannot work adequately in traumatic attachments, in which the attachment figure fails to provide a protective shield against the dangers of the environment, or is, herself, dangerous. Since the attachment system functions as a buffer against extreme fear-

ful arousal, the effects of its failure will be profound, potentially attacking the linkage of states and creating dissociated self-states.

Kalsched (1996) posits the “self-care system” as a mechanism for defending the self against traumatic attachments and providing a supplement to the scarce supplies available in the interpersonal environment. Substantial reliance on the self-care system is a consequence of a failure of the attachment system (Richard Chefetz, personal communication). The threat of “unthinkable” agonies and the terror of going mad (Bromberg, 1998; Winnicott, 1963) activates the self-care system, which operates by using dissociative defenses, such as splitting, psychic numbing, trance states, self-hypnosis, and projective identification. The self-care system splits off the parts of the self that experience these unbearable traumas. Not only does it restoratively create missing aspects of the needed attachment relationships as aspects of the self, it also uses such quasi-delusional methods as perceptually “blinking out” threatening figures. The self-care system then provides two important things: (1) an imaginative use of omnipotence to purvey hope and (2) a self-structure that provides an automatic, effective, and often lifesaving, coping strategy in a frightening or abusive interpersonal environment. Nonetheless, it also leads to the narcissism of a closed system.

The self-care system generates a sense of psychic stability by creating the illusion of sources of protection and comfort. Under conditions of abuse, neglect, or gross insensitivity, an inordinate degree of self-sufficiency is required of the young child. Because this is generally more than the child can genuinely muster, she may invent an omnipotent protector, helper, or inner caretaker (Beahrs, 1982; Bliss, 1986). For example, Janice, a DID patient who was brutally sexually abused, isolated, and periodically subjected to severe neglect and terror as a young child, described how she would create friends and protectors of the rocks and bushes, convincing herself that they would care for her. This illusion of self-parenting is an important part of the self-care system. Speaking of Fairbairn’s conception of the schizoid position and the “phantasmal accommodations for survival” that the infant must make in situations of danger, Grotstein (2000) observes, “Thus, in withdrawing, the infant becomes his own imaginary parent. In addition, the infant must exaggerate his need for inner grandiosity and exhibitionism (relating through showing), in order to compensate for the absence of special meaningful parental confirmation” (p. 138).

As I see it, the grandiose self is a special instance of the self-care system. The construct is used somewhat differently by Kohut (1971) and Kernberg (1975). Bromberg (1983) defines this structure as “a core pat-

terning of self-other representation designed to protect the illusion of self-sufficiency at all costs . . ." (p. 362). A person with narcissistic personality disorder fiercely depends upon this structure for a sense of identity. In my view, the grandiose self is an aspect of the self-care system as applied to interpersonal relationships. It has the function of providing the mirroring, admiration, and sense of appreciation that the caretakers could not, thus supplementing an inadequate primary attachment relationship. However, the grandiose self does not have the transformative capability that an attachment figure does. Because this self-mirroring is illusory, always tantalizing and never enough, it can become increasingly addictive, foreclosing acknowledgement of dependency.

The self-care system is self-protective and compensatory, rather than relational. It cannot gain understanding from experience (Kalsched, 1996). Because it functions protectively to prevent retraumatization, the self-care system strenuously resists transformation. The illusions of the self-care system are only temporarily helpful, and must be continuously replenished. Without a benign-enough connection to the interpersonal world, hope cannot last. The child needs a real caretaker who can respond to his needs for comfort and protection. The self-care system is necessarily narcissistic and dissociative. In Ferenczi's (1931) eloquent description:

. . . [An aspect] of this process of self-splitting is the sudden change of the object-relation that has become intolerable, into narcissism. The man abandoned by all gods escapes completely from reality and creates for himself another world in which he, unimpeded by earthly gravity, can achieve anything he wants. Has he been unloved, even tormented, he now splits off from himself a part which in the form of a helpful loving, often motherly, minder commiserates with the tormented remainder of the self, nurses him and decides for him; and all this is done with deepest wisdom and most penetrating intelligence. He is intelligence and kindness itself, so to speak a guardian angel. . . . But in the moment of a very strong, repeated trauma, even his guardian angel must confess his own helplessness and well-meaning deceptive swindles to the tortured child and then nothing else remains but suicide, unless at the last moment some favourable change in the reality occurs. This favourable change to which we can point . . . is the fact that in his traumatic struggle the patient is no longer alone. (pp. 237-238).

For patients who have not experienced a caring parent, the therapist may offer the first experience of not being alone.

The construct of the self-care system can be helpful in understanding the function of internal persecutors. It is often noted in the dissociation literature that protector parts frequently end up as persecutors. The problem is that the self-care system can only seek care from the self. One reason that the protector becomes a persecutor is that there has been more persecution than protection from the outside; an imitation cannot be better than what it imitates. The protector becomes the persecutor in part because there never was enough real protection—only that in fantasy.

Over-reliance on the self-care system is a consequence of the failure of the attachment system. Next, we will examine certain aspects of the attachment system in more detail, concentrating on disorganized attachment (D attachment).

ATTACHMENT THEORY: DISORGANIZED ATTACHMENT

Bowlby and his followers initially identified three patterns of attachment: secure attachment and two insecure attachment styles: anxious avoidant and anxious resistant. The latter two styles are ways of dealing with grief pertaining to the threat of losing attachment or actual loss. They are understood to be internally consistent coherent strategies. A fourth, later-described category, disorganized (D) attachment (Main & Solomon, 1986), is associated with maltreatment or gross insensitivity on the part the caretaker. When the child faces the dilemma of both fearing and seeking safety from the caretaker, her attachment strategies are likely to become disorganized. As a consequence, multiple, segregated, incompatible, working models of attachment may develop.

Probably the most important concept in Bowlby's (1969, 1980) attachment theory is that of internal working models, which are mental representations of the self and the attachment figure, particularly concerning the infant's expectations regarding the availability of the attachment figure. Bowlby (1980) proposed that under extremely difficult attachment conditions, multiple, segregated, working models could develop. While Bowlby originally applied this concept to the first two types of insecure attachment, today it is understood to be more apropos to D attachment. In a review of the literature on disorganized attachment and dissociation, Blizard (2003, this issue) has noted how a convergence of the literature from various fields indicates that dissociative

processes are essential to disorganized attachment. Indeed, there is a striking functional similarity between the concepts of segregated, incompatible, internal, working models and dissociated self-states.

It appears that D attachment may be an antecedent of both dissociative disorders (Liotti, 1992, 1999) and personality disorders (Lyons-Ruth, 2001). In her research, Lyons-Ruth, (2001) found that disorganized infants could be divided into two groups: D-approach and D-avoid resist. The mothers of these infants tended to have behavioral profiles that were helpless or hostile, respectively. As they grew toward school age, these formerly disorganized infants reorganized their attachment behaviors such that they began to control their mothers and other people in particular ways. These controlling behaviors were grouped into a hostile, punitive style and an over-solicitous, 'caregiving,' style. Like their mothers, these children also become hostile or helpless. Despite the controlling behavior, the child's attachment system fails to regulate fear arousal, because, in either pattern, dominance and submission are not balanced. As a consequence, these internal working models "are also likely to be imbued with more traumatic affects, [and] may be particularly susceptible to dissociation of either the hostile or helpless component . . ." (p. 44). Lyons-Ruth (2001) concludes that

The developmental transition from disorganized behaviors to controlling forms of attachment behaviors over the preschool period supports the notion that one "grows into" a borderline or narcissistic stance through a complex series of alternative developmental acquisitions . . . to construct increasingly polarized coercive or role-reversed "false-self" relations with the parent . . . (p. 45)

Segregated internal working models imbued with traumatic affects of hostility and helplessness seem to lead to personality styles that play out the same interpersonal dynamics. These dissociated internal working models, which develop from the same environmental context as does the self-care system, contribute to keeping the closed system closed.

HOSTILE, DOMINATING, GRANDIOSE SELF-STATES AND HELPLESS, DEPENDENT ONES

How does this play out in personality structure and psychodynamics? In both DID and narcissism, the child had to accommodate to the om-

nipotent domination, grandiosity, silencing, exploitation, terrorizing, and objectification of attachment figures, because these were the caretakers on whom the child depended. The relationship dynamics are re-enacted *intrapsychically* by parts of the self that seek to dominate, silence, and terrorize each other, as well as *interpersonally* (Schwartz, 2000). Yet, this process requires *two* states in interaction. Hostile and helpless internal working models, each holding affects dissociated from the other, are bound together in a dominant/submissive relationship.

Writing of narcissism from a Kleinian perspective rather than in the language of the dissociation literature, Rosenfeld (1972), articulates this interaction between dissociated hostile and dependent self-states,

It appears that these patients have dealt with the struggle between their destructive and libidinal impulses by trying to get rid of their loving, dependent self and identifying themselves almost entirely with the destructive, narcissistic part of the self which provides them with a sense of superiority and self-admiration. (p. 174)

Recognition of a meaningful interpersonal relationship would threaten the hegemony of the omnipotent part. Thus, the destructive aggression of this part is directed against recognition of such a relationship and against any part of the self that would desire as much. The success of treatment depends upon gaining access to the part that can recognize dependency. Yet, this part seems to be enthralled by the hostile, omnipotent part, “as if one were dealing with a powerful gang dominated by a leader” (p. 174). When the patient begins to make progress, there is often a negative therapeutic reaction, frequently personified by dream figures such as Mafia members or delinquent adolescents. In some of these patients, the omnipotent destructive part is linked to a split-off, psychotic, delusional structure. This delusional part may seduce the more “sane” part, which recognizes emotional dependency, to join it in turning away from the need for connection to others. The ability of the therapist to rescue the dependent, sane part depends upon the patient’s gradually becoming conscious of the omnipotent destructive part. This part “can only remain all-powerful in isolation . . . the patient becomes gradually aware that he is dominated by an omnipotent infantile part which . . . prevents him from growing up, by keeping him away from objects who could help him to achieve growth and development.” (pp. 175-176). We may add to Rosenfeld’s description the more current perspective that focuses on the persecutor state’s self-care role to protect the patient from the abusive parent.

For both dissociative patients and narcissistic ones, the attachment of the dependent part to the grandiose, omnipotent part of the self has replaced the capability for trust of another person to a significant degree. In both cases, the omnipotent part, like the original perpetrator, is often out of control, as it attempts to control. Hostile self-states function as trauma membranes (Putnam, 1989), designed to protect the individual from memories of the trauma, and defending against the experience of helplessness. Schwartz (2000) describes hostile self-states as “personified narcissistic and sociopathic defenses” which defend against dependency, vulnerability and guilt (p. 265). Indeed, Schwartz (1994) has conceptualized DID as “a chronic trauma syndrome and as a particular variation of narcissistic personality organization involving an over-reliance on omnipotent defenses . . .” (p. 189). However, an important distinction is that while narcissistic patients may identify themselves almost entirely with the destructive, grandiose narcissistic part, dissociative patients often deal with the same dilemmas by dissociative shifts between attachment and self-protection, both of which are needed for survival (Blizard, 2001). While narcissists direct their contempt upon other persons, dissociative patients, just as often, direct contempt upon other parts of the self.

In DID, the persecutor self-state, which holds much of the fury for the system, often feels omnipotent. Since domination feels good, it is self-reinforcing. Rage, which cannot be contained or expressed by a helpless self-state, may be located in and/or “projected” into a persecutor state which may in turn unleash massive furious punishment onto the helpless state. The fact that the helpless state often does not want to know about traumatic childhood experiences renders it unappreciative of the intended-to-be-helpful activity of the protector/persecutor state and perpetuates the dissociation as well as the grandiosity of the persecutor state. By allying with the omnipotence of the persecutor, the helpless state does not have to feel the terror and may be shielded from memories. The narcissistic grandiosity of a protector/persecutor part in a highly dissociative person is comparable to grandiosity of a highly narcissistic person without DID. (All case vignettes are composites, with any identifying details significantly altered.) For example, Sally is a patient with DID who has a grandiose, dominating part, called Devil. This part persecutes the helpless, host, self-state with brutal self-injury, and will at times erupt into demonic sounding laughter, sounding much like the original perpetrator. Devil boasts to Sally about how powerful he is. Yet, when the therapist tries to engage him, and to encourage him to wield his power by defending Sally against domineering people, he

disappears. He does not come forward to defend. To the contrary, the only real interpersonal defense comes from a precocious nine-year-old part within the intrapsychic system. Devil exerts tremendous power toward counterparts that are weak and helpless; and it is this relational configuration that affords Devil his feeling of power. Devil is only powerful internally. Because Devil apparently originated from a childhood identification with the original perpetrator, in reality, this part has only the power of a child.

Now, let's compare Devil with Jim, a highly narcissistic patient. Jim tends to be domineering, aggressive, humiliating to others, and intensely grandiose. His grandiosity has, at times, seriously compromised reality testing. For instance, he asked to be considered for the CEO position of his company, despite being a lower-level administrator. However, his bombast, like that of Devil, the malevolent self-state of Sally, was only hot air. One day, when his wife threatened to leave him, and he knew she meant it for real, this domineering man suddenly became a whimpering, terrified little boy. He repeatedly begged his wife not to leave him and promised to be good. Unlike Sally, he was not amnesic for the switch from a dominating to a helpless self-state. He reported that his wife had been totally surprised by the sudden emergence of this frightened, childlike self-state. Jim's dominant, grandiose self-state, which was usually evident, appears also to have been based on an identification with an abusive, aggressive father. From infancy, Jim was chronically treated like a narcissistic object, even though his family appeared to be well functioning. As a result of chronic, gross, parental insensitivity, Jim may have been plunged into nameless terror, leading to irresolvable attachment dilemmas and disorganized attachment, which eventually evolved into a personality organization structured by alternating hostile and helpless states. Perhaps because there was apparently only mild, overt trauma, these alternating states became only partially dissociated, without amnesia, rather than fully dissociated. In contrast, because Sally had experienced much more severe and continuous abuse, she developed alternating hostile and helpless states with full dissociation. In both cases, the bombast worked to intimidate other parties: notably, in the intrapsychic arena with Sally, and in the interpersonal arena with Jim. In both cases, the power of the aggressive part derives from the relational dynamics. However, the feeling of omnipotence is an *illusion* because it is based on a *denial of the relational configuration in which the power of the dominant part is dependent upon the weakness of other parts.*

**THE CONCEPT OF "IDENTIFICATION"
WITH THE AGGRESSOR**

In accordance with the self-care system, various models of psychic structure (for example, Freud's harsh superego and Fairbairn's antlibidinal ego) converge on the notion that a part of the self, often an internal persecutor, has become autonomous in monitoring behavior and thought. A part of the self has the "job" cordoning off the experience and/or expression of affect and knowledge that could be overwhelming if known and dangerous if expressed. This part, often called a protector/persecutor (Howell, 1997; Kalsched, 1996), usually starts out as a protector, but ends up as a persecutor. It may be modeled on, and anticipate the behavior of, the abuser, and it generally holds a substantial portion of the rage of the system.

Although these dominating states are maintained according to the self-care system, how do they originate? How does it happen that an "internalized object" becomes a part of the self that can take executive control, as is often seen in DID? Present-day attachment theory can give us more ways of thinking about the process of "identification with the aggressor," which may rely on processes of somatoform dissociation, and enactive, procedural, relational knowing.

Lyons-Ruth (1999) writes of the development of unconscious, procedural, relational knowledge of how to be with another person, which is a product of two-person interactions. These procedural ways of being with another constitute the larger portion of our lives. They may not have been (and may never be) verbally coded, even though they may influence the use of words. They reflect implicit models of relationships, including interpersonal, defensive maneuvers which respond to the attachment figures' own defenses and attachment systems. These "enactive procedural representations of how to do things with others" (Lyons-Ruth, 1999, p. 385), are internal working models of attachment, in Bowlby's sense. When contradictions among implicit and explicit communications between caregiver and child have not been examined or confronted, these internal working models cannot be linked with one another. These models can develop into segregated systems of attachment, in other words, dissociated, enactive, procedural ways of knowing how to be with another.

In Lyons-Ruth's model, when there is mutuality and interdependence in a relationship, much mirroring and validating of the other's experience, affect, and perspective occurs. This allows the child to articulate her own perspective, as well as to learn the roles of both persons in a

connected fashion. In contrast, in traumatic attachments and in dominant/submissive relationships, this does not happen. In traumatic, procedural learning, there is no opportunity for interchange of perspectives, no modification of the aggressor's behavior in response to the victim's plea for understanding, and the roles of victim and aggressor cannot be linked. Hence, they remain rigid and dissociated. There ensues a very constricted internal working model of the aggressor controlling the victim, and a similarly constricted model of the victim complying with the aggressor (Blizard, personal communication).

Traumatic experiences are often encoded in procedural repertoires and somatosensory modalities, rather than in declarative, explicit memory (Courtois, 1999; Terr, 1994; van der Kolk, 1996). Under normal circumstances, procedural and declarative memory systems may be dissociated (Lyons-Ruth, 1999), in the sense that knowing how to ride a bicycle is not the same as *knowing that* one can ride it. In traumatic memory, the declarative is likely to have been more or less knocked out, leaving intact only the procedural repertoires (Erdelyi, 1994).

Like any other attachment, traumatic attachments may involve mimicking an attachment figure. For example, in their descriptions of fixations in trauma, van der Hart et al. (2000), write of "traumatic imitation which Rivers (1920) referred to as *mimesis*, i.e., 'the motor or effector side of the process whereby one animal or person influences another unwittingly'" (p. 47). They give an example of a wounded soldier who had a posttraumatic twitch in his jaw that must have mimicked the agonized gasping for breath that he had witnessed on the dying face of a beloved comrade. In chaotic, neglectful, or abusive familial environments, the child may focus intently on the abuser's postures, motions, facial expressions, words, and feelings in hopes of calming or pleasing the aggressor and preventing harm. As a result of being intensely attached to the aggressor (often much more intensely than if there had been no abuse), the child's mimicking of the aggressor's behavior is a form of enactive, procedural, dyadic learning. All other stimuli and aspects of self-experience, such as proprioceptive cues or awareness of any affect other than fear, may be irrelevant. While the child learns the roles of both abuser and victim procedurally, this learning is adaptively focused on the *abuser's* behavior and experience. In his famous paper, "Confusion of Tongues Between the Adult and the Child," Ferenczi (1949) described how sexually abused children, are "paralyzed by enormous anxiety," which compels them to "subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious they *identify with the aggressor*"

(my italics, p. 228). He emphasizes that, “One part of their personalities, possibly the nucleus, got stuck in its development at a level where it was unable to use the alloplastic way of reaction but could only react in an autoplasic way by a kind of *mimicry*” (my italics, p. 228).

Autoplasic means changing the self. The child’s sense of agency, identity and integrity of self are diminished in the process of identification with the aggressor, while at the same time, the aggressor’s behaviors and ways of understanding the world seem to replace what has been lost. Coates and her collaborators (1991, 1995, 1997) have described similar traumatic mimicry in boys with gender identity disorder, involving trauma-driven compulsive mimicry of the behavior of the mother. The authors have highlighted how this is an “experience of being taken over from the outside” (1997, p. 301).² (See Howell [2002] for a more detailed description of these phenomena involving mimicking of the aggressor.)

The phrase, “being taken over from the outside,” describes so well the assault on the self by trauma. In the extreme, this has been called “soul murder” (Shengold, 1989). In his book, *Soul Murder*, Shengold reminds us of a scene in Orwell’s *1984*, in which O’Brien, who is Winston Smith’s boss, torturer, and brainwasher, says to Winston, “You will be hollow. We will squeeze you empty, and then we shall fill you with ourselves.” This creation of the feeling of an inner emptiness is an important difference between identifications which are the products of secure attachments and those which are traumatic. Non-traumatic identifications add to a person’s already coherent identity, as well as to repertoires of skills, behaviors, and understandings (Bonomi, 2002). In contrast, trauma-related identifications detract from a person’s identity. The aggressor’s goals and behaviors appear to have replaced the child’s own agency, initiative, and rage, because, as a consequence of peritraumatic dissociation, the latter have not been adequately synthesized among various self-states. It is not that a part of the aggressor’s identity has literally become part of the child, but that the child mimics out of attachment and dissociates out of terror. These rageful self-states, which may also embody attachment to the aggressor, are likely to be dissociated from more situationally adaptive ones.

In sum, these dominating and rageful self-states, which we generally think of as deriving from “identification with the aggressor,” and which often embody rage, contempt, and omnipotence, may arise as procedural, imitative, dyadic enactments. They arise from the confluence of trauma and attachment, and may be understood as internal working models in Bowlby’s sense. These working models may lie at the root of

some of the “narcissistic, ” unilateral, and entitled behavior that dissociative and narcissistic patients can exhibit. If the discordant attachment paradigms are not examined, then the dissociated self-states of “isolated subjectivity” (Chefet, 2002) remain like two identifiably magnetized poles that are contiguous, but unjoinable.

TRANSFORMATION: AGGRESSION AND DEPENDENCY

As a result of its protective function, the self-care system resists transformation. When the person is no longer in a dangerous interpersonal environment, these self-protective functions persist. The behaviors and intentions of real others are perceived through the lens of internal experience and thus, are likely to be misinterpreted for the worst or over-idealized. It is hard to “get through” to or to make a real impact upon such a person. Conversely, the person’s awareness of their effects upon others will be curtailed because behaviors are largely mimicked and not under conscious control. Thus, in order to heal both chronic dissociation and narcissism, therapy needs to offer the opportunity for transformation. Aggression and dependency are pivotal issues.

When there is significant dissociation, certain self-states have the dedicated task of feeling rage and aggression. Watkins and Watkins (1989) stress the importance of recognizing and working with the malevolent ego states. Beahrs (1982) and Blizard (1997b) emphasize how accessing the vitality of the person in these states is the key to overcoming resistance. Empathic confrontation (Chu, 1998) is an invaluable way to recognize and contain dissociated aggressive states. This two-stage process first establishes empathic resonance and understanding about the subjective meaning of an aggressive, destructive behavior. This is followed by a containing confrontation. The empathic framing makes the message easier for the patient to hear. Containment of the patient’s destructive aggressiveness also models for the patient that the original perpetrator’s aggression was unacceptable.

Winnicott described how the patient’s experience and expression of aggression toward the therapist, who in turn does not retaliate, can enable the therapist to become “real in the sense of being part of shared reality and not just a bundle of projections” (Winnicott, 1971, p. 88). This transformation involves a very important psychological shift away from a relatively primitive form of interacting, “. . . that can be described in terms of the subject as an isolate . . .” (p. 88), in which the object is expe-

rienced primarily in terms of projection and identification. The object (the other person) becomes real by virtue of having been killed in fantasy, surviving, and not retaliating. The experience of unfettered and unpunished aggression toward a loved one has often been absent in dissociative and narcissistic patients. An important event of this kind, which undoubtedly influenced his theory, occurred in Winnicott's early childhood. In response to his father's mildly humiliating taunts, he "bashed flat" with a croquet mallet the nose of one of his sister's dolls, and his father "good-temperedly" repaired the doll's face in his presence (Winnicott, 1989, pp. 7-8). Thus, when things go well, the child (and the psychotherapy patient) learns that his aggression can be tolerated and that the attachment figure is "real."

Only when the other is perceived as "real," and separate from the self, can dependency be acknowledged. Only then can the closed system begin to open up. Excessive dependency and fear of dependency are ubiquitous for traumatized patients. Because these issues often bear the pejorative connotations that dependency has in our culture, it is vital to deal with them delicately (Steele et al., 2001). Therapy cannot be a transformative experience without recognition of dependency.

Rosenfeld elucidated the link between recognition of the domination of hostile, omnipotent states in the personality and the ability to access the "sane," dependent part. The dissociation of dependent and aggressive states from the rest of the personality, which Fairbairn portrays as the split between the libidinal and the antilibidinal, and Lyons-Ruth describes as helpless and hostile, characterizes both dissociative disorders and narcissism.

CONCLUSION

Pathological narcissism is an inevitable result of trauma-generated dissociation. The omnipotent self-sufficiency of the closed system depends upon pathological dissociation, and generates various forms of pathological narcissism. A closed system precludes intersubjectivity. Conversely, a fully textured sense of subjectivity, of "I," depends upon adequate linkage between self-states, which is only possible if the self is an open system, with a capacity to acknowledge, relate to, and depend upon other people, as separate from the self, that is, under conditions of intersubjectivity.

Grandiose, domineering self-states, often understood as "identification with the aggressor," appear to arise from procedural, somatoform,

dyadic enactments. These working models are at the core of much of the narcissistic entitlement, grandiosity, domination, and self-sufficiency that are so often found in dissociative disorders and narcissism. As an attachment figure with expertise, the therapist has the opportunity to invite formerly hidden and omnipotent parts of the self to come out in the open. This increased, real connection to the outside contributes to the potential for transformation.

NOTES

1. In this article, all uses of the words “narcissism” and “dissociation” are intended to mean pathological narcissism and dissociation.

2. “Identification” seems inaccurate in that it neither conveys this quality of being emotionally overtaken (Eagle, 1999), nor the quality of feeling “the same as,” rather than “similar to” the original traumatizing attachment figure, which would be more characteristic of “identification,” in the usual sense (Blizard, personal communication).

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