As I think and write more about the subject of dissociation, I find the idea that the mind consists of multiple self states increasingly useful in my clinical thinking. I am aware that many self psychologists and intersubjectivists are leery of this relational idea, believing that it runs contrary to central self psychological beliefs that the aim of treatment is a greater sense of cohesion and continuity of self experience and that a divided self is indicative of pathology. Accordingly, I would like to suggest some ways that thinking clinically about self states, while also acknowledging the universal striving toward a sense of integrity, can enrich self psychology.

First, I find that patients find interpretations about their different “states” experience-near. In my view, most people don’t experience themselves as having one self but, rather, as having quite distinct “modes” which come into being in different relational contexts. Indeed, individuals who feel “unitary”—in the sense of being stuck in one narrow state rather than able to flow freely through many—can usually be diagnosed with some kind of obsessional or other psychiatric disorder. They are not, as Slavin and Kriegman (1998) suggest, as able to adapt to an inherently conflictual relational world.
Second, I think a view of the mind as composed of self states contributes to our efficacy in working with empathic failures. As contemporary self psychologists steeped in infant-mother research, we think of ruptures as involving bi-directional dysregulation of self and interactive regulatory patterns within complex systems of interaction. I think we gain even greater clarity if we further understand an empathic break as a sudden shift into a disjunctive self state—a self state which grew out of some kind of relational trauma from the past and which has its own affective “truth,” behavior, sensations, knowledge, and transference. Learning more about all the different aspects of a particular state allows us to empathize more deeply with the patient’s traumatic experience, present and past, in toto.

Third, as Philip Bromberg (2006) has argued, our many patients on the dissociative spectrum are not yet psychologically capable of true conflict. With these patients, our empathy is more accurate when we speak in terms of their different states of mind than in terms of their conflicting longings or motivations. In other words, we can “reach” a dissociative patient more effectively when we say “I’m aware that last session you felt so-and-so, and today you feel so-and-so” (because we are preserving the necessary separation of disjunctive affect states) than if we say, “you feel conflicted or ambivalent about so-and-so” (which can retraumatize the patient by melding together affect states too disjunctive yet to be tolerated together).

Fourth, I think that speaking with patients about their “states” keeps us at the “forward edge” of treatment, because it allows patients to explore troublesome aspects of their personalities without fearing that this is all we see of them. When patients become overly identified with one aspect of themselves or another, it should be our job to recognize and “hold” as many parts as possible and to remind them of their wholeness.

The concept of multiple self states is also in keeping with current neuro-scientific findings about the dissociative structure of the brain: for example, the discontinuity between different brain states (which reflects the operation of different brain systems) and the non-linearity of state changes (the abruptness of which may reflect the intensity of one’s unsymbolized affect). The concept of multiple self states is also integral to what Allan Schore (2003) calls “right-brain to right-brain state-sharing,” in which certain implicit self states of the patient resonate (in part through rhythmic matching) with certain implicit states of the analyst. This, to my mind, is a particularly powerful new way of conceptualizing unconscious affective communication in the analytic encounter.
The concept of multiple, unintegrateable self states is also “at home” in our postmodern world with its focus on relativism, constructivism, non-linear dynamic systems, uncertainty, and paradox. I think that we, including our patients, are all simmering in the same cultural broth and that our theoretical metaphors should capture to the best of our ability where we are in time. Life for all of us in 2009 is complex, uncertain, and paradoxical, and, as Winnicott (e.g., 1951) has said, paradox is not to be resolved.

REFERENCES


Susan H. Sands, Ph.D.
1664 Solano Ave.
Berkeley, CA 94707
susansands@earthlink.net