Functional Dissociation of the Self: A Sociocognitive Approach to Trauma and Dissociation

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Functional Dissociation of the Self: A Sociocognitive Approach to Trauma and Dissociation

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ABSTRACT. A novel sociocognitive theory of dissociation and dissociative disorders is proposed. The model, which is both theoretical and clinical, is based on “functional dissociation of the self.” A new concept is introduced in this paper: the sociological self. While the sociological self may have cultural and societal dimensions, it is regarded here as a universal phenomenon rather than a culture-bound one; as an individual psychological instance rather than a sociological concept per se. It is proposed that the main sources of dissociation are trauma-related detachment of the sociological and psychological selves and the subsequent amplification of the sociological self. Thus, effective psychotherapy must curtail the enlargement of the sociological self and reactivate the psychological self. It is hoped that this conceptualization will contribute to efforts both toward understanding the everyday dissociation of the average contemporary individual and toward developing novel...
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KEYWORDS. Trauma, dissociation, dissociative disorders, psychotherapy

INTRODUCTION

The term “sociocognitive” has generally been associated with the erroneous idea that dissociative disorders are iatrogenic (Spanos, 1994). In fact, a sociocognitive etiology does not necessarily imply iatrogenesis, and therefore need not disqualify any psychiatric disorder. Thus, we introduce herein our (noniatrogenic) sociocognitive theory of dissociation and dissociative disorders.

Our model, which is both theoretical and clinical, is based on “functional dissociation of the self.” The model proposed in this paper aims to describe dissociation from the point of view of both the external observer and the subject. Our approach is concerned with facilitating the active participation of the patient in the psychotherapeutic process, a sine qua non of the effective treatment of dissociative disorders (Kluft, 1993). We introduce a new concept in this paper: the sociological self. While the sociological self may have cultural and societal dimensions, we regard the sociological self as a universal phenomenon rather than a culture-bound one; as an individual psychological instance rather than a sociological concept per se. Although the sociological self may function as an interface between the individual and society, it is not a kind of collective or relational self in the social-psychological sense (Sedikides & Brewer, 2001). We hope that our conceptualization (which needs to be expanded in subsequent studies) will contribute to efforts toward understanding the contemporary individual and toward developing novel psychotherapeutic approaches which might shorten the length of treatment of dissociative disorders.

SOCIOLOGICAL AND PSYCHOLOGICAL SELVES

We propose that two aspects of mental life should be considered as crucial to understand mental health: the sociological self and the psychological self (Table 1). Cooperation between them leads to healthy
TABLE 1. Some properties of sociological and psychological selves

<table>
<thead>
<tr>
<th>Sociological self</th>
<th>Psychological self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imitation, modeling, copying</td>
<td>Creativity</td>
</tr>
<tr>
<td>Dogmatism</td>
<td>Acceptance of probabilities</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Resilience</td>
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<tr>
<td>Conservation</td>
<td>Capacity for building new associations</td>
</tr>
<tr>
<td>Periods of time</td>
<td>Time as continuity</td>
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<tr>
<td>Shared use</td>
<td>Ownership</td>
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<tr>
<td>Metaphors, symbols</td>
<td>Signs</td>
</tr>
<tr>
<td>Single-focus awareness</td>
<td>Multi-focus awareness</td>
</tr>
<tr>
<td>Fixation</td>
<td>Progression</td>
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<tr>
<td>Adjustment</td>
<td>Seeking for novelty</td>
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<tr>
<td>Negotiation</td>
<td>Choice</td>
</tr>
<tr>
<td>Ruling and being ruled</td>
<td>Voluntary participation</td>
</tr>
<tr>
<td>Collectivism</td>
<td>Individualism</td>
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<tr>
<td>Self-seeking</td>
<td>Compassion</td>
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<tr>
<td>Polarization</td>
<td>Synthesis</td>
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<tr>
<td>Reversibility</td>
<td>Constancy</td>
</tr>
<tr>
<td>Aggression</td>
<td>Fight for survival</td>
</tr>
<tr>
<td>Eclecticism</td>
<td>Authenticity</td>
</tr>
<tr>
<td>Distortion</td>
<td>Taking a fact as it is</td>
</tr>
</tbody>
</table>
adaptation. Developmental differences between the two selves, together with their concomitant contradictory sociological and psychological realities, pose basic dilemmas for the individual and, in our view, are the main sources of dissociation, both clinical and non-clinical.

Abuse and neglect during developmental periods inhibit the development of the psychological self but accelerate the development of the sociological self. In such a situation, one part (the psychological self) is saved as a hidden self and remains frozen in time, whereas the sociological self develops exclusively and to an extreme degree. Traumatic experience arrests the development of the psychological self, while all energy is devoted to the development of the sociological self. The result is a loss of balance between the two parts and an enduring enlargement of the sociological self, which exercises dominance over the psychological self. Sociological realities then motivate the person’s decisions and choices. The imbalance is not entirely negative: the shift in fact preserves the psychological self from the full impact of traumatic experience. Thus, while it restricts its overall functioning overall, it protects the psychological self from the more pathological development that traumatic experience would bring. Under normal conditions, the two developing selves would develop cooperative mutuality, whereas, under traumatic conditions, the hypertrophy of the sociological self results in polarity and to one’s denial of the other.

**TRAUMA, INCOMPLETE RESPONSE, AND EXPECTANCY OF COMPLETION**

Trauma is neither limited nor identical to a noxious event; there are both subjective and objective components of the situation. Thus, Fischer and Riedesser (1999) define trauma as the experience of vital discrepancy between threatening factors in a situation and individual coping capacities. Moreover, trauma is not merely a situational phenomenon, but a longitudinal socio-psychological process which develops in time and follows a course. A traumatic life event is, by definition, one that is not fully in accord with a person’s usual inner working models (Horowitz, 1976/1986). Trauma is characterized by extreme loss of control which is experienced by the subject as helplessness. It makes the subject’s conceptualizations of self and world questionable (Fischer & Riedesser, 1999).
Possible ways of response in a traumatic situation are rather limited. One way is to actually escape from this situation. Another is to process it to resolution. A third is dissociation of the experience, wherein traumatic experience is not processed adequately. Fischer and Riedesser (1999) assert that when existential threat is involved, an adequate response to a traumatic situation is not possible. This also relates, however, to what is required in successful trauma processing. The hallmark of trauma resolution is the opportunity and ability of the subject to adequately respond to traumatic experience. The adequacy of a response is measured by its contribution to the somatic, psychological, and social homeostasis of the individual.

If the subject attempts to process the experience and succeeds in resolving it immediately, the psychological self continues to function and develop in cooperation with the sociological self. In cases of a failed or limited impact, sub-clinical dissociation (the dissociation of everyday life) may result. However, if resolution cannot be reached in the immediate aftermath of a traumatic experience (if the process is interrupted), cooperation between the two selves starts to diminish from this point on. Subsequent traumatic experiences may exacerbate this rift to the point of causing the two parts to detach from one another. Thus, in our view, it is the inevitable fate of the sociological self to be able to adequately respond to trauma neither at the time of its occurrence, nor subsequently.

In the absence of immediate resolution of trauma, the subject will subsequently have to devote much energy to its processing. In doing so, the active memory handles past trauma as if it were occurring in the present (Horowitz, 1976/1986). This repetition is inevitable and each repetition generates a new version of the original traumatic reality. Each new reality contains cognitions which aim to provide a solution to the traumatic impasse. However, these cognitions are usually self-destructive, i.e., they do not lead to resolution. In striving for resolution, the sociological self expends copious energy to no avail. That is because trauma can be successfully processed only by the psychological self. When the person is able to process a traumatic experience immediately, this is done by the psychological self, which does not need to produce alternative or distorted versions of reality in coming to resolution.

Adequate response and survival is the task of the psychological self. The sociological self has no role during the survival phase of trauma processing: it operates in subsequent phases. If the psychological self functions suboptimally, reality perception changes and alter personalities form. While distorted reality leads to exclusion of psychological
self, unsuccessful survival leads to exclusion of reality and, subsequently, alter personalities intervene. The traumatic self (a specialized part of the sociological self) then tries to process the trauma in the context of a distorted reality. This fails, and phase two ensues: the sociological self produces further alter personalities, who try, in turn, to process the trauma.

The incomplete processing of trauma has three clinical consequences: loss of temporality, loss of sense of control, and increased or diminished interpersonal distance. The subject thereby loses the leading role in his or her own life drama. In our view, one of the most important points during the processing of trauma is not the issue of whether an adequate response is possible or not, but the degree of preoccupation about developing an adequate response. The subject devotes all his or her energy to this preoccupation and maintains an expectancy about “metabolizing” the trauma. This expectancy of exhaustive “metabolization” leads, instead, to resistance against processing trauma in psychotherapy (Ozturk and Şar, in preparation).

**TIME IN THE CONTEXT OF TRAUMA**

*The Time Dimension and the Perception of Reality*

Time is one component of the general perceptual background (Beere, 1995). All experience, all perception, occurs in and over time: the present moment comes from a past which leads to a future (Merleau-Ponty, 1962, cited in Beere, 1995; Stern, 2004). A traumatic situation does not end in objective time, when the traumatic event actually ends (Fischer & Riedesser, 1999). In fact, the experience is not even conceived as traumatic while the noxious event is happening. It becomes psychologically traumatic only after it is over. Traumatic experience belongs to the past, and yet each subsequent moment that trauma is processed it again becomes present.

The subject concentrates on the past traumatic experience in the present time when trying to process it (van der Kolk & van der Hart, 1991). The main differences between past trauma experience and its versions in the present time relate to time and context. Persistent past traumatic experience creates new and distorted perceptions of reality. The coexistence of multiple versions of perceived reality makes the processing of trauma difficult. The current version will be different from the previous
with each repetition and gradually detach from the original form. The most recent version functions as the final form for the time being. New versions of reality and new cognitions depend on the moment the trauma process is interrupted and the phase of the process in which the subject is stuck. These cognitions are generally futile, providing no solution. Consequently, the subject is unable to complete the processing of trauma.

The distortion of reality, while a part of the processing of traumatic experience, generally doesn’t concern the traumatic event itself. Despite the various overlays of new versions, the original perception of the traumatic event cannot be cancelled or distorted because a “native” copy is saved in the psychological self. Trauma needs to be processed in the psychological self. The severity and frequency of trauma, and related factors, lead to a search for solutions by the sociological self. However, there are distortions of reality in this domain. The sociological self cannot accept reality as it is: it transforms reality when developing narrative versions of it. The main purpose of this operation is to develop a tolerance of trauma and to maintain a sense of security (see also, Sullivan, 1953). By looking at himself/herself through distorted realities, the subject tries to determine his/her position in the face of trauma. When perceiving himself/herself in the context of distorted realities, the subject tries to achieve—albeit transiently—a sense of wholeness. Looking at himself/herself through a single and immutable reality impairs the sense of wholeness (see also, Bromberg, 1998). In contrast to this, the psychological self accepts the reality of trauma, despite noxious aspects, giving it a sort of “objective character.” When processing trauma in psychotherapy, work on the original form of the perceived reality is essential, whereas a focus on the intermediate versions renders psychotherapeutic work unproductive.

**Divided Time and Detemporalization**

The subject who detaches from the present moment is alienated in time. This has been called detemporalization (Beere, 1995). Alienation in time, however entails, alienation to everything. Detemporalization is the hallmark of all alienation. Time and time limits are related to the psychological self, whereas alienation to time facilitates the development of alter personalities in the sociological self. The importance of time distortion and its relationship to reality perception among traumatized dissociative patients was extensively described by Pierre Janet (van der Hart & Steele, 1997).
The psychological self is related to the present and future. The socio-
logical self, on the other hand, is a trauma-related self: its sense of pres-
ent time is shaded by the past. Its present time is affixed to traumatic
experience, compromising real present time. Thus, traumatic experi-
ence divides the time determined by traumatic experience from real
time. This division in the time dimension affects cognition as well:
cognitions in the traumatic time dimension will differ from those in ac-
tual time. This disintegration alienates the subject from time, confusing
past, present and future. In fact, the sense of time is lost (timelessness,
loss of time feeling).

**CONSCIOUSNESS, ALTER PERSONALITIES,
AND MODERATOR INSTANCE**

When traumatic experience is reevaluated by the subject in the pres-
ent, reality distortions may also interfere with the individual’s con-
sciousness (consciousness, control, vigilance, awareness). The subject
may even be alienated from his or her own traumatic experience.
Psychotherapeutic interventions cannot work under these circum-
stances. The processing of trauma and the elimination of pathological
formations require an adequate level of consciousness. In the psycho-
therapy of the stress response syndromes, the process of using con-
scious awareness of change is of central importance (Horowitz, 1976/
1986).

Traumatic experience is characterized by an inflationist proliferation
of solutions in the subject’s mind. These solutions are based on mental
representations of prior inadequate responses to other difficult experi-
ences. One of these options then takes priority for the index traumatic
experience, though it rarely leads to a solution. The subject attempts to
resolve the trauma by activating this mental representations in active
memory. The other options, likewise stuck in traumatic past time, are
relegated to inactive memory during these repetitions, either partially or
totally. The excluded options, related to the sociological self, form the
basis of alter personalities which may develop immediately or in the fu-
ture. Solution methods for recurrent traumatic experiences and repeated
cognitions gradually detach from each other. They become autonomous
inside the sociological self, and manifest separate domains. They lead to
the development of fragments or parts of the sociological self which
transform into alter personalities. The subject will try to use excluded
options, now formed into alter personalities, to solve future life problems.

We propose that the ability to perceive reality is not limited to the sociological and psychological selves. This is primarily the function of a separate psychological entity which plays the role of moderator. The moderator has three functions: perception of reality in relation to the cooperation between the sociological and psychological selves, management of psychobiological emotional systems (Panksepp, 1998), and control of emotions (Horowitz, 1976/1986; Horowitz, 1998).

**DOUBLE BIND AND DIALECTICAL THOUGHT**

Basseches (1980, cited by Fischer and Riedesser, 1999) proposes a further cognitive developmental stage to follow Piaget’s (1947) stage of formal operations: the stage of dialectical operations. Borrowing from Hegel (1948) conception of the dialectic, involving a contradiction between thesis and antithesis resolved in a synthesis, this stage involves integrative thinking which identifies contradictions and resolves them through concept formation at a higher level. Basseches regards this as the central activity promoting the development of a coherent self-system, through which the subject develops meta-schemas which subsume schemas specific to situations, thereby establishing continuity of action—a coherent narrative—in the personal life history. Trauma inhibits the development of these integrating meta-schemas.

Jaspers (1913) defined personalization as one’s experience that all psychological faculties (perception, body perception, memory retrieval, imagination, thought, feeling, etc.) belong to oneself. Intact personalization involves only one perception of reality regarding a given fact (person, situation, etc) in a given time period. One factor which disturbs personalization is the double bind (Bateson, Jackson, Haley & Weakland, 1956; Cattell & Schmahl-Cattell, 1974; Spiegel, 1986; Fischer & Riedesser, 1999). In a double-bind situation, the victim is repeatedly subject to a negative injunction, contradicted by a second injunction, both of which are enforced by punishment or signals that threaten survival. A third injunction prohibits the victim from escaping. A significant element in the theory is that one injunction may be articulated verbally, while a conflicting message is communicated via body language (Blizard, 2003).
We propose that the double bind is an inherent feature of every (interpersonal or impersonal) trauma (Şar & Öztürk, 2006). A double bind creates multiple perceptions of reality. These multiple and simultaneous perceptions of reality destroy personalization. To cope with this, the subject keeps the traumatic fact (person, idea, situation, etc.) at a distance or, alternatively, remains in an oscillating relationship with it. Trust increases personalization and awareness, whereas a double bind disturbs trust. A double bind prevents the subject from perceiving himself as a whole.

The subject perceives herself from the perspective of these multiple versions of reality. Although these perceptions may create opportunities for progression in some areas, they lead to impasses and negative cognitions in many others. The subject who processes trauma dialectically may be able to turn this situation in her favor to a certain degree, on condition that she take the necessary steps for herself. Otherwise, such processing would generalize the previously experienced double bind to her entire life.

A NEW DEFINITION OF DISSOCIATION

Trauma disturbs the cooperation of the sociological and psychological selves. We propose that, to a large extent, it is the sociological self, and not the psychological, which perceives a noxious event as traumatic. The sociological self is the main domain of alter personalities. The fragmented sociological self operates on multiple fronts when trying to buffer the effects of trauma. The various created alter personality states protect the psychological self.

There is a struggle between the sociological and psychological selves in dissociative conditions. The psychological and sociological selves of dissociative subjects deny each other, i.e., dissociation is based on denial. Remaining at a distance from the psychological self leads to alienation and to an enlargement and fragmentation of the sociological self. Even when a single-focused sociological self develops to an extreme degree, i.e., to the point of destructiveness, a covert rudimentary psychological self is kept alive. However, this condition entails a “decentering” (Modell, 1993) of the person.

The DSM-IV defines dissociation as a disruption in the usually integrated functions of memory, identity and perception of the environment (American Psychiatric Association, 1994). Clinically, this unintegrated
functioning may manifest as identity confusion or alteration, depersonalization or derealization, amnesia, dissociative somatic symptoms (i.e., conversion and other unexplained neurological symptoms), or any permutation or combination of them fluctuating over time (Steinberg, 1995). However, neither the DSM-IV definition nor descriptions of the clinical phenomenology convey a coherent understanding of dissociation except, perhaps, by implicitly invoking Pierre Janet’s construct of “diminished integrative capacity” (van der Kolk and van der Hart, 1989).

In his monumental book on childhood and society, referring to the importance of loss of “social mutuality” in lifelong underlying weakness of basic trust in some adult personalities and to the re-establishment of a state of trust as a basic requirement for therapy in these cases, Erik Erikson (1950/1963) stated wisely (pp. 248): “. . . the bizarreness and withdrawal in the behavior of many very sick individuals hides an attempt to recover social mutuality by a testing of the borderlines between senses and physical reality, between words and social meanings.” Thus, mutuality of internal world and external reality is of vital importance.

Thus, we propose herein a new definition of clinical dissociation. Traumatic experiences and, consequently, altered self-perceptions, impair the mutuality which normally obtains between the internal world and external reality. What results is altered perception of both self and reality accompanied by altered vigilance, awareness, control and concentration. In our view, at the level of clinical psychopathology, “depersonalization in the broad sense” is the hallmark of dissociation. We do not limit “depersonalization in the broad sense” to descriptive symptoms attributed to depersonalization (e.g., perceiving one’s extremities as smaller or bigger than they are), but rather intend to invoke a mechanism from “classical” European clinical psychopathology. This is “de-personalization” (loss of personalization) of the individual (Jaspers, 1913; Bleuler, 1916/1979; Scharfetter, 1991), characterized by a partial, reversible and transient loss of ownership of thoughts, affects, behavior and/or body.

In this sense, “de-personalization” is an inevitable prerequisite, accompaniment, and result of alteration of self and reality perception. However, our attributions at the level of clinical psychopathology should not minimize the importance of socio-psychological phenomena (e.g., identity formation). In this sense, de-personalization may also be interpreted as a phenomenon secondary to a decentered human existence unable to claim his/her presence.
This new concept of dissociation is an attempt to develop a definition which is in accordance with our overall model. The aim of this effort is to provide a guide for psychotherapy of dissociative disorders, i.e., the re-establishment of the harmony of the psychological and sociological selves of a depersonalized and decentered individual.

THE PSYCHOTHERAPY OF TRAUMA AND DISSOCIATION

From the Clinician’s Viewpoint

Most alter personalities contacted during the initial phases of psychotherapy have adverse features. The alter personality system renders the host personality passive. Characteristics of the psychological self are frozen in the host personality, blocking its further development. A goal of psychotherapy is the reduction of self-destructive features in alter personalities and the reactivation of positive features in the host personality.

There may be an unlimited number of different (distorted) versions of reality and even multiple identical “copies” of trauma-related cognitions in the sociological self. However, each trauma-related cognition has a single “original” in the psychological self which serves as a kind of ultimate “backup” for these copies. Psychotherapy works on the originals. In psychotherapy, the subject ought to evaluate the various “originals” in the psychological self but not the multiple distorted copies in the sociological self.

Trauma-related cognitions have the function of a cipher. Their originals may be “misplaced” or deleted spontaneously to some extent intentionally. Nevertheless, for each deleted “file” there will still remain an active cipher. The narratives in psychotherapy contain these ciphers which determine the missions of alter personalities: e.g., a child alter might carry a vitality cipher, while another carries a problem-solving cipher. These ciphers need to be “decoded” so as to be reused later by the therapist; e.g., in post-integrative treatment. However, this decoding process is a collaborative work of both patient and therapist.

Effective psychotherapy must curtail the enlargement of the sociological self and reactivate the psychological self. In fact, dissociation can be conceived as an attempt by the psychological self to come forward which is oppressed by the inflated sociological self. In treatment, contact with the psychological self constitutes the therapeutic window through which all further work will be done.
Trauma: A Sociopsychological Response

Trauma happens within a social network, a psycho-ecological reference system or sphere of influence, that centers around the immediate family, but then extends to other relatives, friends and other familiar people and, finally, to the social macro group (Fischer & Riedesser, 1999). The traumatized individual never stands alone, and so cannot solve the problem brought up by a traumatic event alone. Recovery happens in relationships, if at all (Herman, 1992). It is important how the community responds to the misery of the individual (Fischer & Riedesser, 1999).

In everyday life, every subject maintains interpersonal distances in concentric “orbits,” whereas, in dissociation, the social sphere of the person collapses into a “common pool” system, i.e., interpersonal distances are no longer kept in orbit, rendering the subject vulnerable to destructive attacks. Following trauma, the subject has difficulty distinguishing destructive environmental stimuli from helpful ones. Therapy aims to restore this ability (Fischer & Riedesser, 1999). In the dissociative mind, external reality is transformed into an internal world (Lar, Öztürk & Kundakci, 2002) so that dissociative disorders are non-interactive solutions (Crandell, Morrison & Willis, 2002). This is a “closed” system (Howell, 2003) in a person characterized by self care (Kalsched, 1996), social withdrawal and diminished relationships with the external world. Apart from traumatized members of overtly dysfunctional families, even an individual living in an “apparently normal” family (Öztürk & Şar, 2006) characterized by betrayal (Freyd, 1996), delegation (Stierlin, 1978) and pseudomutuality (Wynn, Ryckoff, Day, & Hirsch, 1958) has to maintain this closed system as an unsuccessful attempt of sociopsychological coping.

Trauma processing is both an individual and a social endeavor, a psycho-sociological activity (Herman, 1992). The subject has the need to express his or her opinions and emotions about past traumatic experience, especially if the trauma was within a relationship (Horowitz, 1976/1986). Trauma disturbs responsiveness, leading either to inadequate response or general unresponsiveness to both individuals and society, impairing the individual globally. Such disturbed responsiveness needs to be addressed in psychotherapy.

TRAUMA, SOCIETY AND THE SOCIOLOGICAL SELF

The evolution of the human psyche and of society have been closely connected throughout history and child abuse and neglect have been the
rule rather than the exception for many centuries in many cultures (de Mause, 1998, 2002). In our view, the sociological self is created by others through socialization over time. Thus, dissociation is initiated by society’s neglect of the psychological self. The social environment is usually in conflict with the psychological self, and so socialization primarily induces the sociological self through selective denial of some aspects of the psychological self. The individual’s dilemma involves handling both the psychological self and its psychological reality together with the different sociological self and its different psychological reality.

Culture and historical period both strongly influence the sociological self. Influences include well-established experiences, conditionings and traditions. The sociological self reconciles the individual with his or her culture, allowing for adequate adjustment to the culture, but also allows for the culture to control the individual from within. Traumatization facilitates society’s control of the individual. Society accepts the importance of trauma no more than it accepts the meaning of the individual. In contrast to this, the individual is prone to maximize the importance of his or her traumatic experience.

While the sociological self may have cultural and societal dimensions, we regard the sociological self as a universal phenomenon rather than a culture-bound one; as an individual psychological instance rather than a sociological concept per se. Thus, it is not a kind of collective or relational self in the social-psychological sense (Sedikides & Brewer, 2001). Although the sociological self may function also as an interface between society and the individual, its primary task is to save the psychological self from the destructive influences of other individuals and society. Thus, healthy relationships with other individuals and with society in general are dependent on a harmonic coupling of the sociological and psychological selves.

The extreme dominance of the sociological self leads to a socially dangerous and destructive style, the “reversible person” in our terminology. This is a type of person who may take contradicting interpersonal and social positions in an unpredictable manner. This is a condition between “everyday” dissociation and clinical dissociative disorder. A milder alternative might be losing him or herself in a dominant other; e.g., person, institution, ideology, etc. (Arieti & Bemporad, 1980).

**THE SOCIOLOGICAL SELF IN CONTEMPORARY SOCIETY**

While pointing to the relationship between individual psychopathology and society, Carl Gustav Jung (1912) underlined both the dis-
sociative character of “neurosis” and the reciprocity between the internal world of the decentered person and the external reality who is embedded: “Neurosis is intimately bound up with the problem of our time and really represents an unsuccessful attempt on the part of the individual to solve the general problem in his own person. Neurosis is self division.” Thus, any explanatory theory of human psychology and psychopathology needs to take the influence of the “Zeitgeist” on individual into account.

The position of the individual in society has changed over the twentieth century due to tremendous developments in the economy, social life, science, technology and politics. For the 19th century person, the focus of control was basically inside (Riesman, 1950). Thus, it is no wonder that Sigmund Freud’s theories were based mainly on instinctual drives (Battegay, 1987). Urbanization, industrialization and the development of mass media created a new type of individual who is increasingly influenced, infiltrated and even controlled by the social environment (Riesman, 1950; Gofmann, 1959), i.e., the psychological autonomy of the individual started to be threatened in a new and diffuse way.

In the face of this sociologically-based shift of locus of control to the outside (Ross, 1997), the psychoanalytic “ego psychology” movement after Freud searched for guarantees of individual autonomy. While extending psychoanalytical theory along psychosocial dimensions, these authors tried to describe not only psychopathology but the healthy development of the individual, who was believed to be “adjusted from the beginning” to the “average expectable environment” into which he or she was born (Hartmann, 1960/1975). The psychoanalytical “ego psychologists” assumed the existence of internal psychological forces which guaranteed the independence of human willpower both against internal instinctual drives and external environmental control: the primary and secondary apparatuses of ego autonomy. Concepts of “ego identity,” “identity crisis,” “negative identity” and “identity confusion” were introduced into psychiatry by one of the outstanding clinicians and theorists of this movement: Erik Erikson (1950/1963). Today, they are regarded as basic dimensions of trauma-related dissociative psychopathology (Steinberg, 1995), itself thought to be the result of diverse threats against the autonomy and the social, psychological, and somatic boundaries of the individual; in short, against the willpower and, indeed, the very existence of the individual.

From the perspective of science and technology, the emergence of automation and computers allowed for the human being to be easily recorded, listed, coded, tracked, even replaced, at some cost to the indi-
individual’s freedom, safety and self-esteem. In addition, economic inequalities between countries, between various parts of the community in the same country, abusive political systems, and the ongoing population increase of the world are significant threats that diminish our hope for a peaceful future. Millions of people have been killed by wars. All these events made the worth of the individual questionable; self-esteem and the basic sense of individual safety have been weakened. And so it is no coincidence that narcissism has become a core concept of a recent psychoanalytic movement; i.e., self-psychology (Kohut, 1971; Battegay, 1987).

Given these facts, it is important to realize that the “average expectable environment” the individual is born into is woven by the symbols of a sociological system (Lacan, 1981) which is not necessarily in accordance with the healthy adjustment of the individual. This is the most general context which facilitates the detachment of the sociological self from the psychological self from the onset of life. The properties of the sociological self (Table 1) are well designed for the socio-psychological survival of the individual, however, they place a hidden burden on the person and on society overall. Following this self-division, the subject cannot link his/her symbolizations to his/her willpower and reality. Thus, he/she can not perceive him/herself, other persons, events, attitudes nor thoughts as a whole and, consequently, cannot attribute meaning to them.

When these socio-psychological changes make an impact on close interpersonal and intimate relationships, any part of such relationships can rapidly lose its meaning for the other party; i.e., the individual can be easily rejected or abandoned. It is easier to leave someone or something (partner, religion, occupation, political opinion, etc.) than to acquire a new one. The loss of worth and meaning also facilitates boundary violations in interpersonal relationships. The socio-psychological survival of the individual in the current era depends increasingly on his or her ability to be a “political” creature; e.g., when necessary, he or she should be able to “hide the truth” and to keep “strategic” information as a secret; he or she should not easily trust relationships, and should be able to reverse positions. This type of individual, “the reversible person” in our terminology, has polarized or opposing attitudes and so may easily reverse positions; in fact, even his/her opponent behavior is nothing else than a kind of “radical conformism” (Zizek, 1992).

In our view, this polarized behavior is not Kleinian splitting, an effort to dissociate “the good” from “the bad” in order to preserve “the good” (Kernberg, 1975). The polarized behavior has links to insecure attach-
ment (Blizard, 2003; Howell, 2003), dependency (Steele, van der Hart, & Nijenhuis, 2001), attachment to the perpetrator (Blizard, 2001), and locus-of-control shift (Ross, 1997), but also has sociological origins (in our sense). Being phobic of their psychological selves, people with a hypertrophied and detached sociological self usually learn how to become skillful with it, to their own benefit, e.g., finding a special niche for their capacities somewhere within contemporary society. Individuals raised in today’s “apparently normal families” (Öztürk & Şar, 2006) may develop into three groups: (1) suggestible-obedient and easily controlled; (2) oppositional–creating conflict and fighting; (3) leadership-rigid behavior and thinking with controlling and domineering tendencies. Although all have “apparently normal” (i.e., subtly psychopathological) origins, suggestibility and “leadership” qualities can play an important role in the daily political task of controlling the public. When previously oppositional characters occupy the leadership, on the other hand, this may lead to a flourishing of abusive tendencies, even leading up to fascism on the national and international societal level.

Nevertheless, a recent screening study conducted on college students demonstrated that 8.5% of them satisfy sufficient DSM-IV criteria to yield a diagnosis of borderline personality disorder (Şar et al., 2006). It does not seem to be conceptually accurate to consider such highly prevalent “borderline behavior” in a non-clinical and relatively high-functioning population as a severe and lifelong “personality disorder.” Not surprisingly, a significant proportion (72.5%) of these subjects had a DSM-IV dissociative disorder. It is interesting that, in a recent psychobiological study (Reinders et al., 2006) on patients with dissociative identity disorder, listening to a trauma-script did not activate any cerebral perfusion change in positron emission tomography (PET) when in control of an alter personality; an excellent proof for lack of empathy in alter personalities; i.e., in the domain of the sociological self.

**CLINICAL AND RESEARCH IMPLICATIONS**

The development of this model arises out of the authors’ experiences doing long-term psychotherapy. Extended work with hundreds of dissociative inpatients and outpatients over the years in a university setting reveals great heterogeneity in patient recovery, and underscores the importance of the therapist’s attitude to the outcome. We conclude that
the quality of the therapeutic intervention increases or decreases resistance. Improvement is relatively quick and sometimes abrupt in cases where the appropriate approach can be found.

Treatment-resistant and crisis-prone dissociative patients helped clarify the model. We have focused our inquiries on the origin of the treatment barrier which seems to place the patient out of contact-impossible to reach. Repetitive crisis situations are inevitable without appropriate technical interventions to overcome the barrier. We perceived the barrier as consisting of repetitive and relatively simple psycho-behavioral patterns, below the potential psychological capacities of the patients, and thus conclude that it is a product of the sociological self. “Resistances of the traumatic self” is one example of such a barrier, and will be discussed in greater detail in a subsequent article (Öztürk & Şar, submitted).

We hypothesize that this barrier prevents us from making contact with a qualitatively different aspect of the patient: the psychological self. Thus, we recommend that treatment consist of two phases: an encounter with the sociological self; and then an encounter with the psychological self. Departure from this “agenda” may lead to therapeutic stalemate, with the patient labeled as “treatment-resistant.” The first phase requires appropriate attention to the sociological self, the source of treatment resistance. The sociological self needs to be seen, recognized and accepted. After overcoming the resistance of the sociological self, contact with the psychological self occurs almost spontaneously.

An encounter with the psychological self, and with its world, leads to global clinical improvement which may be relatively sudden. In our view, the world of the psychological self is characterized by absolute reality, with no reality distortions nor doubling of time in contrast to the transformations of reality that pertain to the sociological self.

The sociological self is not, however, a mere barrier to treatment which should be trashed. Indeed, it is crucially important in treatment. The psychological self is quite idle in dissociative patients, because it has “waited for a long time,” and one needs the sociological self to activate it. When harmony is restored between the sociological and psychological selves, the patient’s willpower is reconstituted.

Controlled empirical studies are needed to convincingly argue for the efficacy of any psychotherapeutic method. To envisage such a study, our psychotherapeutic approach would need to be described in greater detail which is beyond the scope of this article. Thus, our next study (Öztürk & Şar, in preparation) will focus on the description of “the
resistances of the traumatic self,” a logical extension of the theoretical model presented in this paper. We also hope to develop a standardized interview to more objectively assess the sociological and psychological selves of a given patient, a complex task which we hope we can pursue in the near future.

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