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Hi All,

As I've reflected on the many responses to the letter I shared—many of which I found quite moving—I've noticed that for those less accustomed to considering vulnerable traumatic affects (fear-terror, horror, disgust, anguish, shame, etc.) as such, it may be that much of what I wrote was lost in translation. So, I will write here with greater granularity.

I realize I am asking something of the community that is sometimes pointed at but in my experience rarely actualized, and that is to bear truly mixed feelings about ISTDP theory itself. We know that life expands or contracts in proportion to our ability to hold complexity, so I truly hope we can hold more complexity here.

My sense is that some of what was missed is due to diverging paradigms. In the traumatic stress paradigm, the dynamics of unbearable traumatic affects (terror, horror, disgust, shame, etc.) are central to theory, while in the ISTDP paradigm, the dynamics of painful reactive attachment feelings (rage, guilt, grief) are central to theory. My experience, both personal and professional, tells me that both paradigms reflect reality and are essential to clinical practice, but that each framework is missing key ideas contained in the other. While I'm focusing here on what ISTDP is missing, I've also sat through many trauma trainings and felt how limited the work becomes without a deep understanding of resistance, PSE dynamics, anxiety pathways, and the central roles of rage and guilt. As Richard Kluft writes—referring to the differences between dissociation as understood in trauma theory and in relational psychoanalysis, though the point applies here—"To conceptualize these two models as competitive, or to privilege one over the other, is realistic only in the minds of their loyalists. In clinical practice, these models address two different types and realms of phenomena. Both may afflict the same patient."

Rather than a paradigm shift, I think what is most helpful is a paradigm marriage. But this is hard to accomplish without the ability to "see" that the other group of ideas is describing phenomena our home model cannot account for. And to see, we need a willingness to name what has been obscured. Surely this is a worthwhile aim – it has already shaped ISTDP twice (first with the graded format, and again with the introduction of psychic integration, though the latter remains unelaborated).

I hope that anyone who is reading this, who treats serious trauma, and has openness to expansive dialogue about clinical practice, will try to 'see' the value of paying attention to those areas that feel fuzzy, those theoretical questions that are not really answered in a satisfying way in the traditional metapsychology. I hope we can collectively foster the opposite of dissociation: true curiosity.

I also want to emphasize that I am addressing the theory, the metapsychology, of ISTDP. Practice is an entirely different matter. Whether we consciously define it as such, we all practice integratively simply because our whole selves are the instrument of treatment, and none of the near-infinite magic of the human heart will ever be captured in a model. If I inadvertently cause

offense here, please know that I am directing my analysis at the metapsychology of ISTDP as presented in teaching and written works, not at any one person's clinical work.

What's tough about critiquing ISTDP theory is that it's such a powerful 'meta-model' that the language easily lends itself towards assimilating just about anything that is therapeutic. For instance, the clinical techniques across modalities that could fall under the concepts of 'defense restructuring', 'anxiety regulation', or 'pressure' are so broad that I'm not sure what is excluded, if anything. While the naming/framing of these over-arching principles is part of what makes ISTDP theory uniquely clinically useful, this broadness is obscuring those areas where classic ISTDP theory simply doesn't have much to say.

I was dismayed that the 'takeaway' from my letter amongst some was something along the lines of 'Davanloo already said all this and taught us how to work with it.' If there is a robust oral tradition in ISTDP that comprehensively addresses traumatic memory, dissociative processes, terror, horror, shame, and so forth, it's curious those considerations have never made it into the written works, or become core aspects of teaching. This is an affect-focused therapy after all, so we would be remiss to leave out those core trauma-induced affects. And why would we do so? Our patients need us to be able to see them, of course, and not dissociatively avoid the spaces they themselves cannot bear.

Let's focus for a moment on the affect of 'fear-terror.' The collective avoidance of fear-terror feels reminiscent of the dissociative processes we see in severely traumatized people. That there is no attempt in ISTDP to justify the exclusion of fear-terror or meaningfully distinguish it from the types/pathways of signal anxiety speaks to a defense that is operating at the level of theory. Rather than being discussed, fear-terror is simply absent, almost like a covert dissociative process is at work. Put another way, fear-terror is not just avoided in ISTDP theory, it is unsymbolized. And, as with all avoidance of reality, symptoms follow.

I wrote the previous letter for one primary reason: I feel profoundly protective of the people whose traumatic memories and associated affects are being treated as defensive, regressive, or a form of 'anxiety', rather than entirely legitimate and specific psychobiological injuries that require recognition and treatment. When the enduring effects of real unbearable experiences—that is, traumatic events—are singularly framed as defenses against reactive feelings, rather than being understood as terror-induced psychobiological disruptions to the integration of mind and body, it is difficult for therapists to attune to the needs of the patient. Put another way, if a catastrophic external event is treated as solely a trigger for unconscious attachment conflicts rather than as a rupture in self-continuity (a fear-terror injury to the mind), the survivor may feel blamed rather than understood, deepening their sense of fragmentation and alienation.

I received a back-channel response (shared with permission) that cuts to the heart of it:
"I am still digesting, but your letter has already influenced my clinical thinking. It helped me recognize how I caused a rupture with a trauma patient by treating her fear response as projection."

Another moment that illustrates this occurred during an ISTDP training I attended last year. A participant described a rupture with her patient who, in response to childhood abandonment, said she felt "cold and empty." When the therapist pressed for what was underneath the cold and

empty, the patient became irritated and felt attacked. Rather than recognizing that "cold and empty" are near-paradigmatic expressions of an unbearable stimulus—a psychobiological shutdown response—the group quickly framed the patient as resistant. The consensus was that she was "taking a helpless position," and her statement that she felt like a child and longed to be held was swiftly labeled as "regressive." In the end, the rupture was understood as evidence of the patient's pathology, rather than as a reasonable reaction to an intervention that may have communicated her feeling of "cold and empty" was not valid or welcome in the therapeutic space.

But truly—what happens to the "cold and empty" of abandonment? Do these states just vanish into thin air? If no one comes—if the child receives no help, no nurturing, no regulation—does that state somehow resolve itself, while the fantasy-based rage and guilt endure? I would genuinely love to hear a coherent argument for this. How, exactly, does the "cold and empty" leave the nervous system and psyche, while the "rageful and guilty" stay?

In reality, the exchange I described is downstream of a theory that does not fully recognize—or symbolize—the phenomenology of severe trauma. And this is why I'm speaking to the community directly. The stakes are real. If we fail to see and account for traumatic phenomenology in our metapsychology—and instead code all traumatic affect as manifestations of the punitive superego or as secondary to intrapsychic conflicts (like projection)—we limit our work in cases where that formulation simply doesn't fit. These are cases where integrative failure and traumatic memory (which I will define below), not resistance, defenses, or anxiety, may be the primary source of suffering.

From a practical perspective, the heart of this discussion is the shared challenge of what to do when a patient doesn't respond in the ways our theory predicts. Jon Anders Lied has framed it thus: *"If you're not seeing the expected progress, it's important to pause and ask yourself if your case conceptualization is correct, if you have the necessary skills to help this patient, or if your theory of change is appropriate for this specific patient. If not, you should consider stopping therapy and referring the patient to someone else."*

Or, rather than refer out, one can widen the metapsychological lens and deepen their skillset. This is the path I—and many others—have chosen. To experiment and learn. In doing so, we've discovered an entire paradigm which, when integrated with the ISTDP metapsychology and technique, has brought new light to trauma cases that didn't 'fit' the metapsychology.

Before I attempt to describe more about the ideas that are forming the Dissociative Format, I want to say something about the painfulness of this moment. It is difficult to speak of integration and expansion within the model while watching the community continue to dissociate from its own wounds.

This is a community dedicated to helping our patients find the courage to face the truth in themselves, in their experience. We believe that facing the most painful feeling of all, guilt, is singularly healing. Guilt leads us back to love. Guilt leads us to repair. Returns us to connection.

As this is all true, it has been unutterably disappointing to see expressions of pain in this community be met with a resounding silence from almost all the major stakeholders. Some

described devastating experiences as ISTDP patients, and many wrote publicly asking for a communal process to heal the clear intergenerational trauma in this community. And it has been met with silence.

The contrast—the dissociative process—is breathtaking. We spend tens of thousands of dollars training and countless hours watching tape, doing everything we can to guide our patients to t**hat sacred moment of repair: to hold the broken bodies of their parents and, in the devastation of guilt and grie**f, reconnect with the field of healing that begins with *"I'm so sorry."* And yet, here in reality—not fantasy—how little willingness there is among our leaders to feel that same pain, to return to connection.

May the UTA win.

I will now attempt to describe the ideas that the developing/emerging Dissociative Format of ISTDP aims to integrate into ISTDP. I'll begin with some background on the study of traumatic stress, outline five key ideas from trauma studies that are missing within ISTDP, and continue with some preliminary thoughts on integrating paradigms. For the sake of clarity, I will use headings to organize what follows. For those who are versed in this history and theory, I would invite you to respond publicly and clarify/add to what I write here, as this is necessarily (extremely) broad-strokes. I will not be going into DID, arguably the most severe trauma related disorder, as it's more complex and layered than I can do justice to at this exact moment. However I am attaching a paper on DID for psychoanalytic audiences, and an incredible paper on shame and dissociative processes.

A (very brief and partial) History of the Study of Traumatic Stress

Although traumatic stress syndromes have been documented quite literally since the beginning of recorded history, it wasn't until the Vietnam War and the women's movement of the 1970s that the psychiatric establishment was forced to formally recognize PTSD. Veterans exposed the psychological toll of combat, while women spoke out about rape and domestic violence, together pushing traumatic stress syndromes into public consciousness. In 1980, PTSD was officially added to the DSM—a monumental shift. Traumatic stress was no longer framed as a sign of internal weakness or pre-existing neurosis but as an injury inflicted by overwhelming external events. This recognition not only validated survivors' experiences but also paved the way for research, treatment, and restitution—including disability compensation for Veterans.

This move to a 'trauma and stressor related' category is significant, and reflects the understanding that rather than trauma being only a developmental or maturation issue, traumatic stress is a result of an overwhelming and unbearable threat.

Key Concept #1: The Defense Cascade and Fear States

So, what is an overwhelming threat? ISTDP theory has been curiously selective in its engagement with neurobiology, focusing almost exclusively on the pathways of signal anxiety, rage, grief, and guilt—while leaving out the neurobiology of traumatic stress and the

psychobiological states linked to survival threats. Despite the prevalence and clinical significance of severe threat responses, this area has remained largely outside the community's scientific curiosity. In reviewing the literature, I found more than a dozen studies—including several highly cited meta-analyses—all reaching the same conclusion: the degree of terror during the traumatic event is the strongest predictor of later symptom severity.

Another confirmation of this concept comes from research identifying the two most consistently traumatizing experiences likely to produce PTSD: (1) waking up from anesthesia during surgery (2) rape. Both share a defining feature—being utterly trapped in a situation of overwhelming, immediate, and inescapable threat, e.g. extreme terror.

So what does 'degree of terror' actually look like? The neurobiology of fear-terror, the affect associated with extreme threat, is now well described in the Defense Cascade model. To explain this clearly I'm going to share a passage from my own work in an unpublished manuscript by Reiko, Jackie Meltz, and I:

"Humans, as well as most other animals, are endowed with an evolutionarily hardwired sequence of automatic and *involuntary* defensive responding which progresses based on level of threat; this sequence is termed *the defense cascad*e (Bracha et al., 2004; Mobbs et al., 2007). Reactions to threat begin with an initial *arousal* response with behavioral correlates of orienting and focusing on a threat, then active defenses of hyperaroused *fight*/*flight* and *freeze* (freeze responses being a state of hyperarousal), then increasingly passive 'shut-down' hypoaroused defenses of *tonic immobility* and *collapsed immobility* which are engaged when threat is inescapable and imminent, and then a recovery state of *quiescent immobility* when safety has returned (Kozlowska et al., 2015; McDonald et al., 2013)."

I continue: "Both hypoaroused 'shut-down' states of tonic and collapsed immobility involve a flood of endogenous opioids which serve to neurochemically cap affect (Lanius, Paulsen, & Corrigan, 2014) which is hypothesized to potentially protect the body from cardiac arrest - being scared to death - while also providing the best defense against a predator (Schauer & Elbert, 2015). In tonic immobility, the body becomes stiff and rigid, rendering movement impossible, while in collapsed immobility the body is completely limp and all emotion and sensation is anesthetized. Often described as 'death feint' given that predators lose interest in prey that appears already dead (Miyatake et al., 2009), collapsed immobility is experienced as a profoundly dissociated detachment from reality, with a trance-like reduction in responsiveness, and sometimes a full loss of consciousness."

Put plainly, there is a point at which feeling an 'active' terror no longer helps someone survive, and a massive dissociative shut-down ensues with massive opioid flooding (e.g. the neurochemical capping of affect, and from this perspective, extreme dissociation is actually a final form of terror).

For those who survive such overwhelming threat, the aftermath is often a traumatic memory marked by both the intensity of the original terror (hyperarousal responses) and the body's

profound dissociative response (hypoarousal responses). So what actually is a Traumatic Memory?

Key Concept #2: Memory is 'About', Traumatic Memory is 'Within'

Traumatic stress symptoms are inextricable from the concept of traumatic memory. It is the core of trauma - memory which refuses to actually be memory. Memory which intrudes into life, experienced as occurring 'now'. A very clear way to explain this (and I wish I could remember where I read this, someone please tell me if you know) is that memory is 'about' something, whereas traumatic memory is 'within'. It is flashbacks, intrusions, re-experiencing. It happens 'now'.

I will again quote my own work from the manuscript for expediency:

"Overwhelming trauma results in a breakdown of the psychobiological capacity to cohesively and coherently connect sensory, emotional, cognitive, and behavioral experiences, understand oneself as the agent and owner of the experience, and connect it to one's life history (Nijenhuis, 2017). This breakdown of integrative function due to overwhelming traumatic stress is concurrent with the formation of traumatic memories (Brewin, 2001b; Conway, & Pleydell-Pearce, 2000; Van der Kolk, 1998). Traumatic memories are fundamentally distinct from ordinary memories in that they are experienced as present-moment events. That is, they have an urgent quality of 'nowness' (Stolorow, 2003). Recent neuroimaging research validates this universal clinical observation. Perl et. al. (2023), found that traumatic memories activate distinct neural circuitry relative to ordinary sad memories, concluding that "traumatic autobiographical memories undergo a parallel or *dissociable mode of representation*…traumatic memory reactivation is not experienced as memory as such, but is rather disconnected from time and space and from current surroundings, and thus experienced as an intrinsic mental event" (italics added, pg. 2234). In other words, "traumatic memories… are fragments of prior events…" (p. 2235). Traumatic memories are recalled involuntarily (i.e. intrusions or flashbacks), and are often experienced more vividly than normal memories (Brewin, 2001a, Brewin et al., 2010). They may also include full somatic activation of the peritraumatic experience, all of which represent elements of dissociative processes at work in the mind and body (Salomons et al., 2004)."

It cannot be overestimated how significant the confirmation of Perl et. al. 's findings are: "Taken together, these findings suggest that traumatic memories are an *alternative cognitive entity that deviates from memory per se* (italics added)."

So – why does this happen? Why does an experience become a 'traumatic memory' as opposed to encoding as a regular memory?

Key Concept #3: Integrative Capacity and the Fragmentation of Experience

The world of trauma is a world of terror and pain - child abuse, sexual violence, neglect, abandonment, torture, war, murder, interpersonal violence and deprivations of all kinds. The sadism and violence is not imaginary in this domain, its quite real. Yet amazingly, people do survive vast fear and pain *without* developing long term symptoms of traumatic stress. So what makes a 'trauma' traumatic? To understand this we have to understand the concept of 'integrative capacity'.

As first articulated by Pierre Janet, integrative capacity refers to the person's ability to carry out the essential mental operations of synthesis (linking experiences into a coherent whole), personification (maintaining a stable sense of self across time), presentification (keeping the present moment oriented in time and place), and realization (making meaning of what has occurred). When this capacity is overwhelmed by an unbearable traumatic stimulus, these functions fail. The result is fragmentation in the form of traumatic memories: experiences that cannot be fully processed become fractured, leaving behind intrusive images or audio hallucination, emotional numbness, or reactive states that feel disconnected from context. Of course, the younger, more frequent, and more severe the traumas (both shock and relational) the more complex this will be.

Integrative capacity depends on both development/ability of a person and the intensity of the traumatic event. Waking up during surgery, unable to move while being cut open, is one of the most extreme traumas imaginable (pure terror and torture) and thus more often than not produces PTSD. But it's not just about the event itself—an infant left crying alone for an hour may experience that as life-threatening, while a six-year-old in the same situation may not. Trauma happens when an experience overwhelms the system's ability to process and integrate what's happening

Consider this: if someone reaches the final stage of the defense cascade (collapsed immobility) during an assault, they are, by definition, unable to synthesize experience. Collapsed immobility is a state of profound dissociative shutdown, marked by a flood of endogenous opioids and a disconnection from self, time, and place (absolute depersonalization and derealization). In this state, the person enters a profoundly altered consciousness, with no capacity to process or integrate what is happening. Without the arrival of safety to restore integrative capacity (and help rarely is present in traumatic circumstances), the experience is likely to be stored not as a cohesive narrative (normal memory), but as fragmented, unsymbolized sensation and affect—frozen outside of ordinary awareness - that is, held dissociatively.

Key Concept #4: Dissociation as Fragmentation

These first three concepts describe the pathway to dissociative fragmentation: overwhelming threat activates extreme defensive states, traumatic memories form when integrative capacity is overwhelmed, and the result is a 'dissociation' of consciousness, memory, and self. This takes

both simple and complex forms—ranging from simple acute PTSD that may resolve fully, to DID, the most severe dissociative disorder.

As central as dissociation is to the treatment of trauma, there is still no universally agreed-upon definition in the field, reflecting the breadth and complexity of the phenomena the term points at. Still, without getting into the weeds, it's easy to say that trauma-related dissociation is a much larger construct than the concept of cognitive-perceptual disruption (CPD). ISTDP literature positions dissociation primarily as a defense against internal conflict—specifically mixed feelings toward attachment figures (intrapsychic conflict). In contrast, trauma-related dissociation is dramatically more expansive, encompassing the fragmentation of consciousness, identity, and memory in response to an unbearable stimulus (that is, due to a lack of integrative capacity, or *deficit*).

At its core, trauma-related dissociation is best understood as a disruption in the normal integration of consciousness, memory, identity, and perception. Rather than being merely transient lapses or cognitive-perceptual distortions as in CPD, trauma-related dissociation involves profound structural fragmentation in response to overwhelming threat. At the most basic, these dissociative processes can manifest as sudden intrusions (positive dissociation), such as flashbacks or re-experiencing, or as absences (negative dissociation), such as amnesia, emotional numbing, or functional sensory loss. At its most complex, traumatic dissociation takes the form of layered self-state processes, in which an individual experiences profound identity confusion and multiple centers of subjectivity—such as distinct first-person perspectives, as seen in the OSDD-DID spectrum. This is understandable as a strategy for managing unbearable reality: if the mind can create the sense that it happened to *her* and not *me*, it offers some protection from overwhelming experience. While ISTDP theory tends to conflate OSDD/DID presentations with fragility or borderline personality organization, research does not support this view.

For the psychoanalytically oriented, I want to briefly mention some of the terms that have been used to refer to dissociative phenomenon in the literature: unformulated experience, unsymbolized affect, the unrepressed unconscious, beta elements, foreclosure, unmentalized affect, splitting of the ego, and so forth (this list is not comprehensive).

Key Concept #5: The (insufficient but important) Theory of Structural Dissociation of the Personality

While not without its limitations, the theory of structural dissociation offers a useful, broad-strokes framework for understanding how divisions in consciousness, memory, and self may form and persist in the aftermath of overwhelming trauma. This matters because it directly challenges ISTDP's psychodiagnostic spectrum, which does not account for dissociative fragmentation as 'a structural feature of the traumatized psyche' (I'm quoting Reiko - I like her wording).

According to Onno van der Hart and Kathy Steele (2023), structural dissociation of the personality refers to a division of the personality into distinct, self-organizing subsystems, each managing different psychobiological action systems in response to overwhelming trauma. The *Apparently Normal Part (ANP)* is primarily responsible for functions of daily life, including attachment, exploration, play, work, and sexuality, while the *Emotional Part (EP)* is organized around defensive action systems such as fight, flight, freeze, and collapse. This division arises when integrative capacity is compromised, preventing the synthesis of traumatic experience and resulting in a fragmented personality structure in which these systems operate with insufficient coordination.

Structural dissociation is a persistent failure of integration due to unbearable experience (deficit, not conflict), and not a transient alteration of consciousness due to anxiety about mixed feelings as described by CPD. It exists on a spectrum: from primary structural dissociation, involving a single ANP and EP (as in standard PTSD), to secondary and tertiary structural dissociation, where further divisions of ANPs and EPs emerge (as seen in Complex PTSD, OSDD, and DID). Across this spectrum, dissociative parts remain partitioned by phobic avoidance of traumatic material and one another's functions, and as the most severe lead to chronic disruptions in memory, identity, perception, and self-regulation. Treatment requires the gradual restoration of integrative capacity to allow for increased cooperation, communication, and eventual unification of these dissociative parts within a cohesive personality system.

The theory of structural dissociation seems to hold up well in many cases—patients often experience "normal" states that manage daily life, and then "switch" into traumatized states that carry an entirely different emotional landscape. Moreover, traumatized patients tend to like the theory and the 'parts' language because it so well matches their shifting inner experience - it 'fits'.

Integrating Traumatic Stress Studies with ISTDP: Preliminary Thoughts

Integrating the trauma paradigm with ISTDP is ultimately about knowing when to shift approaches—continuing with traditional ISTDP when it fits, but recognizing when persistent impasses or lack of progress signal the need for a trauma-informed, dissociation-focused method. At the core of this shift is a fundamental difference in how pathology is understood. ISTDP assumes the patient is actively using defenses to avoid internal conflict, particularly around mixed attachment feelings. In contrast, the traumatic stress paradigm generally considers traumatic stress symptoms as the result of a failure of integration—a collapse of capacity under overwhelming threat. Here, it's not that the patient's defenses are hurting them, but that dissociative processes are protecting them from the full impact of unbearable traumatic affects like terror and horror. Defenses aren't the problem; unbearable terror is. What may appear in ISTDP as resistance is, in these cases, better understood as a lack of integrative capacity.

One way to conceptualize the ultimate aim of treatment in cases of severe trauma is the gradual restoration of the capacity to *know* what happened. Not just to recall it, or to understand it cognitively, but to fully bear the reality—gnosis, realization. This is an existential task: to

metabolize the unbearable into the known, to slowly realize the dissociated, unsymbolized fragments into the embodied, witnessed truth of what was in all the terror and meaning. This is a vast topic, and I have attached a paper that explores it in greater depth, however its worth considering that it is those moments when it feels like there are 'missing pieces of experience' (narrative and memory is fragmented) that you may need to shift to a trauma and dissociation informed way of working.

Here is a (non-exhaustive) list Reiko Ikemoto Joseph, Jackie Meltz, and I compiled to help clinicians recognize signs of traumatic dissociation:

1. When a patient presenting as moderate or high resistance with no signs of smooth muscle repression or CPD reports unusual dysregulation or destabilization between sessions (this would be intrusions/re-experiencing)

2. When a patient enters a state of extreme fear during a session, especially when exploring a traumatic event and temporarily loses orientation to present time, place and safety (emergence of traumatic memory)

3. When a patient reports episodes of debilitating emotional dysregulation and cannot identify an internal or external stimulus (dissociated traumatic memory/fragmented and inaccessible narrative)

4. When a patient appears to suddenly shift into a regressive or markedly different emotional, behavioral or physical state (evidence of structural dissociation/ trauma holding states)

5. When a patient reports or shows signs of profound numbness and detachment in the absence of tactical defenses, CPD or smooth muscle disturbance ('negative' dissociation signs in absence of usual 'fragility' signs)

6. When the patient shifts rapidly between states of hypoarousal and hyperarousal and has great difficulty regulating them (classic signs of structural dissociation and 'switching')

7. When the patient appears listless, collapsed or in an impenetrable state of shutdown as seen with severe depression (possible evidence of emergence of passive defensive state of collapsed immobility)

8. When a patient reports an extensive history of life-threatening and/or developmental trauma

9. When a patient enters treatment with a diagnosis of PTSD or a dissociative disorder

10. When a patient’s symptoms do not improve despite repeated unlockings of the unconscious and passages of guilt

To give a few examples to ground this, one of the defining features of traumatic dissociation is the sudden reactivation of dissociated traumatic memories in response to present-day shifts in safety, attachment, or external cues, often accompanied by full psychophysiological reliving, time distortion, and a collapse of present-moment orientation. For instance (details slightly altered for anonymity), a patient who had survived an extreme sexual assault on a particular holiday experienced annual episodes of near-psychotic flashbacks on the anniversary, including auditory hallucinations of the attack and overwhelming somatic memories, as if the event were happening again in real time. In another case, during a series of unlockings, a patient began re-associating a previously dissociated memory of childhood sexual assault and subsequently spent nights hearing the sound of a child screaming in her mind, a dissociative auditory intrusion echoing the original trauma. In both cases, the return of dissociated material emerged not as narrative memories but as traumatic memories: living, present-tense experiences with full sensory, emotional, and temporal intensity. Unlike repressed material, which may surface as a full coherent story, dissociated traumatic memories flood the system in fragments - sounds, sensations, images. When traumatic memory emerges, the patient is already "unlocked." We are in direct contact with primary material. Because the issue is not conflict, there is often little (if any) sighing, yet the material is profoundly “bottom of the triangle.” A terrified person does not sigh—but they are having a real, full emotional experience. To work effectively in these moments, we must know how to work with terror (which I will describe shortly after addressing the issue of "fragility").

About ‘Fragility’: The previous examples have nothing to do with ‘fragility’. Both patients are high functioning, with no notable regressive character features, splitting or projection, and both have intact relational capacity. Yet in ISTDP discourse, there is a persistent and problematic conflation of trauma and fragility, as if the presence of structural dissociation or traumatic memory implies borderline-level pathology. This is a categorical error. Trauma responses, including dissociation, are not guaranteed signs of personality issues or primitive defenses—they are adaptive psychobiological responses to overwhelming threat. To collapse trauma-related phenomena like dissociative re-experiencing, time distortions, or autonomic collapse into a concept of “fragility” is to misinterpret survival strategies as character pathology, and deny the impact of traumatic events and external reality in general. This not only distorts the phenomenology of traumatic stress but also risks pathologizing patients whose symptoms reflect unresolved traumatic memory rather than developmental arrest (though of course many patients deal with both). In doing so, ISTDP's diagnostic framework fails to distinguish between symptoms and self-fragmentation arising from trauma, defenses arising from attachment conflicts, and Cluster-B personality issues, leading to clinical misunderstandings that harm patients by damaging our ability to clearly conceptualize cases. Traumatic memory being what it is, a traumatized patient may be fully aware that their fear is linked to a past memory and have no belief that the therapist is threatening. Their reality testing remains intact, yet the body continues to relive the terror as if it is happening now. Additionally, though it's too much to

explore in depth here, structural dissociation simply confounds the spectrum more generally - a ‘moderately resistant’ patient may in fact contain structurally dissociated/partitioned emotional parts that are in extreme trauma states despite the appearance of what is ‘at the front’.

What is contained in traumatic memories is terror, and terror is truly the paradigmatic traumatic effect. When someone says ‘traumatic stress’ that quite literally means ‘an experience of overwhelming terror’. And, within ISTDP theory, terror doesn’t exist - it's all ‘projective anxiety’ secondary to mixed feelings. So where does the idea that all in-session fear is projective anxiety get traction? In its partial truth: reactive rage is always present within a traumatic memory. Helping a patient orient to their rage can be powerful and useful, especially if it shifts them out of a collapsed traumatic state while simultaneously reconsolidating a traumatic memory through contrast (big and powerful rather than weak and terrified). Another way to read this is that experiencing rage from a present tense adult perspective is reasserting the structure of time into the timelessness of traumatic memory, given that the child in the traumatic memory (time distortion) usually would never have been safe enough to express it - we might call it ‘presentifying’. But does this work for every patient all the time? Of course not – we need more tools and a better understanding of what actually processes/integrates and soothes terror.

It's right there - soothe. Whereas with other feelings there is some value in catharsis, in expression, terror only ceases in the presence of profound safety. This does not happen primarily through cognitive recaps, it happens primarily through the real therapeutic relationship, and the degree and quality of loving safety contained therein. Within the context of a genuinely safe relationship – which requires true emotional investment on the part of the therapist, e.g. some degree of vulnerability and true mutual attachment, you know, a real relationship – the resolution of terror is supported by the precise use of eclectic somatic and imaginal techniques. Among these (this is non exhaustive) are Brainspotting / use of Gaze Points, Deep Brain Reorienting, Bilateral Stimulation, clinical hypnosis techniques, imaginal resourcing, selective inhibition (a PSIP technique), etc. This eclectic use of technique is not, in my opinion, optional. We need to learn a lot of moves - people are different, they respond to different things.

The trauma world agrees with me on this, as does the APA. This past summer, the APA released excellent guidelines on treating Complex Trauma in Adults, one of whose seven pillars is Integrative Practice. To me, this is obvious—after years of doing this work, I know in my bones that complex trauma demands a diversity of techniques, applied over a long period of time (working with complex trauma is not short-term).

I recently listened to a great conversation between Jeffrey Magnivita (ISTDP teacher and supervisor) and Kristen Osborn, which I highly recommend (link here). What stood out for me was their discussion on the need for flexibility in trauma treatment—and the recognition that no single model is enough. Jeffrey describes it thus:

“There are a variety of approaches, there’s no one approach… What I tell people I’m working with is we’re going to try something and see how it works, because I can’t promise that even EMDR, or IFS, or Short-Term Dynamic Psychotherapy, or any of the approaches we’ve been

trained in that have efficacy… will necessarily work with a particular person. Part of what we need to do when working with trauma is match the treatment not only to the patient—their values, preferences, and characteristics—but also to take the best available evidence, filter it through our clinical expertise, and shift when something isn't working. If all you have is a hammer, everything is a nail. If you only know one approach, it's going to be very hard to get optimal results with patients."

Part of being willing to shift between approaches is being willing to shift how we conceptualize the source of a patient's suffering, which fundamentally shapes how we relate to them. The difference between an attitude of *"you are hurting yourself"* versus *"you are hurt"* changes everything. I find it troubling—at times even sinister—to reframe all harm from a patient's worst experiences (flashbacks, re-experiencing, etc) as an issue with their own inability to bear rage and guilt. The inversion is striking, and at its worst, it can veer into something that feels like victim-blaming or gaslighting (and who's to say that the guilt isn't, at least sometimes, the introjected guilt of the abuser—a reality I eventually and painfully realized in my own treatment). When we assume the patient is suffering because they are defending—actively causing their own pain—the therapeutic stance becomes corrective, focused on dismantling defenses or 'restructuring'. But when we recognize the patient as hurt—overwhelmed, fragmented, and left alone with unbearable experiences—the entire mood of the work shifts. We move toward empathy, protection, and attunement.

After a recent training with Ange Cooper and Reiko Ikemoto Joseph, which I supported, Sky Kushner emailed us this beautiful reflection: "My more 'fragile clients' have definitely benefited by my approaching them as having attachment deficits rather than attachment conflicts. It gives me permission to be much more empathic than I have been recently, and they have been responding very nicely."

When we see the patient as *hurt*, not *hurting themselves*, the entire atmosphere of the work changes. This shift in attitude increases our sense of responsibility to provide a relationship and environment safe enough for someone to brave the terror of their memories. We need to learn; we need to grow. I feel this acutely with a patient for whom I believe Deep Brain Reorienting may be quite helpful. Our work together is so deep and long standing that referring her out would feel unethical, so she needs me to find the time to learn and expand, to add a new skill. It's $250 and an afternoon to learn the basics - I will find the time.

There is more to say here, but this is where I end, and if you made it this far, please know I am grateful you've decided to engage with the complexity and pain of trauma. It means a lot.

Final Thoughts

Davanloo's image of the 'traumatized psyche' has always fascinated me, because the place I've suffered most is right there in the image – it's just not discussed. It's like my mind exists, but only a little bit. He acknowledges it, but then sort of forgets about it. It's the layer he calls 'the pain of trauma'. See, extreme pain doesn't just go away when you feel rage and guilt and grief. You can

resolve vast amounts of intrapsychic conflict, and yet still be left with pain, with heartbreak, which is larger than simple grief.

This pain requires care, requires love. The heart is almost simple. After two decades of intensive effort to heal myself (and with much success), I don't want to be treated as a code to crack. I want to be treated as a person to love.

Though I've been critiquing the theory and metapsychology here, the harms that result are not theoretical—they're real. I have heard and seen story after story of real harm from ISTDP treatments when a traumatized person is forced into a theory that cannot truly *see* the primary affect at the heart of trauma: fear-terror (and aloneness and shame, etc…), and the need for loving care and careful trauma work to make it all more bearable.

For me, once the accessible intrapsychic conflicts had largely been resolved, I found myself at the edge of a vast lake of still immense fear and pain, and the only thing that carried me across was love. It was made up of the eyes, face, voice, hands, presence, words—most of all the heart-energy—of someone who wanted to be there. Someone who wanted to stay. Someone willing to know my pain and bear it with me, and to recognize me as a person in the fullness of who I am. The work was non-linear, relational, and poetic. Sessions ebbed and flowed, and the psychic processes were deep, they took time, and they were powerful. It was unutterably painful, and beautiful, and the therapist was not foremost a technician. They were a spiritual friend.