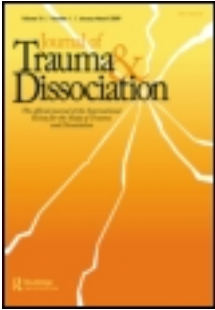


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PRESIDENTIAL EDITORIAL

Reflections on Integration, Mentalization, and Institutional Realization

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We are now poised to enter the middle age of contemporary studies and treatment of complex dissociative disorders. The International Society for the Study of Trauma and Dissociation (ISSTD) had its 25th anniversary in Fall 2008. Having achieved adulthood as an organization, where will our field now venture, carried by our hard-earned collective wisdom and experience? The thought of mature adulthood evokes the idea of integration: We expect an adult to have achieved a relatively sufficient degree of it. Thus, we would do well to examine our level of integration as a maturing field and to apply higher order integrative tendencies to the opportunities and challenges that face us. To do so, we must reflect upon our institutional memory and historical actions, reflect upon our collective representational model of ISSTD, and engage in institutional “mindsight” (Siegel, 1999). To this end, I would like to share a few thoughts on both individual and institutional capacities for realization and mentalization, and ultimately for integration.

More than a decade ago, Stephen Marmer (1991) noted that integration could “be added to the list of those words that suffer from multiple meaning disorder” (p. 681). Everyone talks about it, and typically everyone means something different when they utter the word. We have constructed a tower of Babel with our imprecise language, leaving us all to act as if we know, but secretly wondering exactly what is integration? Yet common sense and experience dictate that integration is as central and fundamental to our existence as breathing, the *sine qua non* of adaptive and healthy living, not merely the unification of dissociative parts in a dissociative individual (Kluft,

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1999; Van der Hart, Nijenhuis, & Steele, 2006). Much has been written about the integration of what is dissociated (e.g., Kluft, 1993), but little on the broader applications of integration. To this end, we must continue to explore integration: its definition(s); its nature and limits; its functions and processes; and its neurobiology, psychology, and sociology. Of all of the mental health-related fields, we are perhaps one of the most equipped and experienced to undertake such studies. But most important, we must practice integrative actions on our own, as individuals and as the only organization dedicated to studying and treating complex dissociative and other trauma-related disorders.

We know so little about integration. This statement is not meant to discount or minimize the vast data we do have at hand, it is only to note that we must be humble in acknowledging that our learning is far from over. Neuroscience has only begun to scratch the surface of the complex and intricate process, and each day in therapy we blindly fumble around this metaphorical elephant, feeling the trunk of it at one time, the tusk of it another, never quite fully grasping its elusive enormity and true wonder.

Integration is necessary for everyone, not only for dissociative individuals, in the same way that oxygen is essential for everyone, not only for those with chronic lung disease. Integrative successes and failures most surely fall along a dimensional continuum from the spectacular to the seriously pathological. And of course, not all that is unintegrated is dissociated. Types of integrative failure involve not only memory, identity, and consciousness, but every aspect of experience: Every action of mind and body is vulnerable to integrative failure. No one is completely integrated; that is an impossible achievement. A reasonable goal is to achieve “good enough” integration in which we can consistently engage in sustained, demanding, adaptive, and high-level actions across time and contexts. Most of us in the dissociative disorders field are convinced that “good enough” integration does, in fact, involve unification/fusion of all dissociative parts of the personality, so that a person has a relatively contiguous, coherent, and unitary sense of self across time and contexts.

It is the act of *being* (relatively) integrated that allows us to constantly synthesize sight, sound, sensation, thoughts, predictions, feelings, along with time, intention, and awareness of action in an apparently seamless experience called “now.” Integrative actions provide us within a seemingly unified field of consciousness that encompasses “me, myself, and I” across time and context (Cleeremans, 2003; Siegel, 1999; Stern, 1985). Integration is the essence of who we are. In other words, our self or personality is not the active agent of integration, but rather is the *result* of integration (Loevinger, 1976; Metzinger, 2003; Van der Hart et al., 2006). Thus, integration is not an actor, a structure, an event, or the end of a journey, but rather a dynamic state of being that is in *constant flux, yet stably constant*. Allan Schore (1997) observed that our self is continually organized, disorganized, and reorganized (p. 607). This dynamic organizational flux *is* integration, such that our “self”—our mental model of who we experience our ourselves to be (Metzinger, 2003)—constantly

evolves and adapts effectively to changing circumstances. Adaptive representational mental models of self and other must be based on the integration of past, present, and future. Representational mental models are not only relevant to our patients and ourselves but can also be applied to macrosystems such as our professional organization (i.e., ISSTD) and to society at large. What is our collective mental model of ISSTD? What from our collective institutional past and present could become better integrated in order to more effectively guide our future direction?

A beginning taxonomy of integrative actions has been proposed by Van der Hart et al. (2006). Integration involves a combination of lower and higher order actions, ranging from simple reflexes to reactive actions to reflective tendencies. Beginning at lower order levels, *synthesis* involves *binding* (linking) and *differentiation* of various stimuli (Van der Hart et al., 2006). For example, “This man looks like my abuser” (binding) “but is not really him” (differentiation). Differentiation as an integrative act is essential to understand and value, because integration is not seamless homogeneity. Rather, it involves capacities to tolerate dialectical tension between similarities and differences, competing needs, conflicting ideas and affects, ambiguity, while maintaining relative equanimity. Such capacities are necessary within the individual, who then influences larger systems—relationships, organizations, societies—to engage in collective actions that reflect those abilities. Then we, as individuals and as groups, hone our adaptive faculties to respond to a complex and often abruptly changing world that displays itself in an array of uncertain grays.

At a higher level, synthesis (binding and differentiation), for example, can be applied to relational experiences and mental representations. Thus we can say that synthesis lays the groundwork for mentalizing, a major integrative action. *Mentalizing* is the capacity to accurately perceive and observe one’s own mind and the mind of the other (Fonagy, Gergely, Jurist, & Target, 2002). More primitive or implicit mentalizing begins with lower order actions involving innate action systems, conditioned reactions, and procedural memory. These implicit tendencies contribute to what we do or do not perceive and infer in relational experiences. For example, a patient who was often ridiculed as a child when she was excited may automatically tense and avert her gaze when she wants to share a nice experience. She inhibits her affect and narrative without conscious awareness, assuming a posture and attitude of shame (cf. Ogden, Minton, & Pain, 2006). She has implicitly inferred that the listener will be shaming. Adaptive mentalizing involves binding among *accurate and relevant* perceptions in the present to modify “outdated” mental representations based on past experiences (e.g., “My therapist is frowning like my father used to do just before he hit me”). But more important, it also involves differentiation based on mental representations that have become more congruent with the present than with the past (e.g., “My therapist is frowning but doesn’t seem angry. She is someone I trust.

I will ask her about it”). In this example, we can observe the implicit adaptive reorganization (i.e., integration) of an earlier negative mental representation, because the patient is able to *differentiate* the therapist’s response from her father’s. That is, the patient responds to the present context adaptively.

Ongoing synthesis can lead to eventual reorganization(s) of the self or personality: If this reorganization is flexible and adaptive rather than rigid and closed, it is integrative. But it is *realization*, a higher order level of integration, that is the real “glue” that supports psychological integrity and allows (re)organizational shifts to take place without disintegration or rigidity ensuing. Realization involves the personal ownership of experience (e.g., “That anger is *my* feeling,” “That little girl is *me!*” “*I* was raped”). This is referred to as *personification* (Janet, 1935; Van der Hart et al., 2006). Once our experience becomes part of a first-person perspective (i.e., is subsumed under the umbrella of our representational model of “me, myself and I”), further realization promotes adaptive action in the present based on what has been synthesized and owned. This form of realization is called *presentification* (Janet, 1935; Van der Hart et al., 2006). It helps us to (re)organize our mental and behavioral actions, our sense of self, promoting full presence in the now with the capacity to act with maximum effectiveness and adaptation. Presentification should include “flow,” a full immersion in what is happening in the moment, with pleasure taken in focus and action in the now (Csikszentmihályi, 1998).

Mentalizing involves high levels of synthesis and realization, particularly in its conscious or explicit form. Not only must an individual have the capacity to empathically and imaginally “walk in the shoes” of the other, he or she must engage in the same observational and empathic actions toward self. He or she must *realize* his or her own mental actions and their accurate meaning (e.g., “These are *my* thoughts, *my* feelings that come from *me*; they help me understand myself and the world; they are different from behavioral actions; I do not negatively judge them”). Such realizations allow one to observe and respond reflectively and with agency to inner experience, rather than reacting like a puppet controlled by mental machinations. Without this capacity for inner-directed realization, a person remains in a chronic condition of what I call *mindflight*, the persistent avoidance of inner experience. But with sufficient mentalizing, an individual can accept his or her experiences and engage in mindfulness, insight, empathy, and resonance with self and other, what Siegel (1999) has referred to as *mindsight*.

Synthesis and realization should lead not only to explicit adaptive changes, but also to changes in procedural memory that maintains rigid and maladaptive patterns. Thus, accurate mentalizing—a very high order of integration—influences adaptive changes in lower order unconscious tendencies, such as approach or avoidance strategies (both mental and relational), body posture, facial expression, gaze, and so on (cf. Ogden, in press).

Synthesis and realization also include an essential imaginal exercise of flexible “mental time travel” (Stern, 2004; Wheeler, Stuss, & Tulving, 1997). This is an important element of auto-noetic consciousness—the capacity to mentally represent and become aware of subjective experiences in the past, present, and future—necessary for mentalizing and other reflective functioning. This mental action allows us to continually (re)organize ourselves in the present by revisiting the past and future (i.e., to integrate ourselves more effectively). But such time travel must include the essential skill of being in two places at once, remaining firmly planted in the present while visiting other times. Dissociative parts of the personality are limited in flexible time travel: They often have a one-way ticket to the past, or cannot purchase a ticket to the present, are devoid of time sense at all, or have serious time distortions (e.g., time is experienced as too long or short or is not held sufficiently in conscious awareness; Van der Hart & Steele, 1997). Thus, the mentalizing abilities of dissociative parts, like many of their other (dis)abilities, depend upon a limited repertoire of lower order reactions sequestered within specific epochs, inhibiting the natural and progressive reorganization of mental representations based on new experiences.

Realization involves our ability to experience the present as most real and the past and future as less imminent and real (Janet, 1928, 1932; Van der Hart et al., 2006). Janet described a hierarchy of reality in which time and reality range from more to less real to an individual. It is most adaptive to be present in the *now* much of the time, while still being able to call upon our past and future to inform, but not control, us. Thus, presentification must be not only momentary but extended across time and contexts so that mental travel begins and ends in the present, after we connect with various “stations” along the way in our past and our imagined future (Van der Hart et al., 2006). Mentalizing requires such presentness, or presentification, including awareness of ourselves, of our mental actions, of others, and of context. But awareness is not sufficient unto itself: It must be accompanied by action to be most adaptive.

Synthesis and realization should, in principle, pave the way to more frequently experienced and expressed innate affects and more stable relationships. That is, we should be able to engage in *mindsight* rather than *mindflight*, to experience (all) our emotions without the need to avoid or interrupt them, and to tolerate the vicissitudes of normal relationships and life. To this end, integration must involve sustained activation of the social engagement system, the innate psychobiological action system involving the ventral parasympathetic branch of the vagus nerve, a relation-seeking system that fosters interaction with the environment (Porges, 2003). The social engagement system mediates control of parts of the body used in relational contexts. It has a role in mediating gaze and emotional expressivity, the capacity to distinguish human voices, speech rhythms and intonation, and social gestures and orientation (Porges, 2003, p. 503). In other words, the affective array can be experienced freely and expressed when the social

engagement system is activated. Integration allows for the maximal activation of this system in the absence of real threat, whereas mentalizing mitigates tendencies to perceive relational threat where this is none.

How then might we adopt this knowledge of integration and mentalizing to our field and, in particular, to our organization, the ISSTD? Traumatization is not only the purview of the individual: Societies also struggle with its effects. The very core of traumatization is a profound lack of realization that the event is over and the present is more real than the past. And traumatization disrupts mentalizing capacities. Without sufficient mentalizing and realization, our work with chronically traumatized people is notoriously fraught with the dangers of reenacting the unintegrated past. As therapists, we have the unenviable task of temporarily embodying someone else's terror, rage, shame, disgust, helplessness, hopelessness, and the like. In the same way, our professional society is vulnerable to these embodied reenactments unless we can engage in collective realization and mentalization. Society at large is also prone to enacting traumatic scenarios, easily slipping into the familiar "no exit" triangle of victim, persecutor, rescuer. Such lower order caricatured paradigms were central to the "false memory wars" of the 1990s, for example.

We have come far from those painful times and have learned much. But could it be that we still carry in our institutional and personal memories the traces of public shame, ridicule, disavowal, and alienation on the one hand, and the narcissistic reaction of believing we are the only ones privy to the real Truth, with a capital *T*, on the other? These experiences may yet color our collective unconscious representational model of ISSTD. If so, it is essential that we consciously reorganize our mental model of our society to conform to the present by understanding and accepting (realizing) the difficult past, while also being aware of where we are in the present. Opportunities to do so now abound: Realization implies taking responsibility for forward-moving action. We have amassed and integrated enormous data from many theories and disciplines. In the meantime, other fields are slowly catching on to the major role of adverse childhood experiences in mental and physical morbidity and overall poorer quality of life. Advances in the neurobiology of traumatization are blooming. Cross-fertilization among various fields is rich and extensive, ripe for harvesting. Dissociative disorders are being studied around the world. We no longer need accept a dark corner of the mental health world, no longer need to fight for survival. The time is now to rise to our full potential as a leader in the mental health field.

Leadership implies higher order levels of integration—sustained realization, personification, presentification—also on an organizational level. To become a leader we must have a strong collective sense of self (mental model), a firm grasp of the science and the art of what we do (realization and integration), an awareness of the intentions and motivations of ourselves and others (mentalization). We, as individuals and as an organization, must not be too reactive or discouraged in the face of the predictable denial

and disavowal that comes when others are faced with hard realizations of trauma and its wake. After all, *not knowing* is a major form of coping when integration is not yet possible: We see this in our patients every day. True realization of the impact of traumatization in the mental health field and in society at large can only occur when individuals and groups can become small islands of realization that slowly coalesce through cooperation, coordination, empathy, trust. Thus, our realization must not be expressed vehemently but rather should be acted upon with humility, balance, and resolve. No one has ever had success by beating a patient over the head with forced realizations; the same holds for our stance toward the mental health field and toward society at large. We must value openness, curiosity, diversity, and healthy conflict both inside and outside our organization, and above all, we must be patient and persistent. We must meet unfair criticism with equanimity and clarity. We need to reach out beyond the trauma field to other areas of study, to teach at other kinds of conferences to reach individuals who are not likely to attend a conference on trauma and dissociation. We can establish relationships with other groups to set common goals and work on common projects. After all, integration and all its benefits *and* responsibilities are not just for our patients, but also for us as individuals and for our organization, which is now all grown up and can mind many minds.

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