RECENT TRENDS AND ADAPTATIONS IN TRAUMA-INFORMED PSYCHOANALYTIC PSYCHOTHERAPIES: A SCOPING REVIEW[1][2]

Carlos Pitillas, Ph.D.

Department of Psychology

Universidad Pontificia Comillas (Madrid. Spain)

cpitillas@comillas.edu

Emma Albarracín

Private Practice

©American Psychological Association, 2026. This paper is not the copy of record and may not exactly replicate the authoritative document published in the APA journal. The final article is available, upon publication, at: 10.1037/pst0000642

[1] Portions of the text in this manuscript were reviewed and refined using ChatGPT (OpenAI) for the sole purpose of improving the grammatical accuracy and fluency of English translations of arguments originally written in Spanish. No new scientific content, interpretations, or conclusions were generated by the tool. All conceptual development, data analysis, and scientific claims remain entirely the responsibility of the authors.

[2] The authors report there are no competing interests to declare

Abstract

A growing sensitivity has emerged within psychoanalytic theory and intervention to the specific conditions of complex post-traumatic pathology and its clinical challenges. Yet an articulated, encompassing view of the diverse proposals within this new sensitivity is still lacking. This article advances such articulation through a scoping review of psychoanalytic interventions focused on trauma and dissociation published over the past fifteen years. Our analysis identifies five axes of trauma-sensitive psychoanalytic practice addressing: vulnerability to dysregulation; limited symbolic access to traumatic material; structural dissociation; vulnerability to disorganization in contexts of intimacy; and enactments arising around dissociative collusions and dilemmas of recognition within the therapeutic dyad. Overall, the reviewed relocates interpretation within a temporally and clinically responsive framework, in which the timing and form of interpretive interventions are calibrated to the traumatized patient's regulatory, dissociative, and symbolic capacities. We conclude by outlining essential aspects of the therapeutic stance implied by these contributions.

Keywords: trauma; psychoanalytic psychotherapy; regulation; dissociation; enactment

Traumatic injury occurs when an event (or a series of enduring events) overwhelms a person's capacity to integrate emotional experience, is perceived as a threat to safety or survival, and precipitates extreme distress or helplessness, all of which triggers subcortical defensive responses of hyper- or hypoactivation (Bohleber & Leuzinger-Bohleber, 2016; Dent, 2020; Ogden et al., 2006; Teichold, 2014). "Developmental", "complex" or "attachment" trauma has been associated to conditions in which traumatic pain originates within relationships of care, trust, or power asymmetry—relationships that the child cannot escape and upon which survival depends (Johnstone & Boyle, 2018).

Recent psychoanalytic journal literature reflects a renewed and increasingly explicit engagement with trauma-sensitive theoretical and clinical questions. Building on foundational contributions by Ferenczi (1928/1994), Balint (1968/2013), or Winnicott (1954), this renewed emphasis has signaled the need for technical adaptations in response to specific features of post-traumatic psychology, as well as greater attention to the difficulties traumatized patients face in symbolizing affect and experience, and the ways in which in trauma may be reenacted by the therapeutic dyad. Despite the promise of this sensitivity, an articulation of its components seems to be lacking. As Purcell (2019) observes, "the important roles played by trauma and dissociated affects in the psychopathology encountered every day in our work continue to be underrepresented in the thinking of significant numbers of clinicians" (p. 316).

To contribute to such an articulation, the present work employs a *scoping review* methodology that intends to approach and provide an integrated response to a set of pressing questions: Given the specific psychopathology of developmental trauma, what clinical challenges do we face? How does the specific way in which traumatized patients experience their emotions, organize their experiences or interpret intimacy affect the

intervention? And, most importantly, what adaptations of the psychoanalytic setting and conversation should we make in light of these particularities?

The present paper is organized as follows. First, we offer a detailed description of the methodological procedures employed in the search, selection, and review of the scientific documents that constitute our corpus. Next, we present the results structured around five axes of trauma-sensitive psychodynamic interventions. For each axis we outline:

1. A relevant feature (or set of features) of posttraumatic psychopathology-
2. The main clinical challenges these features pose for psychoanalytic technique.
3. Therapeutic principles derived from that challenge.
4. Specific interventions and technical recommendations that pertain to each therapeutic principle developed and were identified in the reviewed literature.

Method

Search strategy

A comprehensive search strategy was developed to identify publications addressing psychodynamic or psychoanalytic interventions for trauma and dissociation in adult populations. Searches were conducted across six databases (PubMed, PsychInfo, PBSC, Scopus, Psicodoc, and Medline). For each database, search equations combined terms referring to psychodynamic or psychoanalytic approaches, trauma, and dissociation, using both controlled vocabulary (when available) and free-text keywords. Boolean operators and truncation were adjusted to the syntax of each database to maximize sensitivity while maintaining conceptual specificity. Searches were limited to publications from 2010 to 2025 and to articles written in English or Spanish. Database filters were applied to restrict results to peer-reviewed scientific literature. The full set of

search equations, including database-specific adaptations, is provided in Supplementary Material.

Eligibility criteria

The eligibility criteria were defined in line with current methodological standards for scoping reviews (Peters et al., 2020). Publications were included if they were: (a) published between 2010 and 2025; (b) centered on adult clinical populations; (c) peer-reviewed scientific articles (excluding books, book chapters, and conference abstracts); (d) explicitly psychodynamic or psychoanalytic in orientation; (e) focused on trauma; and (f) written in English or Spanish.

Articles were excluded when they lacked a clear formulation of therapeutic work (i.e., technical principles, procedures, or clinical strategies), were focused on child or adolescent populations, followed non-psychodynamic frameworks, or consisted solely of single-case reports without sufficient elaboration on technique. Studies that did not present an intervention model or were not oriented toward clinical practice were also excluded.

Study selection

The database search yielded a total of 2,251 records. As shown in the PRISMA-ScR flow chart (Figure 1), 1,017 records were removed prior to screening because they were published before 2010 or were not written in English or Spanish. The remaining 1,234 records proceeded to title and abstract screening.

This first screening phase resulted in the exclusion of 1,176 records, primarily because they did not address psychoanalytic clinical work with trauma and dissociation. A total

of 58 articles were retrieved for full-text examination. After applying the predefined inclusion and exclusion criteria at this stage, 30 articles were removed due to irrelevant populations, absence of clinical focus, or lack of an articulated intervention model or therapeutic approach.

Ultimately, 28 articles met all eligibility criteria and were included in the final review. The entire selection process, including identification, screening, eligibility assessment, and final inclusion, is summarized in the PRISMA-ScR flow chart (**Figure 1**).

[Insert Figure 1 here]

Results

Our systematic search yielded a set of papers (see Table 1) that can be characterized as follows.

[Insert Table 1 here]

The articles were published in psychoanalytic journals (e.g., The Psychoanalytic Quarterly; Psychoanalytic Inquiry; The Journal of the American Psychoanalytic Association), as well as, in a few cases, journals of psychotherapy, psychotherapy research, or general psychological studies (e.g., British Journal of Psychotherapy; Journal of Trauma & Dissociation; Journal of Personality Disorders).

Most of the reviewed papers focused on complex posttraumatic presentations associated with cumulative, relational, and early-onset trauma. Some papers explicitly used the term CPTSD, although often in a relatively broad clinical sense rather than

through a strict application of ICD-11 diagnostic criteria. Others moved more ambiguously between PTSD and CPTSD, but still referred primarily to posttraumatic conditions linked to early and interpersonal trauma histories. Accordingly, the five axes identified below should be understood as most directly applicable to complex, developmental, relational, and dissociative trauma presentations, rather than to trauma exposure in the broadest possible sense.

Most of the studies were theoretical in nature, with varying degrees of systematization of an intervention model. For example, the paper by Haliburn et al. (2017) provides a theoretical rationale, a description of clinical principles, intervention phases, and therapeutic techniques corresponding to each phase. This level of specification is present in approximately 3 of the 28 documents reviewed.

Regarding theoretical orientation, most articles operate within a loosely defined field of interpersonal, relational, deficit-based, or attachment-based frameworks. These papers converge in conceptualizing traumatic phenomenology through lenses that emphasize relational (or attachment) ruptures, dissociative self-organization in response to trauma, vicissitudes of dissociation, and emotional dysregulation. In contrast, some articles are built around more specific theoretical models, such as Mentalization-Based Treatment (Rüfenacht et al., 2023), or the Conversational Model (Haliburn et al., 2017). A significant number of papers show varying degrees of "cross-fertilization" with neighboring trauma approaches, including neurobiology-based approaches (Wöller et al., 2012), dissociation theory (Craige, 2023), somatosensory approaches (Dent, 2020), among others (see below for a discussion of the under/misrepresentation of conflict-centered approaches).

Three of the 28 papers used empirical and/or research-based literatures as a central foundation for developing their technical proposals: Rüfenacht et al. (2023) (who draw on research on trauma, dissociation, and mentalization to develop trauma-focused mentalization-based treatment); Knox (2013) (who integrates findings on dissociation, affect regulation, mentalization, and agency into a tiered treatment proposal); and Wöller et al. (2012) (who use neurobiological and clinical research to formulate principles for a phase-oriented psychodynamic treatment manual for PTSD related to childhood abuse). Although the remaining papers are often informed by contemporary trauma and dissociation research, they tend to use this literature in a less systematic way, or to draw selectively on specific findings in order to support particular arguments or technical recommendations.

Beyond these general characteristics, a coherent picture of common proposals for adapting psychoanalytic sensitivity to the treatment of trauma also emerged. This picture is organized into five axes, each representing a clinical challenge stemming from specific aspects of posttraumatic psychopathology, along with the corresponding therapeutic principles and technical recommendations for implementing a trauma-informed, trauma-sensitive psychodynamic intervention. In the following section, we describe each of the five axes and provide specific examples and illustrations (see Table 2 for a summary).

[Insert Table 2 here]

Axis 1. Stabilization, dual awareness and working within a window of tolerable activation.

Psychopathological features and clinical challenges

Modern trauma theory, together with accompanying neuroscientific evidence, indicates that trauma, in its most basic sense, involves a breakdown of the essential psychosomatic mechanisms that maintain internal balance (Ogden, 2012; Van der Kolk, 2014).

The trauma literature has often described the failure of regulatory functioning in terms of a transition from hyperarousal to hypoarousal states (Kozlowska et al., 2015; Ogden et al., 2006). This involves a survival sequence in which the organism, during the initial phases of threat, the organism initiates an alarm reaction (Perry et al., 1995; Schore, 2003). This mobilizes sympathetic (hyperarousal) responses aimed at preserving life and securing protection by means of help-seeking, fight, and flight (with the corresponding difficulty containing affects of fear, rage, or disgust, as well as the organization of attentional resources towards detection of threat cues). When such mobilizing responses fail to secure escape from danger or to reduce pain, parasympathetic (hypoarousal) responses may become dominant, slowing down biological functions, flattening subjective and emotional experience (with corresponding experiences of passivity, helplessness, emotional numbing, or detachment) (Perry et al., 1995; Schore, 2003).

Dysregulation may also be a factor contributing to vulnerability to revictimization and retraumatization. Dysregulation can compromise the victim's ability to detect, evaluate, and respond to present danger. In complex interpersonal trauma, both hypoarusal (i.e., dissociative detachment, emotional numbing) and hyperarousal (cognitive disorganization, extreme help-seeking) may interfere with the patient’s capacity to register threat cues, mobilize protective responses, establish boundaries, or seek help in time, thereby increasing the well-studied vulnerability to subsequent victimization (Chu, 1992; Classen et al., 2005; Kluft, 1990; Messman-Moore & Long,

2003). This point is important in patients whose traumatic histories have involved chronic abuse, coercive attachment relationships, or a confussion of power and sexual dynamics.

The sequence and combination of hyper and hypoarousal in trauma patients can adopt different configurations. Contemporary neurobiological models distinguish between patterns of emotional undermodulation (more typically associated with hyperarousal and intrusive re-experiencing), and patterns of emotional overmodulation (more characteristic of dissociative responses) in which affective experience is dampened or rendered unavailable to reflective awareness (Lanius et al., 2010, 2012). While Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (cPTSD) seem to show a pattern of changes from hyper to hypoarousal (with the addition of profound disturbances in self-organization among cPTSD patients), a dissociative subtype of PTSD has been found in 30% of trauma patients, who show greater reliance on detachment and dissociative states (Lanius et al., 2010). In structurally dissociated presentations (e.g., OSDD/DID), dysregulation may be distributed across different self-states, so that some states may be organized around defensive mobilization, fear, rage, or traumatic re-experiencing, whereas others may be characterized by emotional numbing, submission or detachment. All this highlights diversity of emotional dysregulation across posttraumatic conditions, with the resulting challenge for therapists to assess patients and tailor treatment.

Ogden et al.'s (2006) "window of tolerance" provides us with a dynamic, potentially useful tool to discriminate different forms of dysregulation and to respond accordingly. Patients may oscillate above this window (into states of heightened sensation, emotional reactivity, hypervigilance, and disorganized cognitive processing) or below it (into states of emotional numbing, reduced sensation, diminished movement,

and impaired cognitive processing). Clinicians can be sensitive to each patient's predominant tendencies towards functioning at the upper or lower level of the window of tolerance, or their tendency to shift between the extremes. Particularly, in complex trauma presentations, dysregulation may involve shifts between excessive or insufficient activation, reflecting different points along the defense cascade and different modes of emotional modulation (Kozlowska et al., 2015; Lanius et al., 2010).

Chronic vulnerability to dysregulation can manifest itself within the boundaries of the consulting room (Dent, 2020). Trauma patients can become dysregulated during clinical conversations, under the effect of spontaneous memories or mental images, in the face of otherwise harmless interpersonal exchanges or, simply, when emotions (regardless of their valence) become intense. The very characteristics that define psychotherapy (emotion-focused conversations; biographical retrospection; free-associative dialogue; ostensive cues of empathic attunement from clinicians; etc.) can disrupt the patient's neurophysiological regulation processes. Hyperarousal may contribute to transferential configurations in which the therapist may be rapidly experienced as dangerous, persecutory, abandoning, intrusive, or insufficiently protective. Alternatively, trauma-related hypoactivation may be expressed through affective distance, a pervasive absence of hope regarding the possibility that treatment might offer anything useful, or an active resistance to any form of emotional activation. Attempting to treat trauma without recognizing this can result in analytical approaches that push patients back into a state of dysregulation, with significant iatrogenic danger: "Evoking trauma without a felt sense of safety reinscribes traumatic memory" (Dent, 2020, p. 441).

Therapeutic principle

In this context, the concept of analytical listening can be broadened to recognize the moment-to-moment bodily impact and physiological tensions at play within the patient-therapist intersubjective field.

Drawing on ideas from sensorimotor therapies and polyvagal theory, several of the reviewed authors propose working within the patient's window of tolerance (Craige, 2023; Dent, 2020; Knox, 2013; Music, 2021; Wöller et al., 2012), to explicitly consider, for each patient, where the limits of this window lie, and to modulate interventions so that therapeutic work remains inside these physiological and emotional margins. In sum, a core clinical skill has to do with *calibrating* the intensity of therapeutic work, and one of the therapist's central tasks becomes preventing the clinical encounter itself from turning into a source of overwhelm.

Specific approaches and techniques

This therapeutic principle involves continuous work to stabilize patients' autonomic nervous system through:

- Ensuring safety (through framing, continuous monitoring of the patient's state, therapeutic contracts, etc.) (Wöller et al., 2012)
- The integration of sensorimotor techniques that modulate (downward) dissociation based on hyperarousal and modulate (upward) dissociative states due to hypoarousal (Knox, 2013)
- Discrimination between past and present emotions (Wöller et al., 2012)
- The use of the mind (e.g., thoughts, memories) to regulate bodily states linked to trauma and the use of the body (e.g., controlled breathing, attention to

relaxation) to regulate mental movements linked to trauma (Rüfenacht et al., 2023).

- The incorporation of specific regulatory practices (yoga, sport, meditation, body movement) into patients' lives (Craig, 2023).
- A pendulum swing within the conversation: moving closer to the affect and then away from it, in a logic that encourages the acquisition of affective competence (Dent, 2020).

Sometimes implicitly, these proposals follow the principle of *dual awareness*, which seeks to ensure that when an emotion linked to trauma emerges, the patient can become aware not only of that emotion (i.e., danger, shame, helplessness, anger), but also of a contrary emotion based on security, stability, and contact with a present over which they have control. Slowing down breathing and observing its effects; inviting the patient to speak more slowly; paying attention to the way the body rests against the back of the seat or to the decrease in physiological arousal; looking around and recognizing the familiar coordinates of the therapeutic space; among other practices, can help patients experience intense emotion and separate themselves from it —something that counteracts the helplessness and passivity of trauma. When used repeatedly, this set of interventions opens the possibility for patients to experience traumatic reminiscences not as a reactivated and invasive present, but genuinely as *memory* (Dent, 2020).

Axis 2. Working with the unsymbolized: from bodily contagion to pre-interpretative formulations.

Psychopathological features and clinical challenges

During trauma, "cognitive functioning, including symbolization, thinking, and integration, is compromised or suspended" (Diamond, 2020, p. 847). As a result of the stress-mediated alterations of brain regions that perform integrative work, important aspects of trauma are encoded at the procedural and non-verbal level (Cates, 2014; Craige, 2023), and their expression can be limited to sensorimotor patterns and procedural interpersonal habits (Henley, 2023). In addition to this, early failures of recognition in response to the child's traumatic pain (i.e., a failure of witnessing; Benjamin, 2018) can push important parts of the victim's psychic life to the margins of the unformulated (D.B. Stern, 2010). The limitations that trauma imposes on the mind's ability to represent emotional states may result in a long-term diminished capacity for thinking, or "a compensatory regression to a psychosomatic world" (Brown, 2019, p. 1154). Therefore, an essential aspect of traumatic psychopathology is the existence of "islands" of unprocessed experience that are inaccessible to symbolization and self-reflection (see next section for more details).

In this sense, our traditional tendency to uncover and work through internal object relations, unconscious fantasies, and conflictual affects may become clinically premature in the face of some patients' tendency to experience their inner world as concrete, unsymbolized surges of experience that do not readily lend themselves to symbolic formulation. In fact, for these patients, words may have more impact as *things* that are done with them than in terms of their meaning. The patient may feel that, with words (and particularly with their tone, rhythm, timing, and affective 'temperature'), the therapist *embraces*, *supports*, *penetrates*, *expels*, *pursues*, *envelops*, or *attacks* them. Thus, it is important to recognize "that there simply cannot be a therapeutic verbal conversation *about* unrepresented affects", and "something additional to verbal (symbolic)

conversation must find its way into our clinical practice and theory" (Purcell, 2019, p. 321)[3].

Therapeutic principle

Faced with this aspect of the phenomenology of trauma, the proposals of many authors are variations on the same theme: pre-interpretative intervention. Therapists must facilitate a type of clinical dialogue that is more concerned with being close to patients in their (unformulated) experience as it unfolds than with analyzing it. As stated by Purcell (2019), "a technical attitude –one of doing things *to* our patients– must largely be replaced by a way of being *with* our patients […] in non-meaning as well as in symbolic communication." (p. 317). Rather than revealing unconscious secrets or repressed conflicts, these interventions seek to affirm aspects of the patient's experience that need to be recognized and consolidated. This type of clinical dialogue may, in the mid to long-term, promote the emergence of new opportunities to work symbolically.

Specific approaches and techniques

If symbolization is understood as a matter of degree, and if most trauma-related affects are registered at somatic, procedural, and enacted levels, trauma-focused psychodynamic intervention can be conceptualized as a 'dual-track' technical approach (Diamond, 2020). This approach includes "transformational" forms of work (oriented toward dissociated, unsymbolized traumatic experience) (we could refer to it as Track I), as well as "archaeological" interventions (oriented toward the unconscious drives, fantasies and

[3] A recent paper published after the completion of our systematic search also points in a similar direction. Leikert (2025) emphasizes that, beyond symbolic discourse, voice and body-self participate in the organization of emotional exchange in the analytic space, a level that becomes especially salient when traumatization is associated with disorders of symbolization. From this perspective, the prosodic and vocal dimensions of the analytic encounter may be understood not as secondary accompaniments to verbal meaning, but as clinically relevant carriers of bodily-affective information for both patient and therapist.

defenses that, in interaction with traumatic experience, contribute to the formation of personal meaning) (Track II). Many therapies may be characterized by oscillations between the two modes, "and the central technical issue is the analyst's ability to discover what kind of mind the patient is operating from and to tailor interventions accordingly" (Diamond, 2020, p. 856).

A common intuition found across the reviewed papers is that work with unsymbolized aspects of trauma (Track I work) is largely based on the therapist's vicarious experience of unrepresented aspects of the patient's trauma. The somatic register of traumatic experience tends to be enacted within the transference-countertransference field, and often impacts the therapist's physical experience (Craige, 2023). Postural discomfort, muscular rigidity, somatic numbness, excessively accelerated or slowed rhythms, and mismatches in the tempo of each participant's interventions may express a shared state reflecting traumatic affect. For this reason, several authors invite therapists to carefully attend to their own as well as the patient's body and actions (Cates, 2014; Craige, 2023; D'Agostino, 2011; Diamond, 2020; Henley, 2023). Beyond lending themselves to this bodily and intersubjective "contamination," therapists must be able to retain and process pre-symbolic/unformulated impacts that would otherwise go unnoticed, transforming them through associative work or reverie into communicable material (D'Agostino, 2011). For several authors, a main clinical challenge, then, is to postpone psychodynamic interpretation and transform the raw bodily-affective "contamination" that comes from patients into something that can gradually be symbolized, so that dissociated aspects of trauma may be experienced "as a presence the patient is able to own and thus to represent (initially, together with the analyst)" (Diamond, 2020, p. 858).

Within this framework, language can be used more as a vehicle for attunement than as a conveyor of meaning. It can mirror dissociated or unrepresented emotional states, while also introducing enough markedness and discrepancy to counteract unwanted solitude (Purcell, 2019) and prevent the therapist from being fully absorbed into the patient's traumatized state (Teicholz, 2014). Trauma-sensitive clinical conversations, according to these proposals, would need to shift toward a musical, preverbal, and resonant mode of being-with, in which words matter for their sensory, affective, and aesthetic qualities more than for their semantic content.

It could be argued that Track I and Track II work are not neatly differentiated realities in the actual work of many therapists treating adult manifestations of trauma. From the beginning of treatment, clinicians may often point to conflictual aspects of the patient's experience (e.g., defensive avoidance of certain contents, loyalty binds to traumatizing objects, conflictual fantasies of submission, aggression, etc.). When these interpretations are introduced with adequate pacing and within a containing, recognizing, 'maternally' inflected mode of communication, they may simultaneously function as forms of the very being-with described above.

However, while this argument is clinically sound, a significant number of the works that we reviewed point to the therapeutic priority of pre-interpretive processing of unsymbolized traumatic material, together with the *historization* (Bohleber & Leuzinger-Bohleber, 2016) of trauma and the affirmative recognition of its reality and impact. In this sense, Track I and Track II interventions, although they may oscillate and to some degree be intertwined throughout treatment, follow a certain clinical gradient. The collaborative transformation of dissociated traumatic experience often precedes the interpretation of unconscious conflict.

This gradient also underscores the importance of not conflating the recognition of an injury and its catastrophic effects (trauma work) with the uncovering of unconscious, conflict-laden meanings (fantasy work). This conflation (e.g., when masochistic fantasies surrounding memories of early physical abuse are foregrounded), entails the risk of inadvertently blaming the victim or reenacting the very failure of witnessing that trauma-sensitive psychoanalytic work seeks to repair (Benjamin, 2018; Herman, 1995).

Finally, it may be worth noting that the dual-track formulation that results from our review should be distinguished from, while remaining compatible with, contemporary guidelines that recommend staged and paced approaches to intervention. These guidelines emphasize that work with complex trauma often requires flexible sequencing according to the patient's safety, stability, and readiness to tolerate affective activation (**International Society for the Study of Trauma and Dissociation, 2011**). Whereas this phase-oriented model describes broad treatment phases, the dual-track approach refers to two psychoanalytic modes of attention that may oscillate within and across those phases. In this sense, the dual-track formulation specifies a more circumscribed technical problem: how to articulate and integrate the recognition and symbolization of dissociated traumatic experience with the interpretation of unconscious meanings, conflicts, fantasies, identifications, and defenses.

Axis 3. Talking to all the patients within the patient *(working with dissociation)*

Psychopathological features and clinical challenges

When threats become chronic, dissociative states may become stable policies of internal fragmentation that prevent the reactivation of unprocessed pain. Consequently – as stated above–, an essential aspect of posttraumatic psychology is the existence of

‘islands’ of unprocessed experience. Indeed, dissociation has become central to contemporary understandings of trauma, both within and outside psychoanalytic approaches (see Bromberg, 1998; Howell, 2005; Liotti, 1992; Liotti & Farina, 2011; Nijenhuis, 2015; Schore, 2003; Stern, 1997; Van der Hart, Nijenhuis & Steele, 2006). This argument dates back to the origins and precursors of psychoanalytic thought (e.g., Janet’s concept of “fixed ideas” or Breuer and Freud’s early conviction on the splitting of consciousness as the main pathogenic factor in hysteria) and was developed with particular depth by Bromberg and other relational psychoanalysts (see also D.B. Stern, 2010; Wachtel, 2008). According to Bromberg (1998, 2006, 2011), disjunctive self-states may be held isolated from each other as a normal strategy of the mind to guarantee its own integrity in the face of stress or the complexities of relational life. However, traumatized individuals may resort to a more rigid, all-encompassing mode of dissociation, where the mind organizes itself in a solution of segregated self-states, each holding a “relatively non-negotiable affective ‘truth’” (Bromberg, 2011, p. 15). This works as “an anticipatory protective system” (p. 15) that proactively shuts down experiential access to self-states, some of which may contain the shadow of a traumatic “tsunami” that the subject experienced in the past. The traumatized mind, therefore, can become a “balkanized” (Gaddini & Riefolo, 2020) solution of segregated parts that harbor sensations, images, feelings, procedural memories that do not inform one another (Dobrich, 2024). This entails at least two significant challenges for psychoanalytic work.

Sometimes, dialogue is organized exclusively around pseudo-functional states of the self (those that are easier to understand or compatible with the therapists' identity), excluding the patient's most vulnerable or aggressive states from the analytic field. In short, we sometimes speak to a *partial* patient. However, everyday functioning should not be mistaken for the whole person; rather, such functioning can be understood as one

part of the self that remains unable to integrate traumatic experience (the reverse error may occur: taking the defensive emotional parts as more real than the more adaptive daily-life self).

In other occasions, the patient's dissociative oscillations can induce parallel fragmentations in the therapist, who may shift between contradictory representations of a patient, losing their reflective function or their ability to maintain a protective frame. In short, when working with a single patient we sometimes seem to relate to a *multitude* of patients, each demanding different things from us and evoking conflicting perceptions and affects.

Therapeutic principle

A significant number of contemporary psychoanalytic articles coincide in the refusal to privilege one dissociated part over the others. This involves refraining from hierarchical discourse (e.g., believing one part of the patient is more relevant/healthy/authentic than another part), in other words, speaking to *all the patients within the patient*. Clinicians are encouraged to recognize and speak empathically with all the patient's dissociated parts; not only those that are most visible or functional, nor solely those associated with what has traditionally been considered a marker of psychoanalytic health (e.g., the renouncement of negative impulses). Granting clinical dignity to all parts requires acknowledging that each one carries memories, expectations, and procedural habits linked to specific aspects of the traumatic experience (Dent, 2020). It also entails recognizing that parts filled with rage, parts that feel omnipotent or defend against intimacy, or parts burdened by shame often serve a protective function, even when their effects are maladaptive or paradoxical.

The therapist who manages to empathize with all parts and simultaneously sustain their coexistence can be internalized by the patient as an integrating presence (Dent, 2020). Dobrich (2024) emphasizes that this does not imply the pursuit of complete self-cohesion (something that only some patients could achieve), but rather a growing ability to tolerate one's own division, to recognize it and to use it creatively. The overarching aim is to help patients become better "conductors" of their inner world, capable of tolerating their internal diversity without losing psychological cohesion.

Specific approaches and techniques

Dent (2020) describes the case of a man who, after a particularly intimate session, returned the following week displaying a confident and distant attitude. Her therapist noted aloud that the part of him speaking that day was different from the one that had been present the previous week. Invited to be curious rather than challenged, the patient admitted that he had probably detached from his feelings and, near the end of the session, shared a mental image: he saw himself as a general marching at the head of a besieged and wounded army, shouting orders for his troops to move faster, completely ignoring their injuries or the attacks they were facing. Upon identifying with the general and his disastrous leadership, the patient felt discouraged, fearing that he might never change. Her therapist responded: "And notice –you're seeing the whole thing– the general in his determination and obliviousness, the hardworking overwhelmed soldiers, the angry deserters, and all the dangers the troops are contending with. You can see the whole picture, you can understand all the players, and as a result, we can help you help everyone in that army, and so help yourself." (Dent, 2020, p. 446)

This vignette connects well with the Dobrich's (2024) proposal of using the therapeutic conversation to describe the relationships between different self-states and

their inter- and intrapersonal contexts. For each of the parts that appear within the therapeutic relationship (and it is important to remember that some parts will appear in a microscopic, pre-symbolic, inchoate format), the clinical dialogue can focus on their quality, their associated affects, their history, their function within the overall picture of the person's emotional life. In this way, therapy may facilitate a *conversation* between parts of the self that are often lived as discontinuous.

In some works, this proposal for a "democratic" conversation in the face of dissociation carries an important corollary: the recovery or re-voicing of certain parts that, within traumatic psychologies, are typically dissociated.

For example, Gaddini and Riefolo (2020) invite us to be attentive to the parts of the psyche that obey what they call *creative dissociation,* that is, specific islands of self-functioning that harbor a potential for meaning, adaptation, and transformation. The authors describe a patient who arrived at a session yawning, giving vague excuses for missing the previous session, and saying he felt too tired to think. This reflected a defensive dissociation aimed at avoiding thought, feeling, and unwanted parts of the self. Unexpectedly, however, an image appeared in his free association: a clumsy dancer trying to find the rhythm. This image seemed to express a dissociated aspect of the self, but also suggested the possibility of new subjective formations –a sign of "creative dissociation." Working from this image, the patient recalled his mother's recipes and the difficulties she faced cooking without proper utensils. This memory opens further associations: remorse about not being close to his children in recent weeks, and a wish—felt as partly futile—to be more present and caring. Gradually, a new subjective landscape emerged, shaped by both the desire for change and the fear of failing to achieve it, alongside associations with his absent father and the wish to parent differently. The authors suggest that classic

interpretative interventions should be reserved for moments when defensive dissociation predominates (presenting an obstacle to creative work). Conversely, they invite us to speak pre-interpretatively (i.e. from a stance of genuine curiosity, support and affirmation) with creative dissociations that emerge within the clinical conversation.

Axis 4. Avoiding regression and modulating intimacy

Psychopathological features and clinical challenges

For victims of early interpersonal trauma, approaching others in search of protection and comfort led, in a significant proportion of cases, to the experience of unsolvable fear, the loss of control and predictability, and confusion. Across development, shared vulnerability, trust, or the search for protection or comfort (all related to the activation of the attachment system) can become associated with the threat of disorganization (Liotti, 2004). Trauma psychology is often built on an equation between intimacy and danger.

The main clinical challenge arising from these considerations involves a paradox: patients need us to get close to them and, at the same time, fear feeling close to us. The characteristics that define a good-enough therapeutic device (i.e., empathy, care, recognition, or the promise of mutuality) make our patients vulnerable to falling back into disorganization, internal fragmentation, or loss of control over their mental states. This phenomenon can intersect with structural dissociation (see Axis 3 for details): dissociated parts react in sharply divergent ways to the therapist's interventions (e.g., gestures of warmth or overt care may activate suspicion in the patient's protective parts; indications of irritation, anxiety, or frustration on the therapist's side can be experienced by more vulnerable attachment-oriented parts as catastrophic; etc.). Under these conditions, both patient and therapist can feel immobilized, caught in an interpersonal configuration that

echoes Hesse and Main's (2000) notion of "fear without solution", in which no response seems safe and every option risks reproducing old injuries. In these situations, standard therapeutic instincts, such as deepening the relationship or increasing session frequency, may inadvertently escalate the patient's internal conflict, heightening both the longing for and the terror of closeness (Dent, 2020).

Therapeutic principle

The fundamental principle that derives from these clinical challenges is that of modulating intimacy within the therapeutic relationship. Contrary to the reliance on transference neurosis or holding/containment dynamics that have governed a good part of psychoanalytic traditional sensitivities, the reviewed works agree on the importance of preventing regression and making the patient's mind a more 'habitable' space.

Taken together, these proposals converge wanting to promote, among patients, a stable capacity to sustain and regulate themselves. Rather than occupying the position of omnipotent container or distant interpreter, the therapist becomes an active, steady, and trustworthy partner in the course the patients' task: that of recognizing, appreciating, and responding to their internal world with compassion (Dent, 2020).

Specific approaches and techniques

This therapeutic principle involves an important departure from one of the most traditional, central aspects of psychodynamic approaches to the therapeutic dialogue, namely: transference interpretations. A diversity of authors (Bohleber & Leuzinger-Bohleber, 2015; D'Agostino, 2010; Dent, 2020; Wöller et al., 2012) propose minimizing or postponing transference-focused interventions, reserving them for moments in which

transference becomes a direct obstacle to the therapeutic alliance, rather than treating it as the primary analytic vehicle of change.

In parallel, therapeutic processes may strengthen patients' available internal resources. For example, Rüfenacht et al. (2023) advocate the use of stabilization strategies (see Axis 1) combined with targeted psychoeducation to help patients understand the basic mechanisms governing their psychobiological functioning (i.e., dissociation, hyperactivation, etc.), in order to foster, among patients a rational and compassionate relationship with their internal states. Craig (2023) sees value in integrating discussions about actions and life habits that support self-regulation and restore a sense of competence (e.g., connecting socially, participating in group activities, modulating exposure to stimulating content, and engaging in restorative bodily practices). These proposals can be complemented by the consolidation of positive internal objects, for example through encouraging patients to evoke memories of well-being or secure attachment figures, or (again) by explicitly adopting a resource-centered approach (Wöller et al., 2012).

Music (2011) reflects upon the adaptive value of deploying angry parts that are related to trauma but may be dissociated. Anger can be a vital aspect of the patient's self-experience: an affect that can generate vitality, agency, and self-worth. Providing space for angry parts to articulate their claims may allow patients to explore adaptive ways of asserting their rights, establishing protective boundaries, or recognizing the vulnerable self-states that anger often defends.

Axis 5. Putting one's own fragility at the service of the process

Psychopathological features and clinical challenges

A final key principle in the psychopathological consideration of post-traumatic states is their strong tendency to generate relational pressures that turn others into what Wachtel (2014) describes as “accomplices” in the re-experiencing of relational pain. Enactments often unfold at preverbal and bodily levels, in the form of contagious tensions, impulses, and affects. They can be acute and explicit, or otherwise chronic, obstructive collusions in the therapeutic dyad (often, acute enactments are an open manifestation of previous chronic, implicit therapist-patient collusions; see Cassorla, 2008). The communicative significance of enactment (i.e., the totality of what happens and is done unconsciously between patient and therapist) often eclipses the meaning of what is said (Purcell, 2019, p. 324).

For therapeutic dyads that work around trauma, these enactments in therapy often encapsulate a dilemma concerning truth and acknowledgement. Therapists may find themselves caught in patterns of oscillation when confronting traumatic material — connecting too much or too little (Bohleber & Leuzinger-Bohleber, 2016). The patient’s traumatic shame can infiltrate the therapist’s emotional experience, stimulating collusive dynamics in which both participants (the patient out of shame, the therapist out of fear of exposing the patient) leave essential aspects of the experience unprocessed (Goldblatt, 2013). Alternatively, when patients express their suffering in language that is inchoate or childlike, therapists may respond with well-intentioned, adult, technically informed interventions that unintentionally reinforce the suspicion that these nuclei of traumatic “knowing” should remain sealed off (Levy & Shalgi, 2022). In all cases, a conflict between knowing and not knowing is enacted, reproducing one of trauma’s defining features: the fear of acknowledging pain and the participation of others through ignorance or silence (Herman, 1995).

Benjamin (2018) alerts us that, in face of these dilemmas, traditional interventions (e.g., interpretation, containment) can paradoxically re-instantiate the failure of witnessing. By attributing the patient's suffering to their unconscious processes, some interpretations may reproduce the patient's early experiences of non-recognition. Likewise, containment may evoke the victim's unwanted solitude when the therapist assumes a position of emotional immunity (echoing caregivers who denied their own vulnerability and therefore failed to acknowledge moments of relational rupture).

Therapeutic principle

Diamond (2020) states that enactments "may become a necessary therapeutic tool for representing and interpreting the meaning that has been unconsciously repudiated" (p. 855). In fact, following D.B Stern (2010), we can think of enactment as a process through which dissociated experience becomes interpersonalized within the analytic field. This would mean that unprocessed, unformulated parts of the patient's (and, often, the therapist's) trauma become available for the therapeutic dyad to work upon. Thus, enactment may become the site where dissociated experience, unconscious meaning, and conflictual affect converge, raising the question of how both can be integrated and timed in work with traumatized patients.

Across some of the works that were reviewed, a good "use" of enactment in therapy stems from the therapists' basic disposition to lend their subjectivity to the impact of the patient's trauma and *using* that impact as a platform for interactive repair and shared reflection. For Levy and Shalgi (2022), the only way of transforming shared dissociation into imagination is for the patient to meet a therapist who sometimes can respond from their own emotional vulnerability. The therapist allows themselves to be vicariously

“traumatized” to counteract the patient's loneliness, to recover their ability to bear witness, and to help the patient reclaim their own pain.

Specific approaches and techniques

Participating in the inhibitions, fears, and catastrophic anxieties that patients cannot process on their own represents an essential way in which this principle is expressed (Katz, 2015). Purcell (2019) compares this to a sort of clinical “duetting”, where therapists follow the patient’s lead:

> Ideally, the “following” analyst gives himself over to the singing and dancing of the patient and partners there; he lends the patient his subjectivity, he doesn't impose it. […] This sort of following and companioning with dissociated patients […] feels like descending into chaos and darkness, […] It is in this territory where analysts are most likely to dissociate from what could be a shared experience (Purcell, 2019, p. 334).

Gordon (2023) speaks of a “dissociative bond” as a particular modality of this therapeutic participation. The author defines it as a shared space between patient and therapist where not knowing and not feeling become a shared experience. By inhabiting this state of shared emptiness, paradoxically, therapists may enable the creation of a therapeutic bond, a sense of joining and mutual trust. The therapist embodies both the dissociative impulse (which they share with the patient) and the prospect of a creative conversation about content that is unmanageable or not yet formed. The clinical task would consist of evolving towards creative formulation and transforming physical contagion into symbolic material, moving out of the ‘dead space’ projected by the patient into a living space of recognition, thought, and creativity (Diamond, 2020), introducing

small incremental deviations that open up a new category of shared experience, making patient-therapist contagions visible and “fantasizable” (Bohleber & Leuzinger-Bohleber, 2016; Waldron, 2010).

Levi and Shalgi (2022) describe a deeply depressed patient who texted the therapist to express inner tension and wordlessness. The therapist first responded in a brief, emotionally detached way, but later realized that this had repeated the patient’s experience of emotional unavailability. Observing the patient’s vigilant, searching stance in session, he also recognized his own withdrawal and linked it to unresolved reactions to parental depression in his family history. This recognition enabled a shift toward greater affective presence. The therapeutic turning point lay in his ability to acknowledge the rupture in emotional contact, recognize the patient’s hope and fear in reaching for him, and return to the interaction in a more responsive way:

> "I see your furtive glances and I’m glad that you’re looking for me. […] I’m terribly sorry that I was sleeping on the job when you texted me. […] Your harsh voices met harsh voices of mine and caused me to fall asleep. […] I see you hoping for someone to be with you. […] And then the adults, outside and inside you, take over and suppress any other conversations, and you are voiceless. I let those adults delude and captivate me, and I lost you. I hope I will not fall asleep anymore.”

This vignette illustrates how enactments can become an opportunity for therapists to become objects of the patients’ inquiry. Note that traumatized adults come from interpersonal environments where the caregivers’ minds were difficult to understand and predict (Fonagy et al., 2002), or who responded under the influence of unresolvable conflicts between different motivations (e.g., caregiving vs defense) (Solomon & George, 2011), which made interactions confusing for the child. Moreover, trauma can involve

the caregivers' denial of their own aggressiveness and vulnerability, making it very difficult for the traumatized child to read into parental motives and emotions. In face of this, psychodynamic therapy can be a space where patients are allowed to scrutinize the therapist's flaws and expect therapists to speak assertively and congruently (always in the interest of the clinical process) from their own areas of confusion and vulnerability (Levi & Shalgi, 2022).

Discussion

Modern trauma-focused psychodynamic psychotherapy, as we have seen, seeks to become theoretically and technically porous to integrate specific and psychopathologically informed ways of working with patients that are vulnerable to disorganization, unable to fully symbolize important aspects of their experience, and in need of but also fearful of intimacy. Our review suggests that, faced with these challenges, contemporary authors –using different terms and nuances– invite us to use therapy as a space that allows the patient to reinhabit a safe body, tell their own story –always threatened by the shadow of dissociative fragmentation– and experience intimacy and trust without losing their self-organization. And, to achieve all this, they invite us to become therapists who constantly monitor and (help) regulate the patient's state of arousal; pay attention to the aliveness and resonance of clinical encounter; foster the patient's ability to cooperate with us without becoming confused; and bear witness to the patient's suffering. Overall, this review identifies a set of tendencies that comprise what might be called a "trauma-informed sensitivity" in contemporary psychoanalytic journal literature.

Taken together, the proposals brought together here suggest that trauma-informed psychoanalytic treatment must situate conflict-centered work within a temporally and

clinically responsive framework in which the timing, form, and intensity of interpretation are calibrated to the patient's regulatory, dissociative, and symbolic capacities. In this sense, the relative emphasis of regulation and conflict may shift according to the patient's clinical needs, but remain deeply intertwined. Efforts to foster regulation may bring underlying conflicts, defensive arrangements, and relational dilemmas into awareness, just as conflict-focused interventions, when adequately timed, may strengthen the patient's capacity for affective regulation and symbolic integration.

This integrated view also helps preserve a central psychoanalytic concern. According to Diamond (2020), when the question of *who* dissociates –the *agent* who needs or comes to dissociate– drops out of the clinical picture, "several essential tenets of unconscious mental processing (pertaining to primitive endogenous fantasy, impulse, somatic experience, and conflict)" may be lost to the clinical dialogue (p. 845). This concern recalls Stephen Mitchell's (1988) classic warning against the "developmental tilt" that, within modern psychoanalysis, may have pushed the conflictual/agential dimensions of psychic life into the background. For these authors, even severely traumatized patients cannot be reduced to psychobiological mechanisms of shutdown, since trauma and its effects always interact with an internal world of fantasy, defense, guilt, desire, and unconscious meaning. These discrepancies reflect a long-standing psychoanalytic tension between the recognition of exogenous trauma and dissociation and the tendency to translate traumatic suffering into intrapsychic conflict, fantasy, and defense (Diamond, 2020; Howell & Itzkowitz, 2016). In his work with hysterical patients, Freud recognized the traumatic mechanisms underlying symptom formation (Breuer & Freud, 1895). Drawing inspiration from Janet and Charcot, he believed that trauma leads to the division of consciousness (i.e., dissociation) to exclude *conflicting* ideas or memories. Importantly, this formulation integrates a

dissociation-centered with a conflict-centered understanding of the response to trauma. For biographical and socio-historical reasons (Herman, 1992; Howell & Itzkowitz, 2016), Freud moved away from this sensitivity in favor of a perspective that privileged internal conflict, to the detriment of the recognition of the patients' actual experiences of abuse and neglect. From then on, trauma has remained a persistent, if unevenly recognized, thread within psychoanalytic history.

Ferenczi's work provided one of the most explicit early correctives to the marginalization of exogenous trauma. Later, developments within object-relations and attachment-oriented traditions, particularly in Balint, Fairbairn, Winnicott, and Bowlby, kept alive the clinical importance of environmental failure and the pathogenic effects of caregivers' failures of protection, recognition, and response. This line evolved into the contemporary relational approach, which emphasizes the ways in which early relational trauma is reenacted within the therapeutic setting (Benjamin, 2018; Bromberg, 2011; D.B. Stern, 2010).

As Howell and Itzkowitz (2015) note, psychoanalytic ambivalence toward trauma-centered work has been sustained by conflicting views on the nature of psychoanalytic data (i.e., whether actual experiences qualify as properly psychoanalytic material alongside fantasy, drive, and inner conflict), persistent concerns about "proper" technique and, more broadly, the demand that trauma places upon clinicians (one that is clearly reflected in the papers reviewed here) to depart from classical approaches to treatment . In the face of these tensions, Diamond (2020) suggests that, instead of replacement, a relationship of supplementation should take place between dissociation-centered and repression-centered sensitivities. This

would involve understanding that trauma not only has an economic dimension (its "*too muchness*"), but can also produce structural/intrapsychic conflicts, while also having an object-relational aspect (dealing with the absence of the object and/or its protective function) (Diamond, 2020). Or, as Levine (2021) points out, trauma "will to some extent be understood and integrated into our particular subjectivities according to our unique, subjective organizations of self, understandings of and position in the world" (p. 794).

This argument about the need for supplementation between dissociation-centered and conflict-centered perspectives should be read in light of the scope of our corpus. Because our search strategy was restricted to peer-reviewed journal articles, this article cannot determine the full extent to which similar integrations have already been developed in psychoanalytic books, clinical monographs, or other non-peer-reviewed sources. Our results characterize a specific journal-based corpus, rather than the entire psychoanalytic clinical literature.

In sum, one implication of this scoping review for psychoanalytic work with trauma may be the value of oscillating between two modes of clinical attention. One mode focuses on helping the traumatized patient maintain stability while gradually recovering representational capacities and more resourceful ways of functioning. The other explores unconscious fantasies and identifications, conflictual affects, defenses, and the ways patients unwittingly sustain their own deficits or maladaptive patterns in the service of identity cohesion or loyalty to internalized objects (Mitchell, 1988). From this perspective, trauma-informed psychoanalytic treatment does not abandon conflict-centered analytic work, but relocates it within a temporally and clinically responsive model of technique.

The literature surveyed in the present work represents a renewed attempt to address a tension that has accompanied the field since its inception, and, with new insights coming from neighboring schools (e.g., Sensorimotor Psychotherapy), to relocate traumatic injuries, dysregulation and the dissociative mind (Itzkowitz & Howell, 2015) at the center of the psychoanalytic stage. This valuable effort enriches our view of trauma-centered psychoanalytic psychotherapy while leaving open important questions for future psychotherapy research: Are these trends an extension of psychoanalytic technique or a more substantial reconfiguration of its premises? How can regulation and interpretation be integrated without reducing one to the other? And under what clinical conditions can such integration take place?

References

Alessi, E. J., & Kahn, S. (2017). Using psychodynamic interventions to engage in trauma-informed practice. *Journal of Social Work Practice, 33*(1), 27–39. https://doi.org/10.1080/02650533.2017.1400959

Balint, M. (2013). *The basic fault: Therapeutic aspects of regression*. Routledge. (Original work published 1968)

Benjamin, J. (2018). *Beyond doer and done to: Recognition theory, intersubjectivity and the third*. Routledge.

Bohleber, W., & Leuzinger-Bohleber, M. (2016). The Special Problem of Interpretation in the Treatment of Traumatized Patients. *Psychoanalytic Inquiry*, *36*(1), 60–76. https://doi.org/10.1080/07351690.2016.1112223

Breuer, J., & Freud, S. (1955). *Studies on hysteria*. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2). Hogarth Press. (Original work published 1895)

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Analytic Press.

Bromberg, P. M. (2011). The shadow of the tsunami: And the growth of the relational mind. Routledge.

Brown, L. J. (2019). Trauma and representation. *The International Journal of Psychoanalysis*, *100*(6), 1154-1170.

Busch, F. N., & Milrod, B. L. (2018). Trauma-Focused Psychodynamic Psychotherapy. *The Psychiatric clinics of North America*, *41*(2), 277–287. https://doi.org/10.1016/j.psc.2018.01.005

Cassorla, R. M. S. (2008). The analyst's implicit alpha-function, trauma and enactment in the analysis of borderline patients. *The International Journal of Psychoanalysis*, *89*(1), 161-180.

Cates, L. B. (2013). Insidious Emotional Trauma: The Body Remembers … *International Journal of Psychoanalytic Self Psychology, 9*(1), 35–53. https://doi.org/10.1080/15551024.2014.857751

Chamberlin, D. E. (2019). The predictive processing model of EMDR. *Frontiers in psychology*, *10*, 2267.

Chefetz, R. A. (2015). *Intensive psychotherapy for persistent dissociative processes: the fear of feeling real (Norton series on interpersonal neurobiology)*. WW Norton & Company.

Chu, J. A. (1992). The revictimization of adult women with histories of childhood abuse. *The Journal of Psychotherapy Practice and Research, 1*(3), 259–269.

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse, 6*(2), 103–129. https://doi.org/10.1177/1524838005275087

Craige, H. (2023). At Home in Oneself: Self-States and the Treatment of Trauma. *Psychoanalytic Inquiry, 43*(6), 468–481. https://doi.org/10.1080/07351690.2023.2235305

D'Agostino, G. (2010). Analytic listening as a holding function of the dissociated parts of the patient. *International Forum of Psychoanalysis*, *20*(1), 31–37. https://doi.org/10.1080/0803706X.2010.514944

Dent, V. (2020). When the Body Keeps the Score: Some Implications of Trauma Theory and Practice for Psychoanalytic Work. *Psychoanalytic Inquiry*, *40*(6), 435–447. https://doi.org/10.1080/07351690.2020.1782144

Diamond M. J. (2020). Return of the Repressed: Revisiting Dissociation and the Psychoanalysis of the Traumatized Mind. *Journal of the American Psychoanalytic Association*, *68*(5), 839–874. https://doi.org/10.1177/0003065120964929

Dobrich, J. (2024). Expanding dissociation informed psychoanalytic practice: How to make conceptual sense of Not-Me, No-Me, and Many-Mes. *Psychoanalysis, Self and Context*, 1–22. https://doi.org/10.1080/24720038.2024.2400216

Ferenczi, S. (1928). The elasticity of psychoanalytic technique. *In Final contributions to the problems and methods of psychoanalysis*. M. Balint (Ed.) & E. Mosbacher (Trans.). (pp. 87–101). London: Karnac. 1994.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Gaddini, A., & Riefolo, G. (2020). "I-ness" and the dissociative process. Working with defensive and creative dissociations in the analytic process. *American Journal of Psychoanalysis 80*(1), 53–68. https://doi.org/10.1057/s11231-020-09240-4

Goldblatt, M. J. (2013). Shame in psychodynamic psychotherapy of post-traumatic states. *The Scandinavian Psychoanalytic Review*, *36*(2), 104–111. https://doi.org/10.1080/01062301.2013.852877

Gordon, N. (2013). The Dissociative Bond. *Journal of Trauma & Dissociation*, *14*(1), 11–24. https://doi.org/10.1080/15299732.2012.694595

Haliburn, J., Stevenson, J., & Halovic, S. (2018). Integration in the Psychodynamic Psychotherapy of Severe Personality Disorders: The Conversational Model. *Journal of personality disorders*, *32*(1), 70–86. https://doi.org/10.1521/pedi_2017_31_290

Henley, B. M. (2023). Psychodynamic techniques elicit emotional engagement in complex post-traumatic stress disorder. *Psychoanalytic Psychotherapy*, *37*(3), 231–242. https://doi.org/10.1080/02668734.2023.2231059

Horowitz M. (2018). Redefining Identity after Trauma or Loss. *Psychodynamic psychiatry*, *46*(1), 135–144. https://doi.org/10.1521/pdps.2018.46.1.135

Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. JAPA, 48, 1097–1127.

Howell, E. F. (2005). *The dissociative mind*. Analytic Press.

International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12*(2), 115–187. https://doi.org/10.1080/15299732.2011.537247

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Katz, G. (2015). Repressed Ghosts and Dissociated Vampires in the Enacted Dimension of Psychoanalytic Treatment. *The Psychoanalytic Quarterly*, *84*(2), 389–414. https://doi.org/10.1002/psaq.12006

Kluft, R. P. (Ed.). (1990). *Incest-related syndromes of adult psychopathology*. American Psychiatric Press.

Knox, J. (2013). The Mind in Fragments: The Neuroscientific, Developmental, and Traumatic Roots of Dissociation and Their Implications for Clinical Practice. *Psychoanalytic Inquiry*, *33*(5), 449–466. https://doi.org/10.1080/07351690.2013.815063

Kozlowska, K., Walker, P., McLean, L., & Carrive, P. (2015). Fear and the defense cascade: Clinical implications and management. *Harvard Review of Psychiatry, 23*(4), 263–287. https://doi.org/10.1097/HRP.0000000000000065

Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D., & Spiegel, D. (2010). Emotion modulation in PTSD: Clinical and neurobiological evidence for a dissociative subtype. *American Journal of Psychiatry, 167*(6), 640–647. https://doi.org/10.1176/appi.ajp.2009.09081168

Lanius, R. A., Brand, B., Vermetten, E., Frewen, P. A., & Spiegel, D. (2012). The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications. *Depression and Anxiety, 29*(8), 701–708. https://doi.org/10.1002/da.21889

Leikert, S. (2025). Voice, body-self and trauma in the analytic space. *The International Journal of Psychoanalysis, 106*(6), 1108–1126. Advance online publication February 2, 2026. https://doi.org/10.1080/00207578.2025.2503358

Leuzinger-Bohleber, M. (2015). Working with severely traumatized, chronically depressed analysands. *The International Journal of Psychoanalysis*, *96*(3), 611-636.

Levine, H. B. (2021). Trauma, process and representation. *The International Journal of Psychoanalysis*, *102*(4), 794-807.

Levy, D., & Shalgi, B. (2022). Imagination and Fantasy: The Dialectic Nature of the Encounter with Trauma and Dissociation. *Psychoanalytic Dialogues*, *32*(1), 54–69. https://doi.org/10.1080/10481885.2021.2011731

Liotti, G. (2004). Trauma, dissociation, and disorganized attachment: three strands of a single braid. *Psychotherapy: Theory, research, practice, training*, *41*(4), 472.

Liotti, G. (2017). Conflicts between motivational systems related to attachment trauma: Key to understanding the intra-family relationship between abused children and their abusers. *Journal of trauma & dissociation*, 18(3), 304-318.

Liotti, G., & Farina, B. (2011). *Sviluppi traumatici: Eziopatogenesi, clinica e terapia della dimensione dissociativa*. Raffaello Cortina.

Lupien, S. J., Juster, R. P., Raymond, C., & Marin, M. F. (2018). The effects of chronic stress on the human brain: From neurotoxicity, to vulnerability, to opportunity. *Frontiers in neuroendocrinology*, *49*, 91-105.

Lyons-Ruth, K. y Jacobvitz, D. (2016). Attachment disorganization from infancy to adulthood: Neurobiological correlates, parenting contexts, and pathways to disorder. En Cassidy, J. y Shaver, P. R. (Eds.). Handbook of attachment: Theory, research, and clinical applications (pp. 667-695), Guilford Press.

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation. *Clinical Psychology Review, 23*(4), 537–571. https://doi.org/10.1016/S0272-7358(02)00203-9

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Harvard University Press.

Music, G. (2021). Being safe and being brave: new thoughts on trauma, and adaptations to technique. *Psychoanalytic Psychotherapy*, *35*(4), 318–334. https://doi.org/10.1080/02668734.2021.1992490

Nijenhuis, E. R. S. (2015). *The trinity of trauma: Ignorance, fragmentation, and treatment*. Vandenhoeck & Ruprecht.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy (norton series on interpersonal neurobiology)*. WW Norton & Company.

Ogden, T. (1990/2018). *The matrix of the mind: Object relations and the psychoanalytic dialogue*. Routledge.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal, 16*(4), 271–291. https://doi.org/10.1002/1097-0355(199524)16:4<271::AID-IMHJ2280160404>3.0.CO;2-B

Peters, M. D., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., ... & Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI evidence synthesis*, *18*(10), 2119-2126.

Purcell, S. D. (2019). Psychic song and dance: Dissociation and duets in the analysis of trauma. *The Psychoanalytic Quarterly*, *88*(2), 315-347.

Rüfenacht, E., Shaverin, L., Stubley, J., Smits, M. L., Bateman, A., Fonagy, P., & Luyten, P. (2023). Addressing dissociation symptoms with trauma-focused mentalization-based treatment. *Psychoanalytic Psychotherapy*, *37*(4), 467- 491. https://doi.org/10.1080/02668734.2023.2272765

Schore, A. N. (2003). *Affect dysregulation and disorders of the self*. W. W. Norton.

Solomon, J., & George, C. (Eds.). (2011). *Disorganized attachment and caregiving.* The Guilford Press.

Stern, D. B. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Analytic Press.

Stern, D. B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. Routledge.

Teicholz, J. G. (2014). Treating Trauma: The Analyst's Own Affect Regulation and Expression. *Psychoanalytic Inquiry*, *34*(4), 364–379. https://doi.org/10.1080/07351690.2014.899790

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. W. W. Norton.

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Viking Penguin.

Wachtel, P. L. (2008). *Relational theory and the practice of psychotherapy*. Guilford Press.

Wachtel, P. L. (2014). *Cyclical psychodynamics and the contextual self: The inner world, the intimate world, and the world of culture and society.* Routledge/Taylor & Francis Group.

Waldron S. (2010). A curious metaphor. Engaging with trauma: an analytical perspective. *The Journal of analytical psychology*, *55*(1), 74–90. https://doi.org/10.1111/j.1468-5922.2009.01825.x

West, M. (2013), Trauma and the transference-countertransference: working with the bad object and the wounded self. *Journal of Analytical Psychology, 58*(1), 73-98. https://doi.org/10.1111/j.1468-5922.2013.02018.x

Winnicott, D. W. (1958). Metapsychological and clinical aspects of regression within the psychoanalytical set-up. In *Collected papers*, *through paediatrics to psychoanalysis*. London: Tavistock. (Original work published 1954)

Wöller, W., Leichsenring, F., Leweke, F., & Kruse, J. (2012). Psychodynamic psychotherapy for posttraumatic stress disorder related to childhood abuse--Principles for a treatment manual. *Bulletin of the Menninger Clinic*, *76*(1), 69–93. https://doi.org/10.1521/bumc.2012.76.1.69