Falling Forever: The Price of Chronic Shock

Kathleen A. Adams, Ph.D.

Kathleen A. Adams, Ph.D. is a clinical psychologist in private practice in Austin, Texas.

ABSTRACT

Manifestations of chronic shock and annihilation anxiety—including autistic defenses, chaotic relationships, disorganized attachment, split-off affective states, and vulnerability to disintegration—exist side by side with apparent ego strength and high functioning, even in non-abused patients. Chronic shock stemming from uncontained distress and failed dependency during childhood can persist throughout the lifespan, creating ripples of dysfunction that mask as character distortion and contribute to therapeutic impasse. Patients rely on omnipotent defenses to provide a sense of "having skin" in the face of the fear of breakdown, striving to avoid vulnerability, and to insulate themselves from shock experience. Although the relinquishment of autistic defenses and subsequent integration of disowned affect states are overwhelming and painful, patients can emerge from this process with significant shifts in intrapsychic, interpersonal, and existential/ spiritual functioning. Clinical material from one psychodynamic psychotherapy group tracks the group process and growth trajectories of seven group members struggling with chronic shock. The ability to recognize subtle dissociative states is a valuable tool in the repertoire of the group psychotherapist.

Marilyn was a thirty-year old company CEO who loathed her group therapy session every Tuesday night. She insisted that I ignored her and gave preferential treatment to all the other group members, as her mother always did with her sisters. Worse yet, she could hardly stand to look at me because I resembled the Wicked Witch of the West. For four years, she had been game-playing, sulky, and non-communicative in group. I knew from her individual therapist that she desperately longed for my eyes and my warmth. Yet whenever I tried to engage her on a verbal level I felt rebuffed, inadequate, and incompetent. If I would catch her eyes and smile at her the moment she walked into the group room, she would briefly light up, only to descend into haughty frozenness once group began. She spoke in a rote, distant, intellectualized manner that was perplexing, given the consistent vulnerability she brought to her individual therapy. She confided to her therapist that she had fantasies of throwing herself down my stairs to compel my concern, but would become blank and dismissive when I asked her about these fantasies, acting like she had no idea what I was talking about. She knew that her therapist and I discussed her progress on a weekly basis, but whenever I brought up any content from those sessions, she acted confused.

Since she was working actively in individual therapy about the agony she experienced with me, but was "playing hard to get" with me in group, I allowed her to wrestle silently with her ambivalence, inviting her to share her disappointments in me but not pressing the point when she chose to be dismissive. I thought of her as an entrenched "help-rejecting complainer," a quiet borderline who was stuck in a re-enactment of her early childhood. A bit of background: Marilyn's mother was abandoned to an orphanage at an early age and tended to be eerily silent. Marilyn's father was a combat veteran who was unable to talk about his feelings. When Marilyn

was one, her mother had another baby. Simultaneously, the mother became gravely ill and was bed-bound for two years. During Marilyn's toddler-hood she had to gaze distraughtly from the floor at her mother holding the new baby; she was not big enough to crawl up on the bed nor could her mother reach down and pick her up. And to make matters worse, Marilyn was so nearsighted that she could not rely on maternal eye contact for emotional connection or reassurance.

Marilyn gradually began to thaw towards other group members and interact warmly, but she maintained the "ice queen" façade with me. One evening she shared a dream in group: A botanical garden had a rare and beautiful species of tree, lush with multicolored flowers and delicious fruit. The tree was slowly dying, however; unbeknownst to the caretakers, the ground beneath the apparently healthy tree was frozen. The roots beneath the tree were rotting, starving, and desperate for nurturing attention. This dream heralded a major shift in our work together. As I listened to this dream, I developed a new understanding that Marilyn was not so much characterologically disturbed, as she was quietly and subtly dissociative (Dissociative Disorders Not Otherwise Specified [DDNOS]). She struggled with vertical splits ("side-by side, conscious existence of otherwise incompatible psychological attitudes in depth" (Kohut, 1971). While part of her was an over-intellectualized executive, another part of her was a frantic toddler, with fractured affects and concrete thinking. I thanked her for her dream and told her that I suddenly understood that I had been torturing the "baby" in her all these years, and that I was deeply sorry. She burst into a heart-wrenching, undefended wailing of rage, terror, and tears. In vulnerability and confusion she asked why I was being nice to her *now* when I used to watch her fall and fall without trying to catch her. She turned to the group to ask why they hadn't said something all those times she obviously shattered into pieces in group. The group members explained that they

were startled to find out that she was suffering, that she always looked quite "together," if somewhat irritated by my incompetence. She was flabbergasted by the group's response. How could all of us have so missed the obvious: *she was in shock all the time in group, just like she had been in shock all her life; she might as well have been left on a mountain to die, for all the help she had received trying to connect with me.* She thought group was supposed to help her learn how to connect; instead, I had helped her do what she did best: survive nothingness. I told her that if I had *known* there was a frantic two year old inside of her trying to beg for help, I would never have left her to die in the cold, frozen ground; that I had presumed she had the skills to come to me since she was so sophisticated in many other respects. She was fascinated to learn that she looked so different on the outside then she felt on the inside, and resolved to learn to take better care of her needs for emotional attunement. She had buried her emotional self behind a wall of impenetrability, which even she had difficulty accessing.

THE TUESDAY NIGHT GROUP

For the past nine years, this group was comprised of middle-aged individuals who manifested vulnerability to disintegration, in conjunction with a high level of functioning, considerable ego strength, and a demonstrated commitment to personal growth. Most individuals were in at least twice a week individual therapy, some with the author, others with various other primary therapists. I collaborated weekly with these primary therapists. The group had slightly more men than women, totaling 12 in all, most with some history of a difficult childhood but not outright abuse. None carried a PTSD diagnosis or presented with amnesias, "lost time," or other formal signs of dissociation. All the patients in the Tuesday group had experienced extensive cumulative trauma (Khan, 1974) due to failed dependency and/or neglect. None of the patients carried a dissociative diagnosis, but eight of the patients demonstrated

chaotic and alternating attachment patterns consistent with the construct of disorganized attachment (by clinical observation and history). Of the other four, two appeared to be avoidantly attached, and two displayed preoccupied/anxious attachment. Three of the group members were in stable marriages; most had been married and divorced long before entering group. Two group members had never married. Only four group members had any substantial or enduring friendships before entering group.

Reverberations of Marilyn's Work in the Group Process

After Marilyn revealed her dream and introduced the notion of chronic shock into the group, group themes increasingly depicted shock, deprivation, terror, shame about needs, and yearning. Although Marilyn's dream had served as a gateway to her inner world of fragmentation, she remained unconvinced that she had done the right thing (bringing her dependency needs into group). She guardedly asked me how I felt about the last session, confessing that she was terribly mortified to have acted like such a baby. I told her that I thought her dream had powerfully captured her inner reality to help me finally understand her, and thought her rage appropriate, not babyish. I added that I looked forward to many such interactions with her and other group members who felt let down by me, because the only way to find out if you could really be yourself in a relationship was to test the waters and find out if the other could survive your rage. Marilyn was startled to notice that she was already feeling closer to me, and said so. On the other hand, she admonished me; although her "little girl" was happy that I had finally apologized for being so mean to her, my apology had not let me off the hook. While she would continue to work in individual therapy with the "little girl" self to enable her talk with me at some future time, she didn't know if this little girl could ever learn to trust me. Marilyn herself trusted me, but she said the little girl still believed I hated her.

The group went on to explore the meaning of apology in their lives. Several members expressed their surprise that I would admit having made a mistake, much less be willing to apologize. John shared how meaningful it was to him that his father had admitted to him that he had not been the greatest father to him. Others wept at the futility of wishing that their parents might ever realize or acknowledge their mistakes. Raine talked about how loving both her parents were, and complained that the group seemed to be into parent-bashing. Group members told her that while her parents had been loving, she would eventually have to face the reasons she had so much anxiety and terror, which she kept locked up in a metaphorical closet. Paul scoffed at the idea that apologies from parents could be meaningful, as his father whined constantly about being a bad father, while simultaneously asking for reassurance and continuing to be abusive. Yet he was intrigued that I had offered no excuses and simply focused on Marilyn's pain, without asking her to forgive me or take care of me emotionally. He asked me why.

I talked for a few moments about secure and insecure attachment, explaining that two experiences seem to facilitate attachment security: the experience of someone trying to understand what is going on inside us (Siegel & Hartzell, 2003) and emotional repair when something distressing has happened within the relationship (Tronick & Weinberg,1997). By assuming that Marilyn was playing hard to get during her early years of group, I failed to understand her or resonate with her struggles. My apology, given in the context of my empathic failures, had specifically addressed her frantic helplessness when I turned *away* from what she thought were desperate cries for help, leaving her to stew in a sulk.

Split Off Affects

As accretions of chronic shock accumulate without emotional repair, children develop defensive strategies to wall off unbearable anxiety. Similar to the numbing/flooding cycles of

chronic PTSD, the cycles of chronic shock manifest in a paradox: patients oscillate between feeling just fine and then inexplicably falling apart. Frank, a high-powered attorney who was cool as a cucumber in his manner provides an apt example of this oscillation in process. He had experienced occasional short-lived periods of breakdown throughout his life, which he usually attributed to a "bad trip" on psychedelics. Although last group he had said that he couldn't really relate to Marilyn' sense of chronic shock and abandonment, he reported that Marilyn's work last week had led to a breakthrough for him into the world of feelings. A dramatic encounter with disavowed feelings had opened him up to his own experiences of massive childhood deprivation. His wife had been telling him for years that he had had an awful childhood, but he had insisted to her, and to himself, that his childhood had been "normal." Marilyn's work in the group last week had catalyzed an emergence of primitive feelings he did not know were inside him. One day last week, his wife and children had been fairly demanding. When his wife snapped at him, Frank had dropped to the floor of his bedroom, sobbing that he just wanted *her* to take care of *him* right now. He remembered hanging onto the floor until she joined him there, and he clung to her for the first time in their long marriage. He had grown up in a house dominated by illness. His mother had contracted severe MS when he was less than a year old, and his father had had a massive stroke in front of him while Frank was in a shared bedroom with him. Chronically unaware of any internal experience (alexithymia), Frank had never been able to feel anything about his life before he "went to the floor." Five other group members reported that they also went to the floor (like toddlers do) when overwhelmed; they described a sense of needing secure ground to hold them together.

Over the next months, Frank's frozen self began to thaw, always in bursts of raw, unexpected affect, remnants of an unprocessed life. He re-experienced a recurring nightmare he

had had all of his life that conveyed early horror (Tronick, 1989) about his inability to find

himself in his mother's face. His mother had gradually lost her ability to smile or achieve facial

expression after he was born; by the time he was six months old, she had no capacity for facial

mirroring. In the dream, he was frozen, inches away from a blank wall directly in front of his

face. He would always wake up from this dream screaming, wondering why he couldn't just

turn away from the wall.

Other group members also brought in repetitive dreams reflecting annihilation anxiety

and dissociation consonant with their life histories: hiding; digging up the bones of someone one

had killed and buried long ago; falling from an airplane; sliding uncontrollably on roller skates;

raving, psychotic attackers; and chaos. Allowing themselves to fully acknowledge the

devastating havoc that debilitating childhood anxiety had wreaked on their lives, group members

began to work seriously on identifying needs, wishes, and self-soothing. Waves of grief swept

through the group: grief for stuckness, lost time, barren childhoods, missed opportunities,

investment in destructive relationships, developmental delays, and lives with unfulfilled

potential. The toll of chronic shock, they discovered, was the walling off of unbearable

experience through disavowal and encapsulation.

The Balloon as Metaphor for Encapsulation Processes

The following vignette demonstrates the inner contents of an encapsulation in a powerful

moment of projective identification: Paul communicated his inner experiences of violence,

shock and terror to all of us in the group by "acting in" with a balloon. In group Paul seemed to

float among extremes of bitter cynicism, paranoia, insightful and touching warmth, and

hopelessness. A gifted artist, he used black humor to deflect the intensity of his feelings and to

avoid vulnerability. His parents had both been both emotionally volatile, bursting into rages and

disparagement at the least provocation. Up to now, he had kept his own rage and terror tightly under wraps in group, but frequently had episodes of frantic weeping, raging tantrums and desperate pleas for help in his individual therapy. He, along with the rest of the group, had been highly supportive of Marilyn's risk-taking, as well as openly envious of the progress she was making. Some weeks after Marilyn's confrontation of me, he came into the group uncharacteristically late, exploding a balloon aloud as he opened the door.

This group meeting occurred the week after the Washington snipers incident. Because of seating arrangements, I and one other group member (John) jumped in our seats at the sudden loud noise; we could not see Paul coming through the door, balloon and pin in hand. My first thought was that a gun had gone off. Paul and several others laughed uproariously at my discomposure. My adrenaline was so high from startling so severely, I momentarily entertained a fantasy of kicking him out of group for the night. For awhile the group tossed around the issue of whether the joke was hilarious or just a cruel and tasteless acting out of aggression, given the snipers at large. John joined in the general hilarity (being first and foremost a prankster himself) but then brought the group to order, asking if Paul couldn't see how he had scared me. Besides, the snipers were a big deal, someone else added, nothing to laugh about. The group fell silent and stared at me with consternation. Before I could think clearly enough to comment with any clinical acumen, I quietly asked Paul not to bring any more balloons to group, but said that his angry feelings were welcome anytime if he brought them *in words*. I was secretly embarrassed and furious that my well-hidden PTSD had been exposed.

Paul of course felt shamed by me and said so angrily. He talked about how he had handled his feelings through delinquency and vandalism as a teenager, and that he could relate to the snipers' thirst for vengeance and mayhem. He confessed he wanted to talk about his rage but

was afraid the other group members and I would be afraid of him, or shame him as I had just now. Marilyn gently suggested that perhaps Paul's baby self didn't know how to talk to me in words yet, but that she at least admired him for his courage and creativity in bringing his rage into group with the balloon. The shock inside him, she said, was now something we could all relate to; he had found a way to make us, on the outside, feel what he often felt on the inside. A chorus of agreement murmured through the room. Westin added that it was Paul's parents that more resembled the snipers, with their chaos and violence, and not Paul.

I puzzled inwardly about what was going on with Paul, me, and the balloon, and realized that Paul was envious of Marilyn's articulate self-expression, as he himself was close to exploding with bottled up rage and sadness. I commented that his balloon was kind of like Raine's bulging closet of disavowed feelings. I wondered if he was afraid of exploding in the group like the balloon did; at least with the balloon he could feel in control, and choose the time of the explosion. He angrily responded that he did occasionally explode just like the balloon out in the world, and that he always felt ashamed afterwards. He worried that the group couldn't hold all of his feelings; that its skin was as thin as the balloon's. My skin was certainly pretty thin, he pointed out, as I couldn't even take a joke without retaliating. Several group members chuckled anxiously, watching to see what I would say next. Marilyn said that she understood, that she too was afraid that if she continued to open the door to her feelings, that she would go crazy or have a breakdown, exploding all over the group like Paul's balloon. Westin and John joined the fracas: how could I expect people to share their feelings if I just humiliated them when they did? The group rallied around Paul and Marilyn: was I eventually going to shame everyone like I had just shamed Paul?

I was torn: I had always held that putting things into words, not actions, was the meat and potatoes of group work. I also realized that I had inappropriately shifted my embarrassment about being so nakedly vulnerable into Paul. I needed to find a way to acknowledge my inappropriate affect if I expected to teach group members to be accountable. Having difficulties with sensory-motor integration due to premature birth, I have always been overreactive to loud sounds and prone to manifesting exaggerated alarm reactions. I admitted to the group that I had been embarrassed by my obvious startle reaction, and told Paul I was considerably better at handling anger than I was sudden sounds. I asked him if he would trust me and the group enough to continue exploring the part of himself that was trapped inside the balloon, doing his best to use words whenever he could. He grudgingly agreed, with the proviso that I try to remember his sensitivity to humiliation. I invited the group to keep a watchful eye on me. If the group had stood up to their bad mother once, I pointed out, perhaps they could count on each other to do so again.

The group encouraged Paul to take the risk of opening his heart to the possibility of being understood. He talked for the first time about the part of him that could understand serial killers and murderous rage. Paul was touched by their concern, but still expressed worry that everyone would be afraid of him now that they knew the truth about him. His mother had identified him as "The Devil" throughout his childhood, and called him by that name. He had always been a devout Catholic, and had worried obsessively since childhood that he was already condemned to hell because his mother said so. This level of concrete thinking stood in sharp contrast with his philosopher/Renaissance man persona. John immediately jumped in with reminders of his own brushes with homicidal rage, urging Paul to stay with exploration instead of bottling it up again:

"This group is big enough to hold all of our feelings, no matter how awful." The group-as-a-whole was preparing to undo dissociative defenses against chronic shock.

Encapsulation and Dissociation as Group Themes

Marilyn's dream, Paul's exploding balloon, and Frank's identification of going to the floor as an emergence of dissociated affect heralded a watershed epoch of growth in the group. From the outset, group members were astonishingly facile at identifying and working with dissociative encapsulation processes in themselves and each other, as if they had discovered all by themselves a new language that opened up entirely new therapy vistas for pursuit. The level of risk-taking, authenticity, empathic confrontation of destructive defenses and interpersonal exploration increased as the group explored a common ground of terror of vulnerability. I myself was continually surprised and startled with what the group and its members were teaching me. By a year's end, five of twelve group members had incorporated work on split-off self-states into their group and individual therapy; of the other seven group members, five had made significant breakthroughs in self understanding as they began to comprehend the impact of defenses against annihilation anxiety on their inner and outer lives.

Despite my familiarity with more florid dissociative defenses, each new revelation of severe encapsulation surprised and shocked me a little as if I were encountering dissociation for the first time: I never saw it coming, not anticipating to see such severe vertical splits within a non-abused population. (One patient had a paranoid state that spoke only in French, his native language; another had an immature needy state that compulsively pursued unavailable women and insisted he was a "bad, bad boy" whenever rejection inevitably occurred.) Moreover, after Marilyn's group work I had expected the group-as-a-whole to organize defenses against

deepening primitive themes such as terror, mortification and annihilation anxiety, instead of dropping with quiet profundity into the blackness of the abyss.

Theoretical Underpinnings of Chronic Shock and Sub-Clinical Dissociative States

Chronic shock is a construct with applications well beyond the attachment relationship. Chronic shock and ensuing encapsulated self states can accrue from repetitive pain syndromes and medical procedures during infancy and childhood (Attias & Goodwin, 1999; Goodwin & Attias, 1999a, b; Schore, 2003a); accidents of impact (Scaer, 2001); and physiological disfigurement and subsequent peer ridicule due to congenital impairment, developmental disorder, disease process or traumatic occurrence (Sinason, 1999). However, examination of chronic shock due to non-attachment etiologies, and its impact on body image and somatoform dissociation (Goodwin & Attias, 1999b; Nijenhuis, 2004), is outside the scope of this paper, as is the exploration of dissociative states due to abuse.

Here, we will be looking at the devastating ripple effects of early neglect and deprivation on the nervous system and patients' capacity to feel safe with others, to tolerate and manage feelings, to envision a better life, and to self-soothe. We will examine the crucial roles of attunement and repair in developing secure attachments with others and a sturdy sense of self. I hope to build a platform for understanding the profound role that failed dependency plays in the build up of unbearable affects. I propose that repeated shock states within attachment relationships and unrepaired distress during the formative years contribute to an inherent vulnerability to psychic shattering and abrupt fragmentation, which I characterize as "attachment shock." In the face of these unbearable affects, children cope by encapsulating the affects in autistic enclaves or covert dissociative self-states. These walled off affects of attachment trauma are intransigent to change and difficult to access. I will interweave recent

developments in post-Kleinian psychoanalysis and traumatology with interpersonal neurobiology and attachment theory to help us begin to think about how to reach these deeply protected psychic structures of shock, despair, meaninglessness and terror embedded within many of our high functioning patients.

Relational chronic shock is the embodied imprint of attachment traumata, persisting from early childhood flooding from uncontained, unrepaired distress, what Neborsky (2003) terms "the pain of trauma." "[E]ffective psychotherapeutic treatment can only occur if the patient faces the complex feelings that are 'inside the insecure attachment'" (pp. 292-3). We are not surprised when shock states stemming from disaster, war, torture manifest in severe dissociation (PTSD/DESNOS). Nor are we surprised when sexual and criminal abuse result in DID/DDNOS, and insecure or disorganized attachment patterns. Only recently did the international clinical/academic community formally posit the existence of a subclinical variant of dissociative process related to attachment trauma (Liotti, 2004). Like the Tuesday group members, many high functioning patients without history of overt trauma, abuse or blatant character pathology develop dissociative traits, encapsulations of annihilation anxiety, autistic enclaves (Mitrani, 1996, 2001; Mitrani & Mitrani, 1997) and vulnerability to disintegration and addictions. Why do these patients live in the chill of chronic apprehension, to the detriment of their ability to truly relax into peacefulness, play, and the pursuit of deep contentment? These are the compulsive caregivers and high achievers whose success masks clinical or sub-clinical dissociative states and chaotic relationships. In the course of depth therapy these individuals sometimes reveal covert primitive ego states existing in parallel with sophisticated, mature functioning.

Perplexed by a bewildering blend of strength and vulnerability, the Tuesday group

members were quite relieved when they come to understand that some of their more problematic

behaviors and decisions had been driven by primitive states of mind they were unaware of.

Encapsulated ego states oscillate reflexively between terror of intimacy and desperate need for

human contact, striving to insulate the patient from the vulnerability and vagaries of being

human (Mitrani, 1996). Myers (1940) first described these alternating states as the "emotional

personality" (EP) and the "apparently normal personality" (ANP). A topic once considered

controversial, revolutionary, and exotic, clinical discussion about segregated self states has now

become commonplace among attachment theorists, interpersonal neurobiologists,

traumatologists, many relational analysts, and many post-Kleinians. Nijenhuis & van der Hart

(1999), Siegel (1999), Blizard (2003), and Liotti (2004) have integrated Myers' concepts with

cutting edge breakthroughs and innovation from the fields of neuroscience and traumatology to

provide a powerful model for current-day understanding of subtle dissociative processes such as

those presented in clinical and sub-clinical manifestations of DDNOS.

> Repeated experiences of terror and fear can be engrained within the circuits of the
>
> brain as states of mind. With chronic occurrence, these states can be more readily
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> activated (retrieved) in the future, such that they become characteristic of the
>
> individual. In this way our lives can become shaped by reactivations of implicit
>
> memory, which lack a sense that something is being recalled. We simply enter
>
> these engrained states, and experience them as the reality of our present
>
> experience. (Siegel, 1999, pp.32)

The "emotional memories" of the EP tend to be experienced as intense waves of feelings

accompanied by visceral and kinesthetic sensations such as sinking, falling, exploding, and the

like. Lacking the internal shock absorbers of securely attached individuals, the covert

dissociative patient is vulnerable to emotional flooding and disrupted functioning under

conditions of stress. Catastrophic anxiety states encoded in preverbal, implicit memory surface

without any sense of being from the past, and underlie behavioral choices and strategies.

Marilyn's shattering, and other high-functioning members' desperate panics, whimpering,

paranoid episodes, ego-dystonic keening, and primitive raging are typical examples of EP

presentations in clinical work. The defining characteristics of an EP state are the patient's utter

conviction of clear and present danger in the here-and-now, mixed with a strong somatic

experience and concrete thinking. Marilyn's EP was attachment based, but it is important to

note that many traumatized EP's are defense-based (Steele, van der Hart, & Nijenhuis, 2001), as

was the case with the French-speaking paranoid ego state. So deep was his need to disavow

needing anything from another, this patient would find himself savaging important relationships

and discarding them, as if in the throes of mortal danger, without questioning why or exhibiting

the slightest curiosity about the extremity of his actions. He was content to repudiate all need

for people, creating an illusion of self-sufficiency by hiding in an internally constructed

"bunker" where humans could not penetrate and he had absolute control.

Encapsulated Self States. Group psychotherapists are well acquainted with the differing

character structures and typical clinical presentations of individuals whose character is organized

around fears of rejection and abandonment; anger, resentment, and fears of non-recognition;

shame and humiliation; or sorrow and melancholy. However, the character structure of many

high-function individuals struggling with chronic shock, terror, dread and overwhelm is typically

organized around some variant of encapsulated self states which function silently in the

background until activated by the environment. Hopper (2003) considers that failed dependency,

prolonged helplessness, cumulative strains, and a childhood atmosphere of dread, chaos, or

oppression are crucial etiologic factors that have largely been overlooked by the clinical

community of group psychotherapists. Prolonged hospitalization and physical distress in a child,

spouse or aging parent, bereavements, medical crises, the anxiety of parental unemployment or

financial reversals, the chaos of divorce, the intrusion of horror affects which accompany disaster

and criminal assaults, all contribute to exhausted and depleted parenting. Disavowal,

dissociation, and splits within the child's developing self may ensue. "Basically, in order for life

to continue and psychic paralysis [to be] avoided, the entire experience [of annihilation anxiety]

is encysted or encapsulated, producing autistic islands of experience" (p. 59). We need a wider

lens than those provided by terms such as trauma or abuse to capture the gamut of overwhelming

challenges to infant development that distort character in hidden ways and interfere with

patients' mobilization of their internal resources. Hopper describes encapsulation

>as a defence [*sic*] against an annihilation anxiety more basic than "paranoid-
>
>schizoid anxiety" in which feelings of persecution and feelings of primal
>
>depression are completely intertwined and undifferentiated. . . . [A] person
>
>attempts to enclose, encase and to seal-off the sensations, affects and
>
>representations associated with it . . . a sense of "having enclosed" and of "being
>
>enclosed." (pp. 199-200)

Berenstein (1995) underscores the enduring nature of defenses against annihilation in

patients who were poorly nurtured:

>It is impossible to live with such anxiety. The mind springs into action to save the
>
>child; the defense mechanisms are born. Inevitably, however, the defense
>
>mechanisms outlive their value. The child grows older and more competent. He is

no longer realistically on the brink of destruction, yet the defenses refuse to die.

Not in touch clearly with the real world, the defenses insist that if they are

abandoned death will follow. The terror of this possibility gives them continued

life at a terrible price; little by little they get in the way of a child's development,

isolating him from reality and the warmth of other human beings. (p. xvii)

Hopper (2003) likens the selves of encapsulated patients to sets of nested Russian dolls that

develop in parallel, but not without a price. The encapsulated selves never mature without

grotesque distortions and can't help but impoverish life by their limited priorities and over-

emphasis on safety at any cost. They are by and large "ontologically insecure," (Laing, 1959),

concerned mainly with survival and preserving the self rather than with fulfillment. These

patients are bewildered by the ease with which others develop hobbies, marry well, and spend a

fair portion of their leisure time in pursuit of peace, pleasure, and contentment.

Clinicians as a group are largely unaware that vulnerability to fragmentation, shattering

and accumulations of chronic shock disrupt one's capacity for the experience of pleasure across

neurological, developmental, and cognitive dimensions (Migdow, 2003). Marilyn, for example,

has been preoccupied all her life with themes of survival. She is fascinated by articles, movies,

and books about people who have been shipwrecked, set adrift in a lifeboat, left for dead, or lost

in the wilderness. The metaphor which best describes her life is one of endlessly treading water,

enduring rather than living, hoping against hope that someone would find her before it was too

late but not knowing how to ask for help. Ideas of pursuing hobbies and pleasurable off-time are

merely quaint notions that don't apply, in the same camp with "wouldn't it be nice if I were a

millionaire."

Kinston & Cohen (1986) propose that people who can conceive of wishing for things in the future have experienced need fulfillment in childhood. Patients who have experienced chaotic or impoverished attachment relationships may not only live less fully in the present, but may have difficulty envisioning a better future for themselves (Siegel, 2003). For these individuals, anxiety and a vague sense of dread are omnipresent in the best of times; at the worst of times they are struggling to overcome shock: shocking disappointments, shocking abandonments, shocking betrayals, shocking reversals in health and fortune. The substrate of shock lives in their brains and bodies as a shadow imprint of their earliest experience. Many of the Tuesday group members struggled with meaninglessness and a sense of having come into this world missing something essential. Each of them functioned publicly in the world as if he or she had exceptionally high ego strength, brilliance, generosity of heart and exceptional self-awareness. Each was privately vulnerable to shattering into mind-freezing terror, social awkwardness, disintegration/fragmentation, catastrophic anxiety and the desperate question, "What on earth is wrong with me?" What was missing was the psychic skin provided by good-enough mothering.

Omnipotent Protections. The most prominent leitmotif in the Tuesday group pertained to omnipotence: "No one has ever held me all my life. Everything is so much harder for me than for others. I have had to figure out some way to hold myself together, by myself." Bick (1968) first proposed the notion of a "psychic skin" as a projection of or corresponding to the bodily skin, which would hold and bind the fragmented mental and emotional components of the personality together:

>[T]he need for a containing object would seem in the infantile unintegrated state to produce a frantic search for an object . . . which can hold the attention and thereby

be experienced, momentarily at least, as holding the parts of the personality

together. (p. 484)

The bodily ego provided by the skin was further described by Anzieu (1989, 1990) as a skin ego and psychic envelope. When parenting is not "good enough," the inchoate psyche experiences insufficient containment, which creates metaphorical holes in the psychic envelope and renders the individual more vulnerable to shattering and fragmentation. Under conditions of failed dependency, disturbances develop in the domain of the psychic skin, and "second skin formations" develop (Bick, 1968) through which dependence on the mother is replaced by pseudo-independence (edgedness) or adhesive relating (Tustin, 1981, 1986, 1990) to create an illusion of omnipotence (Mitrani, 1996, 2001; Mitrani & Mitrani, 1997). Kinston & Cohen (1986) maintain that the failure of need mediation during infancy leads to a "persistent wound," a "gap" in emotional understanding, a "hole" in the fabric of experience: "Hole repair is what psychoanalytic therapy is about*"* (p. 337).

Mitrani (1996) represents the post-Kleinian perspective that the purpose of second skin formations, encapsulations of vulnerability (like Marilyn's little girl-self), and autistic enclaves (encapsulated self-states which contain not excess vulnerability, but excessive omnipotence), is to provide the vulnerable baby-self with an "omnipotent, omnipresent, and therefore thoroughly reliable mode of safe passage–'bruise-free'–through life, that is, free from madness, psychic pain, and overwhelming anxiety" (p. 96). To escape facing the depth of their vulnerability, contact shunning patients (Hopper, 2003) may paper over the holes in their psychic skin with encrustments such as toughness or gruffness, "crustacean" character armor (Tustin, 1981), intellectuality, over-reliance on rhythmic muscularity such as compulsive weightlifting and exercise, or addictions. Merger-hungry or "amoeboid" patients (Tustin, 1981) cling onto the

surface of another person in a style of pseudo-relating (Mitrani, 1996), using people as interchangeable band aids for as long as they are available to plug the holes within. The cultural phenomenon referred to as serial monogamy by savvy singles is often revealed, in depth psychotherapy, to be more of an attempt to staunch the flow of uncontrollable psychic bleeding with at least someone, however unsuitable, than it is a genuine search for a compatible partner.

Efforts to "hold oneself together" by skin-related self-soothing, called "the autistic/contiguous position" (Ogden, 1989), is a dialectical (transformative) mode of being-in-the-world which complements and interpenetrates with the depressive and paranoid/schizoid modes of being-in-the-world. When operating from the autistic/contiguous position, sensations and other nonverbal dimensions of self-other experience predominate: feelings of enclosure, of moldedness, of rhythm, of edgedness. As the infant develops into an adult capable of thinking about his sensations, terms like soothing, safety, being glued together, able to relax, peaceful, connectedness, cuddling, and merger may eventually become attached to the experiences of enclosure, moldedness, and rhythm. Words like shell, armor, crust, attack, invasion, impenetrability, bunker, and danger relate to sought after experiences of edgedness.

Psychoanalyst Symington (1985) highlights the survival function of omnipotent protections as an effort to plug gaps in the psychic skin through which the self risks spilling out into space, and underscores the dread of endless falling:

> The primitive fear of the state of disintegration underlies the fear of being
>
> dependent; that to experience infantile feelings of helplessness brings back echoes
>
> of that very early unheld precariousness, and this in turn motivates the patient to
>
> hold himself together . . . at first a desperate survival measure . . . gradually . . .

built into the character . . . the basis on which other omnipotent defense

mechanisms are superimposed. (p. 486)

Mitrani (1996) warns that these omnipotent defense structures are easily mistaken for

intentionally destructive resistance and a turning away from the therapist. In actuality they may

be motivated by a will to survive the treatment, but to do so they activate omnipotent defenses

to balance their acute vulnerability. Whereas some children of neglect turn to skin-related

defenses for insulation and omnipotence, others learn to retreat into their own minds rather than

rely on the vagaries of human relationship.

The Mind Object. In the wake of failed dependency, six non-abused members of the Tuesday

group turned to their own minds to hold themselves together and ward off the abyss of chronic

shock: "I think, therefore I am." Unlike skin-related defenses, the psychic skin of the "mind

object" gains omnipotence by repudiating the body and its signals, replacing reliance on the

mother with precocious self-reliance (Corrigan & Gordon, 1995). Unfortunately, opportunities

for attachment and its vitality affects (spontaneity, sensuality, and pleasure) disappear in the

process. "The baby compensates for who is not there by enclosing himself in a mental

relationship with himself" (Shabad & Selinger, 1995, p. 228).

Raine, despite the continuous presence of two loving parents throughout her childhood,

was chronically overwhelmed at age two by their affects of dread and horror as they struggled to

parent her desperately ill newborn brother who was not expected to live past three. She

remembers trying to make as few demands as possible on them. Her parents, both professors,

attempted to master this ordeal by dint of their superior intellectual firepower, and Raine

followed their lead. She constricted her emotions, as they did, trying to think her way out of the

nightmare. In childhood she suffered from obsessive preoccupations, which manifested in group

through perfectionism and a search for answers to an interminable list of questions.

Raine struggled to tolerate "feeling anything;" it seemed to her that everyone else in

group was able to open and close the floodgates at will. She desperately feared losing her mind,

the only barrier to chaos she had ever known. She spoke breathlessly and rapidly, making

frequent jokes about her dread of learning about her inner life. The group was very gentle with

Raine, recognizing the extreme vulnerability underlying her apparent self-sufficiency and

intellectual aplomb. Her looming abyss of chronic shock was created not by insensitive

parenting, but by the inadvertent flooding of her immature neurological system by parental

turmoil and dread. She began vehemently rejecting being held after her brother was born,

dreading the price of toxic shock she would pick up by osmosis. Her attachment style is

anxious/preoccupied, with the tentativeness of a wild fox poised to flee. She and her spouse

share an asexual marriage by choice.

Westin, the French-speaker with a bunker, remembers a childhood filled with rage, panic,

and confusion as he tried to make sense of his bizarre parents. Once he discovered the soothing

logic and predictability of mathematics, he turned permanently away from people, replacing the

uncertainty of relationship with the quest for scientific certainty. Like the high-functioning

paranoid characters described by McWilliams (1994), he would spend hours after an upsetting

group or individual session trying to figure out "what was *really* going on."

Inside the Insecure Attachment. Failures in parental attunement result in shock affects being

stored in the body/mind as working models of how to relate to others, resulting in insecure

attachment (Solomon & George, 1999). Insecure and, especially, disorganized/disoriented

attachment are the characteristic attachment styles of children who experienced chronically

misattuned, unpredictable, and/or frightening/frightened parenting, along with little or no

emotional repair of distress. Trauma doesn't just overload the circuits in some mysterious

neurological fashion, but is related to meaning making (Siegel, 1999; Krystal, 1988; and

Neborsky, 2003). Group therapy is an ideal matrix for the working through of the cumulative

trauma that manifests later in life as "fear of breakdown" (Winnicott, 1974). In individuals with

no conscious remembered experience of breakdown or abuse, vulnerability to dread and horror

affects may point to intergenerational perpetuation of anxiety states (Hesse & Main, 1999), as

Raine's group work demonstrates. Repeated entrance into disorganized/disoriented states in

infancy, what Hesse & Main term "fright without a solution" (p.484), may then increase the risk

of catastrophic anxiety states, paranoid states, DDNOS, and other manifestations of fear of

breakdown in the adult patient, even in the absence of overt trauma history.

Neuroscience now supports Winnicott's longstanding tenet that fear of breakdown may

be terror of something that has already been experienced in the past. Hebb says, "Neurons that

fire together, wire together" (as cited in Siegel, 1999, p. 26) to form states of mind (Siegel,1999;

Perry, 1999). Fear experiences, especially, are practically indelible (LeDoux, 1994, 1996).

Attachment shock is the implicit memory of chronically uncontained and unrepaired distress in

attachment relationships, which accumulates during childhood and manifests throughout life in

the form of insecure attachment. As shock states become increasingly engrained and dissociated,

they may evolve from transitory states of mind into encapsulated, specialized sub-selves (Siegel,

1999) *whose purpose is to assist in insulation and recovery from shock.* Even in the absence of

overt maltreatment, when parents have unresolved, partially dissociated traumatic anxiety that

they transfer to their infants through subtle, behavioral and emotional cues, their infants are

seemingly unable to develop an organized attachment strategy (Hesse & Main, 1999). Instead

these children develop disorganized internal working models of attachment with multiple,

contradictory, and alternating dimensions, along with a vulnerability to catastrophic anxiety

states. The simultaneous need for the caregiver, along with fear of the caregiver's own internal

states or reactions, disorganizes the infant's ability to seek and accept soothing from the parent as

a solution to stress and fear. Thus even some children who had loving parents (like Raine) may

grow up into adults who isolate or insulate, fearing to turn towards others when distressed. In a

recent study of children of mothers suffering from anxiety disorders, 65% of offspring had

disorganized attachment (Manassis, Bradley, Goldberg, Hood, & Swinson, 1994). Both terror

and shame mechanisms may be involved in these children's developmental trajectories. Raine

was so acutely aware of her parents' internal distress that she developed intense shame about her

dependency needs as well as chronic dread of impending doom and fragmentation, all of which

she camouflaged behind a veneer of jocular intellectuality.

Fragmented Self Esteem and the Fractured Self. I believe Kohut (1971, 1977; Kohut & Wolf,

1978) was approaching the threshold of terror trauma in his observations of traumatized patients

who experienced early selfobject catastrophe and narcissistic fragmentation. The self disorders

Kohut delineated, involving a central focus on shame and self-object dynamics, represent a

slightly different population than the dissociative spectrum autistic/contiguous disorders

described in this paper, whose issues of fracture require a central focus on attachment dynamics

and utter terror (with shame dynamics playing an important, but secondary role). Kohut

relegated skin-based defenses to the domain of auto-erotic perversion, but his concepts of

selfobject functioning, narcissistic injury, vertical splitting and emphasis on shame were

revolutionary.

Unlike most narcissistic patients, the high-functioning dissociative patient struggling with annihilation anxiety generally does not establish a stable self-object transference, and struggles with encapsulated terror of emotional contact regardless of any apparent idealizing transference. The transference resembles disorganized attachment rather than anxious or avoidant attachment. In addition to craving admiration or emotional connection, dissociative patients also overtly and/or covertly mistrust any situation that requires involving another human being. Empathic connection and interpretation of fragmentation subsequent to empathic failure is a necessary technical intervention, but is nowhere near sufficient for the development of a cohesive self in dissociative patients. Cognitive restructuring of dependency fears (Steele, van der Hart, & Nijenhuis, 2001), explicit acknowledgement of vertical splits/dissociated states and their attendant working models of attachment (Liotti, 2004), and a recognition of the survival function of the dissociated state (Mitrani, 1996) are prerequisites for growth, along with efforts to make sense of emotional turbulence and somatic flashbacks. Dissociative patients learn to work empathically with their own internal self-states, repudiating disavowal and learning to tolerate vulnerability. Interaction in the group supplants interpretation as the medium for change. The potential for multiple transferences within the fertile group environment increases the likelihood of emergence of self-states that specialize in handling the dangerous and unpredictable.

Kohut recognized two different kinds of self states: the "fragmented self" and the "depleted self," (1977, p. 243). In so doing, he foreshadowed advances in developmental neurobiology which have identified two phases of traumatization experience: winding up to explosive fragmentation, and shutting down into dissociation. Schore (2004) charges psychoanalytic theoreticians with overlooking and undervaluing the impact of early helplessness, annihilation anxiety, and dissociation in developmental psychopathology. Both overstimulation

(prolonged protest) and understimulation (detachment and despair) wreak havoc on the development of right brain structures which underlie the emotional self. He describes two types of disintegration: *explosive* disintegration characterized by dysregulated sympathetic hyperarousal, a shock-like paralysis in the right brain core self, which I liken to group members' paranoid states and panic attacks and episodic rages; and *implosive* collapse, on the other hand, which manifests in dysregulated parasympathetic hypoarousal, dissociation, withdrawal and abject depression as manifested in group members' severe anaclitic depressions.

Especially in this latter state, helplessness, hopelessness, and meaninglessness prevail, what Grotstein (1990a, 1990b) calls "the black hole." Black hole despair is linked etiologically to the fundamental psychic damage and structural deficits of the "basic fault" (Balint, 1979) due to insufficient parental response to the infant's needs. Splits within the self and a subjective experience of something essential missing inside are characteristic, as are failures in self regulation and affect integration. The something missing may well be psychic skin. It is probably no accident that Balint was Esther Bick's training analyst, sensitizing her to the prominence of fragmentation and disintegration experience in infants with inadequate parenting. Overstimulation, understimulation and dissociation stemming from failed dependency create an impoverished psychic organization characterized by feelings of "emptiness, being lost, deadness and futility" (p. 19): the black hole of chronic shock.

Black Holes and the Basic Fault. Most dissociative defenses encountered in group therapy are attempts to avoid entering the essence of the black hole experience, "an infinite cauldron of pain which annihilates all that enters it" (Hopper, 2003, p. 201). Many patients report that no matter how hard they tried to communicate what they needed to their families, they felt responded to as if they had never tried to communicate at all. Their universe felt arbitrary and randomized.

Their efforts to connect meaningfully around their inner experiences failed. Grotstein (1990a)

links black hole affect to failed dependency experience: "[T]he experience of randomness *is*

[italics added] the traumatic state (the black hole) which can otherwise be thought of as the

experience of psychical meaninglessness . . . ultimate terror of falling into a cosmic abyss" (p.

274). People traumatized by chronic shock speak of randomness and meaninglessness as

devastating signifiers of their overwhelming powerlessness.

Proposing a deficit model of psychopathology underscoring the role of environmental

failure, Balint (1979) developed the construct of the basic fault to describe an emerging new type

of patient, one who could not find his or her place in life due to early failed dependency and

excessive helplessness. Balint described the basic fault in the personality very carefully:

> not as a situation, position, conflict or complex . . . . [I]n geology and crystallography
>
> the word fault is used to describe a sudden irregularity in the overall structure, an
>
> irregularity which in normal circumstances might lie hidden but, if strains and
>
> stresses occur, may lead to a break, disrupting the overall structure. (p. 21)

As chronic shock accumulates, so do experiences of meaninglessness. The more a youngster

experiences himself as unable to forge a meaningful bond with his parents wherein he feels

understood and responded to emotionally, the more desperate, alienated, and bereft he feels.

Meaninglessness is the link-breaker of connection (Grotstein, 1990a, b) and the doorway to the

black hole experience indigenous to the basic fault.

> The disintegrative nature of the black hole is a chaotic state of turbulence, an
>
> experience of the awesome force of powerlessness, of defect, of nothingness, of
>
> zeroness - expressed not just as a static emptiness but as an implosive, centripetal
>
> pull into the void . . . . (Grotstein, 1990a, p 257)

Krista tumbled into the abyss during her first group-as-a-whole silence (a rare phenomenon in this group). She was the first to break the silence after about two minutes, by asking some question of another group member. As the group members explored their reactions to the silence, she was surprised to hear that others could experience it as a time to deepen, to self-reflect, to be curious. The silence had followed an especially profound moment between two group members, which had stirred up longing and attachment hunger in the rest of the group. Krista said that any silence was filled with bleak dread and horror, along with a sinking feeling in her stomach, a consequence of many silent hours waiting for the police to knock on her door, either bringing her drunk father home, or announcing his death. She and her mother had sat in mute apprehension, listening to the clock tick, as another catastrophe loomed nearer and nearer. Her mother had had no capacity to distract Krista by playing games, talking about her life, or the like. An only child, Krista's job was to break the silence during the (almost nightly) long watch, staying up with her mother until dawn, when her drunken father, the police, or her father's buddies showed up (with her father slung over their shoulder).

The black hole experience indigenous to the basic fault thus results from a lifetime of being abandoned, unprotected, confused, oppressed, or overwhelmed by significant others who cannot relate helpfully to signals of internal distress. Raine's driven search for answers, Marilyn's icy detachment, Westin's self-sustaining enclave of omnipotence and paranoia, Frank's going to the floor, all represent determined efforts to ward off, or climb out of, the black hole. A colleague once talked about the basic fault in the following way:

> You can tell who came into the world with his parents' blessing, and who did not.
>
> The worst part is, everyone else can tell, too. No matter how successful someone
>
> is, if they are struggling with the basic fault, they will be certain anything that goes

wrong in a relationship is their doing, and they will telegraph this certainty to

others, who according to human nature, will almost certainly agree. The abyss is

likely at any moment to swallow them up and eradicate their existence. (S. Sikes,

personal communication, 1995)

Chronic shock is the visceral knowing of structural instability and the ever-present danger of

fragmentation, the lived experience of the basic fault in patients who had sub-optimal parenting.

Chronic shock silently telegraphs its presence via facial expression, postural patterns, gait,

voice, muscular rigidity and other nonverbal communications. Therapy groups provide an

invaluable opportunity to connect meaningfully around experiences of black hole despair,

chronic shock, and terror of vulnerability, but such topics seldom arise spontaneously (outside

of crises) due to dissociative defenses. The high functioning patient has spent a lifetime

containing and concealing disintegration and shattering shock experience, waiting for the safety

of solitude to sort out all the feelings. The one exception to this rule is the paranoid state, which

may either explode into the group in a rush of sudden consternation, or slip unnoticed into the

group initiated by silent shock. Stoeri (2005) speculates that moments of shock and dread

erupting into the transference demonstrate the dissociation of the positive transference from the

negative. When the positive transference is dissociated, affects inside the insecure attachment

can emerge, illuminating the other side of disorganized attachment which is usually

inaccessible:

when ingrained pathological dissociation is operating, each self-state exists in

isolation from others and is incompatible with others, so that for any one self-state

to express itself, it is as though the others do not exist. (p. 187)

Such eruptions are quite disconcerting for therapist and group members alike, as they don't make

any sense from a historical vantage point, and make all the participants feel crazy. Dissociative

patients seldom tumble into the abyss because they put so much energy into preventing trauma

from occurring by always anticipating it (Bromberg, 1998). Yet such moments represent a

highly sensitive fulcrum for change: either impasse or progress may result. Any previously hard-

earned therapeutic insights and self awareness are temporarily AWOL, as the patient and

therapist become caught up in a powerful physiological current of shock and dread. The

therapist withdraws from the emotional abyss, preferring to "manage" patient by finding a

solution: "It is at such times that an analyst is most inclined to bolster his protective system by

selecting his favorite version of the different ways [to] convey to a patient 'it's your problem' (p.

24).

Yet the abyss of the treatment crisis creates the therapeutic space to forge new ground.

No compromises stand in the way of the patient finally making himself understood in all his

vulnerability. The life and death nature of his existence become apparent as the patient risks all

pretense of safety by coming out into the open. Because he does so against all his better

instincts, he believes he is fighting for his life, for its dignity and meaning, even with his back up

against the wall and fangs bared. This is the low road of neurological functioning: a road paved

with chronic shock.

The "high road" and the "low road". In group therapy, the multiple, contradictory and

alternating working models of attachment disorganization present clinically as patients capable

of swinging rapidly from "high road" to "low road" modes of functioning (LeDoux, 1994, 1996;

Siegel & Hartzell, 2003). Low road functioning is initiated by the fear center of the brain, the

amygdyla, and may account for transient paranoid states. The amygdala has limited pattern-

assessment skills, and if sensitized by previous traumatization, it will over-assess innocuous

stimuli resembling a previous threat as a current threat. Flooding and an automatic trauma

cascade follow in the here-and-now, triggering dissociated affects, perceptions, behavioral

impulses, and bodily sensations with no sense of being recalled from the past:

> Low-mode processing involves the shutting down of the higher processes of the
>
> mind and leaves the individual in a state of intense emotions, impulsive reactions,
>
> rigid and repetitive responses, and lacking in self-reflection and the consideration
>
> of another's point of view. Involvement of the prefrontal cortex is shut off when
>
> one is on the low road. (Siegel & Hartzell, p.156)

It is the prefrontal cortex that supports self-reflection, mindfulness, self-awareness, and

intentionality in our communication, even in the face of alarm.

High functioning dissociative patients like Marilyn, Westin, Frank, Raine, and Krista

easily confuse therapists by presenting initially with high ego strength, apparent observing ego,

and a solid therapeutic alliance. All were perceptive, psychologically sophisticated, self-

reflective, and unusually active group participants even as new members. Their vulnerability to

tumbling precipitously off the high road onto the low road was in no way apparent. The first

time Krista tried to share about her life, she began a long fact-laden chronicle of her failed

marriage and early childhood. I and other group members attempted to slow her down so that we

and she could feel the emotional impact of what she was sharing. She burst into furious tears,

and said she wouldn't risk sharing anything for the next several months until she learned to do it

"right." I asked about her pain, and again crying, she threatened to quit group if the group

couldn't let her share at her own pace. "I'm not ready to trust you—or myself—with feelings

yet. I feel like I'm a therapy kindergartner and you are all running a therapy graduate school.

You're not respecting my rhythm. I don't know if I can stay in this group." I talked about

emotional attunement in infancy, and how babies need to look away sometimes, to be the ones in

control of eye contact, else they end up feeling overpowered. She recovered her balance, became

animated and agreed that, yes, I had failed to understand her need to be in control. When she had

tried to "look away" by continuing to tell her story in her own way, it felt like I had grabbed her

by the chin and forced her to look at me, and herself.

Shock States: Of the Body, Not the Mind. By definition shock is a jolt, a scare, a startle, a fall, a

sudden drop, or a terror reaction; shock can daze, paralyze, stun, or stupefy us. We draw a sharp,

deep breath inward and almost stop breathing. The shock of the sudden, the random, in an

attachment relationship can have staggering impact. Bollas (1995) describes the devastating

impact of the random and unexpected attachment shock that can be triggered by the relatively

innocuous occurrence of a parental blowup, *even on the mind psyche of a child with secure*

attachment:

> Every child will now and then be shocked by the failure of parental love . . . . But
>
> when a parent is unexpectedly angry with the child . . . the child's shock may result
>
> in what seems like a temporary migration of his soul from his body. This is not a
>
> willed action. It feels to the child like a consequent fate, as if the parent has blown
>
> the child's soul right out of his body. Each of us has received such an
>
> apprenticeship experience in the art of dying. We know what it is like for the soul
>
> to depart the body even though we have as yet no knowledge of actual death . . .
>
> Each adult who has had "good enough parenting" will have a psychic sense of a
>
> kind of migration of the soul, sometimes shocked out of the body but always
>
> returning. This cycle of shocking exit, emptiness, and return gives us our

confidence, so that even when we are deeply disturbed by traumatic events . . . we

feel that somehow "it will turn out all right in the end." (p. 215)

In his metaphor "migration of the soul," Bollas pays homage to the dense physicality of

shock experience, what mind/body therapists refer to as disembodiment and traumatologists as

dissociation. Chronic shock response takes its toll on the nervous system and musculature of

infants who are stressed, leading eventually to dissociation (Aposhyan, 2004; Porges, 1997). We

now know from neurobiology that dissociation "is a consequence of a 'psychological shock' or

prolonged high arousal," according to Meares (as cited in Schore, 2003a, p. 214). If even

occasional shock states under conditions of secure attachment are shattering, what impact might

repetitive shock states have even on the non-abused developing child who grows up with less

than optimal parenting? What happens when attempts to soothe are non-existent, and experience

teaches that things will not turn out all right in the end? Schore's 2003 two-volume opus on

affect dysregulation makes the case for the cumulative trauma of neglect and early relational

stress within caregiving relationships being powerful variants of childhood PTSD. Infants

adapting to being handled instead of being securely held and understood develop "cephalic

shock" syndrome (Lewis, 1984) in the body/mind. They are thrown back on their own immature

nervous systems to maintain balance and homeostasis, being unable to relax into their parents'

embrace. Chronic muscular stiffness(especially in the neck and shoulders), CNS hyperarousal

and visceral tension are the result. Such ambient attachment trauma interferes with brain

development and the functioning of biological stress systems, and contributes to dissociation as a

preferred defense strategy, even if no formal abuse occurred during childhood.

When traumatic mental states become ingrained in the body/mind by repetition, they

 become more and more likely to re-occur (Hebb, 1949). Psychopathology at this level occurs

first at the level of the body, before reaching the mind. Shock initiates a low road experience

unless the patient has learned to work with the physiological overwhelm. The cortex strains to

make sense of the urgent danger signals fired from the amygdala, along pathways of implicit

memory. Aposhyan (2004) notes the far-reaching effects of shock experience from neglect on

all the body systems of traumatized patients, including disembodiment (dissociation) and

rigidity of skeletal, endocrine, muscular, and breathing structures:

>There can be agitation or frozen stillness in all the other body systems as a result of
>
>lingering shock. Generally the autonomic nervous system has to find its regulatory
>
>balance first, and then the muscles or the fluids can begin to release their shock and
>
>move back into full participation in life . . . By educating clients to track their
>
>states, they can come to recognize a state of relative presence and embodiment in
>
>contrast to the static or fog of even mild shock states. (p. 254)

In a series of drawings, Keleman (1985) graphically depicts a continuum of physical adaptations

to shock states which eventually result in somatic patterns affecting breathing, muscular

bracing, postural rigidity and/or collapse, vitality, and muscle tone:

>These somatic patterns are processes of deep self-perception–a way of feeling and
>
>knowing the world. They are more than mechanical. They are a form of
>
>intelligence, a continuum of self-regulation …. Muscles and organs are not just
>
>contracted, they are organized into a configuration. These organizations become
>
>the way we recognize the world as well as ourselves, and in turn, they become the
>
>way the world recognizes us. (p. 75)

Group therapists are in a unique position to observe the physiological indicators of shock

experience in their traumatized patients as multiple and contradictory models of how the world

works flicker across the landscape of group psychotherapy. "These models can shift rapidly outside of awareness, sometimes creating abrupt transitions in states of mind and interactions with others" (Siegel, 1999, p. 34). Shifts in voice, posture, bracing, and rigidity are regulated via implicit memory. Cognitive science suggests:"implicit processing may be particularly relevant to the quick and automatic handling of nonverbal affective cues" (Lyons-Ruth, 1999, p. 587). The superfast, supercharged early physiological warning signals of alarm, bracing the body for shock, may well initiate the transitory paranoid state shifts and low road functioning we so often encounter in group work. The paranoid states which occur during group psychotherapy are easily and frequently triggered by innocuous interactions, but since they occur primarily on a nonverbal level, neither patient nor therapist typically recognize the phenomenon while it is occurring unless the patient blasts into an irrational rage.

Far more frequently, however, the patient will quietly "freeze," suppressing awareness and exploration of his bodily cues, and the opportunity for intervention may pass. Having spent a lifetime quietly enduring periods of primitive affect, hoping against hope to keep the crazy feelings from showing, high-functioning dissociative patients often successfully mask full-blown threat reactions unless directly asked about them, and even then frequently disavow their inner experiences. Thoughts accompanying the threat reaction tend to be somewhat unrealistic, inaccurate, and concrete: "My body is screaming danger, danger!" Paranoid, aggressive, and withdrawn self-states may become even more rigid and inflexible with each repetition, until the therapist catches on and actively intervenes to help the patient down-regulate.

Porges (2004) has proposed the existence of a polyvagal theory of an integrated neurological social engagement system, and coined the term "neuroception" to denote how

neural circuits distinguish whether situations or people are safe or dangerous. His polyvagal

model encompasses a hierarchy of autonomic states: social engagement, fight/flight, or freeze.

> Faulty neuroception – that is, an inaccurate assessment of the safety or danger of a
>
> situation – might contribute to the maladaptive physiological reactivity and the
>
> expression of defensive behaviors .…When our nervous system detects safety, our
>
> metabolic demands adjust. Stress responses that are associated with fight and
>
> flight, such as increases in heart rate and cortisol mediated by the sympathetic
>
> nervous system and hypothalamic-pituitary-adrenal axis, are dampened. Similarly,
>
> a neuroception of safety keeps us from entering physiological states that are
>
> characterized by massive drops in blood pressure and heart rate, fainting, and apnea
>
> – states that would support "freezing" and "shutdown" behaviors…Specific areas
>
> of the brain detect and evaluate features, such as body and face movements and
>
> vocalizations that contribute to an impression of safety or trustworthiness. (p. 4)

Groups clearly provide an ideal matrix for exploring interpersonal as well as intrapsychic

terrors. Without being dependent on conscious awareness, the nervous system then evaluates

risk in the group and regulates physiological states accordingly. A group member's ability to

recognize and contain affects, ask for emotional repair, and engage in self-exploration, depends

somewhat on his or her ability to activate the social engagement system, which inhibits defensive

maneuvers of aggression and withdrawal, and allows the involvement of cortical functions which

promote empathy, introspection, and relationship. Aposhyan (2004) notes that both sympathetic

and parasympathetic shock states may fluctuate from moment to moment or get frozen into an

ongoing state over time. Such fluctuations or body/mind frozen paralysis may well contribute to

instances of impasse in group psychotherapy. Repeated experiences of emotional repair

facilitate the gradual development of secure attachment. Thus enactments of terror and

attachment danger followed by resolution may be critical factors in some group members' ability

to eventually tolerate and process overwhelming body experiences of chronic shock and mistrust.

Low road functioning, as every marital therapist knows, is typically triggered by relatively

innocuous interactions. Primitive affect is less likely to be inhibited in the marital relationship

than in the group, where withdrawal into invisibility is a venue of escape. As Westin put it: "I

just hoped no one noticed I was feeling nuts, everything was going too fast and I just didn't trust

the group to be able to handle me well."

"Earned secure attachment". The resolution of successful psychotherapy can result in the

patient and therapist/group creating an "earned secure attachment" (Pearson, Cohn, Cowan, &

Cowan,1994). As we have seen, issues of chronic shock and insecure or disorganized

attachment often go unaddressed in therapy, with resultant impasse or therapeutic failure when

therapists lack either the technical or theoretical skills to overcome the patients' resistance to

experiencing the dissociated feelings inside their insecure attachment. Lewis, Amini, & Lannon

(2000); Stern (2004); Siegel (1999); Beebe & Lachmann (2002) and many others represent the

breaking wave of clinicians striving to integrate attachment theory, interpersonal neurobiology,

and relational perspectives. They emphasize the power of presymbolic and implicit forms of

relatedness in psychotherapy, believing that the mind can update its maps of relatedness. The

group therapist working with chronic shock must closely track the complex *meanings* that

patients attribute to interactions, often meanings that are not readily apparent or traceable by the

normal routes to unconscious communications. Therapists may even need to listen to dream

language with a slightly different ear when they work with traumatized patients, scanning for

encapsulation as well as conflict.

Attachment therapists tell us that that psychoanalytically oriented therapists have been looking in all the wrong places to understand the enactments of preverbal primitive states that occur in certain patients, since early memories are encoded in preverbal form and not in narrative memory (Lewis, 1995; Lyons-Ruth, 1999). We have tended to look for, expect, and find the traditional psychoanalytic themes, words, symbols, and fantasies rather than listen for the physiological responses, behaviors, bodily states, and affects that are prodromal indicators of catastrophic anxiety and fear of breakdown: "Note that the system that underlies psychotherapeutic change is in the nonverbal right as opposed to the verbal left hemisphere. The right hemisphere, the biological substrate of the human unconscious, is also the locus of the emotional self" (Schore, 2003b, p. 147).

Group therapy with traumatized patients thus requires the group to monitor closely its members' bodily states, potential dissociative communications, and working models of attachment. "Interactiveness is emergent, in a constant process of potential reorganization" (Beebe & Lachmann, 2002, p. 224). Anzieu (1999) describes the development of a "group ego-skin" as a function of group-as-a-whole processes. As group members observed Marilyn and others bring fury, shattering, and longing to the table, *without meeting retaliation or distancing in the here-and-now*, they became more willing to take such risks themselves. Interaction— primarily confrontation, body-centered observations, affective attunement and engagement— gradually moved into the limelight as the group's therapeutic strategies with me and one another, displacing but not altogether dislodging interpretation and the exploration of fantasies and dreams. Successful group psychotherapy with traumatized patients "may be viewed as a long-term rebuilding and restructuring of the memories and emotional responses that have been

embedded in the limbic system" (Andreasen, 2001, p. 314), as the group itself grows a psychic skin capable of containment.

High-Functioning DDNOS: A Workable Population. Hopper's work (2003) on failed dependency focuses upon "the difficult patient" in group therapy, presumably involving the severely characterological dissociative patient: a very different population from the Tuesday group. As illustrated in this paper, high functioning dissociative patients are potentially much more workable than they initially seem, lapsing into constricted role behavior and primitive functioning only during times of stress when encapsulated affects are stirred up. The key that helps unlock these patients may lie in therapeutic attunement with dissociated affects and attachment struggles. Psychoanalysts Beebe & Lachmann (2002) place nonverbal and presymbolic forms of relatedness in the foreground of work with difficult patients; the verbal, symbolic, and transference aspects of their treatment remain more in the background. Interpretation is therefore less helpful than interaction.

Marilyn, Frank, Paul, Westin, and Bernie, for example, metamorphosed from challenging patients into easy patients to understand and work with, once I understood I was dealing with second skin formations and encapsulations. Frank initially presented as a schizoid with alexithymia, which is highly associated with dissociation (Grabe, Rainermann, Spitzer, Gaensicke, & Freyberger, 2000). Yet Frank was able to access his walled off feelings when emotional flashbacks were triggered physiologically; he treasured these moments of anguish because during them he felt alive—senses flaring, tears flowing. His access to affect was constrained by a hitherto unconscious template operating behind the scenes to shape his present, a template of absent opportunity, what Stern(2004) terms the "nonexistent past." He used to believe he had never suffered, because he had never experienced an opportunity to be listened to.

Despite his exposure to intense suffering by his parents, both their suffering and his reactions were snuffed out before they could be acknowledged,

Paul looked like a tough nut to crack, with his paranoid personality, bleak cynicism, constant black humor and intermittent explosive behavior, until his vulnerable self-states became accessible in group. His tough psychic skin belied his tender heart, vulnerability to shattering, helpless fury, and hidden terror. Westin appeared to be schizoid, passive-aggressive, and narcissistic until I stumbled upon speaking to him in French. I was then able to access the fragile self that was utterly terrified of being annihilated. Another self state predictably appeared who was desperate to find a mother. As he worked through terror and yearning he entered many periods of compartmentalized paranoid transference which required sensitive handling. Ultimately Westin himself began to experience these feelings from the perspective of an adult, and he worked through the anaclitic depression which lay underneath his terror. Bernie initially presented as a perplexing inadequate personality with unusual strengths. His long-term analyst feared he was recalcitrant to therapy but referred him to group anyway. He had always silently struggled with three distinct emotional self-states: the brilliant, detached surgeon who was charming and successful, alongside both a cold, furious Machiavellian state who was ruthless and manipulative, and a regressive state in which he would tolerate any abuse from a woman if she just let him stay near her sometimes and please her. He could sob incoherently for hours or days if he thought one of these women was pulling away slightly or was displeased with him, insisting he must have been a "bad, bad, bad boy." Within months of diagnosis of his covert ego states, his therapeutic progress accelerated exponentially.

Unlike traditional character pathology, which typically presents as a Gordian knot requiring long years of painstaking untying before any progress is apparent, the undoing of these

quietly persistent "pathological organizations" (Mitrani, 1996) pivots around a therapist's ability

to teach the group and its members to recognize, identify, elicit, and resonate with the unbearable

affects that were split off into defended self-states. All of these patients had the motivation and

introspective capacity necessary to monitor shifts in their age perspective, body sensations, and

thinking patterns, which facilitated their capacity to self-soothe. Goldman (2000) presents a

model for teaching patients to override amygdala-centered fear-conditioning, teaching them that

shock states are modifiable although not extinguishable. "Patients develop a sense of acceptance

and inevitability rather than finding themselves constantly unprepared and terrorized" (p. 707).

Frank, Marilyn, Paul, Westin, and Bernie, for example, rapidly mastered the ability to notice

when they were sliding down into the low road, using self talk and what they knew about

themselves to make sense of the trauma cascades reverberating throughout their body-selves and

learning to recognize when they were beginning to feel "young." As a result, Frank was

increasingly able to embrace his feelings, shedding the skins of empty intellectualism and

formality. Paul, Westin, and Marilyn learned to stop paranoid states before shattering, replacing

certainty of danger with curiosity about apprehension. Westin and Bernie were able to learn how

to calm down from panic attacks, to reassure themselves about reality instead of running wild

with fantasy, to stay in the present instead of regressing to the past, and to stop obsequious

clinging to destructive or uninterested love objects, once they discovered the magical

incantations "It's only a memory" and "Is this an adult or a child-like perspective?"

Personal Comments on a Paradigm Shift

My own group training taught me to not work harder in group than a patient does. I was

thus horrified when I realized that by following this precept, I had been re-traumatizing Marilyn

instead of facilitating her growth. I confused her genuine needs for attachment bonding with

wishes that I pander to her. While frustration of wishes may promote growth, frustration of needs results in structural disintegration of the self (Akhtar, 1999).

Siegel's work (1999, 2003) on the nascent sense of self suggests that it is in mind-to-mind emotional resonance that we learn who we are, how to feel, and how to regulate how we feel. A therapist's inability or unwillingness to establish mind-to-mind resonance collapses the intersubjective space between patient and therapist/group and renders the patient at the mercy of the therapist/group's feelings, defenses, and projections. In this situation the terrified patient does not exist in his own right as a person to be consulted, or made amends to, but rather just as a problem to be "managed" however the therapist/group sees fit. I had "managed" Marilyn by ascribing the gross discrepancy between her emotional availability with her therapist (and other group members) and myself to hostile dependency and defensive extraction processes. Marilyn's dream helped me to become more accurately attuned to her inner world. "The first part of emotional healing is being limbically known – having someone with a keen ear catch your melodic essence" (Lewis et al., 2000, p. 170).

Bowman & Chu (2000) suggest that trauma is the fourth paradigm for understanding psychopathology, interweaving with psychodynamics, behaviorism, and neurobiology. "Until psychological trauma – especially devastating trauma occurring early in life – is incorporated into the other three paradigms of mental illness, a 'unified field theory' of mental health will elude us" (p. 10). The recent confluence of psychoanalytic cross-fertilization with fields of traumatology, dissociation, attachment theory, neuropsychoanalysis, developmental psychopathology, and interpersonal neurobiology nurtured my interest in integrative thinking.

In the months leading up to Marilyn's dream I had fortunately been teaching the concepts of chronic shock, black holes, the cumulative trauma of failed dependency, attachment trauma,

encapsulation, and dissociation to other clinicians. Throughout the previous two decades I had

trained extensively with psychoanalytic trauma specialists in areas of DDNOS and DID. I had

taught workshops on dissociative character and dissociation in groups for many years. Yet

before Marilyn's dream, I had not adapted my general group psychotherapy practice to

accommodate these broader integrative perspectives unless patients reported abuse. I pay

homage to Mitrani (1996, 2001), Mitrani & Mitrani (1997), and Hopper (2003) for opening my

eyes to the more subtle variants of encapsulation and autistic enclaves in patients who both crave

and repudiate intimacy. A well-known truism in medicine is: "If you don't at least look for it,

you certainly won't find it." Fortunately several of us collaborating in an outpatient treatment

team had experience working with more florid dissociative spectrum patients, which helped

prepare us to recognize the more subtle encapsulation processes evident in the Tuesday group. A

caveat: the clinical or subclinical DDNOS patient first and foremost needs access to the secure

base of an individual therapist in order to be able to endure and work through the rigors of faulty

neuroception and its aftermath within the group.

"Posttraumatic growth" (Tedeschi & Calhoun, 1995) is a relatively new concept that

addresses the inherent potential of suffering to catalyze spiritual, emotional, and interpersonal

growth. Emerging from work with bereavement and disaster victims, their model stresses

numerous opportunities for resilience provided by crises of heart and spirit: potential for

improved relationships, creative destruction of constricted barriers to vitality, a greater

appreciation for life, enhanced sense of personal strengths, and spiritual deepening. My

experience in the Tuesday group has taught me that working through the chronic shock of

cumulative attachment trauma is no less effective an incubator of growth.

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Correspondence

Kathleen Adams, Ph.D.

3355 Bee Caves Road #611

Austin Texas 78746

Email: shockdoc@austin.rr.com