CHILDREN OF PERDITION: FIVE FACES OF SHOCK

"As a hurt child refuses comfort
We hide from one another, fearing to be hurt again
Should we give love or receive,
Vulnerable each time one small green shoot
Breaks through the hard wood
The years have ringed the heart with:
Where love, there pain." (Raine, p. 259)

"Perdition" refers to hell, complete destruction and ruin. Our world these days has run amok with pain on a global level as well as in the hearts and souls of our children and adolescents; in a sense, it has "gone to hell." They seek confirmation and mastery of the harshness of their world in their reality TV which mirrors the little deaths, the little horrors, and the little tragedies in 60 minute bite size pieces, far easier to swallow than a Columbine, a World Trade Center, a Waco or a Oklahoma City. Shock is no longer shocking; or really it is, but if we caricature it, mock it, make it grotesque, then we can turn passive into active experience and pretend we are on top of it all. In our consulting rooms there is no remote control, no laugh track, and no commercial breaks. Just 45-50 minutes of undiluted Stephen King without the palliative of "this is just pretend." Treating patients with shock states and other fallout from a difficult childhood is a little bit like walking into the wrenching horror of post Saddam Iraq or the dreary re-building of post-Taliban Afghanistan. Although the reign of terror has fallen, the aftermath is almost as bad as the tyranny itself. When an entire country has operated according to the rules of disorganized attachment, with randomness, arbitrary cruelty, terrorization, and unpredictability the norm, every citizen is a prisoner of war, a survivor of political torture, and a refugee of horror.

Unless we are trauma specialists, we may not think of ourselves as having "trauma" patients in our practice, but we do. We consider "trauma" patients to be those disaster victims emerging from sites like Columbine, Oklahoma or the World Trade Center. Then there are the ubiquitous crime victims, who perhaps were physically or sexually abused as children, or assaulted as an adult. What about more subtle, "small t trauma"? Like disaster recovery dogs who are sensitive to the faintest sounds of a survivor buried under tons of rubble, we therapists can deepen our repertoire of listening perspectives to sense the faint hallmarks of shock experience in our patients' material. For example, even one unmetabolized disastrous medical experience as a youngster can set up shock reverberations that persist throughout the life span. Imagine, then, the impact of the thousands of individual shock experiences that accrue in a disorganized attachment relationship with a non-empathic parent. Our patients with disorganized attachment experience are the sine qua non of trauma patients. Their flashbacks are not of bombs and blasts, but of broken connections, harsh rebukes, silent tears, rages against the self for not being better, and deafening screams of unrelenting distress and confusion.Our patients with unbearable affects have come to depend upon us as reliable dance partners in this grim waltz with the macabre, the grisly, and the grim. They have had to tolerate the

unbearable paradox (Pizer, 1998) of stillness and escape, just as their companions in war-besieged countries have had to do. They nervous systems have been relentlessly barraged and besieged by the aftershocks of unattuned parenting.

The Living Dead

The patient who speaks endlessly, desperately, of suicide is perhaps casting out for an anchor somewhere, to stop the ceaseless falling with his therapist's recognition that he has been dying psychically for yea so many years already. Benedetti, in Koehler (2003) speaks of a kind of countertransference he calls counteridentification in which the therapist empathically identifies with the patient's preverbal pain, forming a bridge between nightmare and possibility that leads to the creation of a new self, a mutually constructed identity: "*The counteridentification comes…from the present day feelings the therapist has towards a psychically dying human being*" (p. 80). Psychic dying is the penultimate agony, a torture of relentless reproach for being alive, without foreseeable relief or surcease. Ferenczi (1931) described psychic death very movingly: "*When a child finds himself abandoned, he loses, as it were, all desire for life….Sometimes this process goes so far that the patient begins to have the sensations of sinking and dying…What we here see taking place is the reproduction of the mental and psychical agony which follows upon incomprehensible and intolerable woe*"(p. 138).

Benedetti's "psychically dying human beings" spend a lot of time in my office. Jane, (whom we met in the last chapter) is a 39-year-old mother of twins, came to me a year ago after nineteen years of therapy with four therapists. She had come from a chaotic family with disorganized attachment on both sides, a teenage mother, a pedophiliac frandfather, an alcoholic stepfather who physically abused her mother. Her stepfather repeatedly tried to strangle her mother in front of her. When violence would erupt at home she would flee to neighbors' homes, trying to be as unobtrusive as possible so they would let her stay until the violence at her house ebbed. Her earliest memories were taking care of her mother "because she seemed to need it so much." She once found her mother curled up in the shower, sucking her thumb, overwhelmed with bills; the electricity had been shut off for a few days. A medical professional, she is divorced, a stable and loving mother determined to provide for her children what she had not had. When overwhelmed she "loses" moments to hours of time, which frightens her greatly. Terror stalks her whenever she is alone. Indeed, she was robbed and physically assaulted in her apartment several years ago. For the first few years of therapy she could not remember the details of the assault.

Jane is an attractive, lively mother. She has a charming smile, which she resorts to in a self-deprecating way whenever she feels vulnerable. She blames herself for "being a burden" to me, although I don't feel particularly burdened by her at all. She is afraid to cry, because "If I cry, I will just end up having to take care of someone." She tries too hard to be a "good" patient and to take care of me. When I intercept these maneuvers she giggles in embarrassment and looks down at her lap. She often sits curled up in a big easy chair, her feet tucked up underneath her. On other occasions she lays or sits, Indian style, on the couch, looking out the window. Her eyes cast about for anywhere to look but at

my face, especially when she feels herself beginning to "disappear." I have a large reef aquarium in my office, and sometimes she looks at the fish to ground herself and try to get present at the end of a session. She has many gradations of experience on the spectrum of dissociation. "Being not present" always seems to begin with her hands, for reasons we used to not understand. She learned to tap her hands and remind herself that they belong to her (Levine, 1997) when she begins to lose sensation. Eventually she tied the "hands" to her robbery/assault experience. As she entered the house with a broken window, she had become terribly angry at the invasion and devastation to her house, and had begun screaming at the (presumably) long-gone robbers as she viewed the detritus of her family's Christmas. The Christmas tree was thrown aside, presents ripped, broken and stolen. She had slammed her hands against the wall moments before being assaulted viciously by two armed men who had been quietly hiding out in a back room. Now her body feels pain in the places that were violated, every time she experiences anger of any kind. At my encouragement, she uses my voicemail as a container of sorts, to hold her unbearable experiences. We have agreed I will call her back if it is convenient, and will not if it is not. Most often she lets me know she prefers no callback, but is just "checking in," our euphemism for using my voicemail to try and become more present. This arrangement seems to be working for both of us. Incidentally, I do not offer this arrangement to more than a couple of patients at a time.

I learned long ago to differentiate between "dead thoughts," "suicidal ideation," and suicidal plans. "Dead thoughts" contain unbearable affect states, which are not yet "known" or "named." "*If what is dreaded remains unformulated, one does not know what it is, of course, but one may very well sense that whatever it is, it is dreadful*"(Stern, 2003). "Dead thoughts" are a way of beginning to "know" what cannot yet be felt, described or remembered; dead thoughts are also a way out. Jane feels enormous shame about confiding her "dead thoughts" to me, not wanting to be a burden, and was amazed when I differentiated "dead thoughts" from suicidal ideation and suicidality; I told her I wanted to hear all about her dead thoughts. Her dead thoughts are a great comfort to her, as they offer a way out of intolerable agony. When she was eight, she nearly drowned in the ocean. She vividly remembers the relief of sinking into blackness, hoping her hard little life would now stop. She remembers no sense of panic or will to survive, but does remember being disappointed when she was revived. Thus thoughts of death are for her what heroin is to a heroin addict: a wonderful peacefulness, one which she actually has tasted before.

When her twins are away at their father's, she will sometimes call me frantic, lost and agitated. If I happen to answer the phone or call her back immediately, she might well have "come to" in her car in a location she does not know. Horribly ashamed, she is often seriously dehydrated and on a back road somewhere in a rural area. I tell her to drive to a gas station and ask for directions back to the main freeway. She feels exhausted and discouraged about going through this again: "This is no way to live. I need to figure out how to stop doing this, or just stop everything. I can't stand this. I can't stand never knowing when I'm going to dissociate, I feel so out of control." When I see her next, she talks of urgently needing to find a way to get control over dissociating. One part of her wants to live, another to die. Part of her wants to crash the car, another part of her gets

her lost on a country road to keep the body alive, so the suicide plan fails. We talk about dissociating as a little death. I tell her she had already died a thousand times, over and over again throughout her lifetime: every time her grandfather invaded her body, every time her mother lashed out at her in hysteria, and every time her stepfather tried to kill her mother. No wonder she wants it all to just stop. I point out that losing time is one way of making the unbearable feelings stop, but that she just ends up exchanging one awful feeling for another. She is caught in an intolerable dilemma: she blames herself and her anger for the assault: "If I hadn't gotten angry maybe they wouldn't have hurt me." She turns her anger in on herself; the only way out is to die. I caution her to be very patient with herself, that working slower is really faster, that we can't hurry things along. I then talked about how shock lives in her very pores, and about how awful shock feels, and she bursts into tears. The "shocky" state of mind has never been crystallized in words for her as a state of mind that could be shared, or thought about, or even known before, but it is so familiar to her it she can't believe she's been in therapy for so long and it has never been named before. Of course, our work has just begun. At times she has been legitimately suicidal; she twice made deliberate, serious attempts to end her life by car wreck. However she is committed to her children and her therapy, and determined to not end her life for at least the foreseeable future. She loses time less than she used to, and different self-states communicate with me in person, on the phone and over e-mail. All of her self-states speak with the same voice and identify as Jane. Being able to talk about parts of her wanting to be dead is the essence of our work together right now, even as she dedicates herself to being the best possible parent to her young twins during the weeks she has custody.

States of Mind

States of mind are created within the psychobiological states of the brain and other parts of the body. Thus attachment shock experiences are rooted in the brain and viscera. Damasio (1994, 1008) has suggested that changes in bodily states are perceived and represented in the brain as what he calls "somatic markers." Siegel believes that somatic markers may be one of the keys to felt emotional experience: "*Our brains create a representation of bodily changes that is independent of the present-day response. A thought can be associated with an emotional response containing a somatic marker that has been generated internally. This is a representation of a shift in bodily state created by our brains from imagination and past experience: an "as-if " loop, in which an internal stimulus (such as a thought, image, or memory) can activate an "as-if" somatic marker."... Memories of emotional experiences evoke as-if somatic markers, which can feel as real as direct bodily responses and can deeply enliven the associated imagery of the recollection. ...An "as-if" somatic marker reveals how the process of imagination or memory can elicit a sensory response, which then initiates a cascade of fear-related associations that may be quite debilitating. This may be one way in which unresolved posttraumatic conditions continue to perpetuate frightening reactions from long ago; such individuals feel as if they are being traumatized over and over again"* (Siegel pp.143-4). Siegel (1999) postulates that we know how we feel based in large part upon the nature of these somatic markers, and that some people are more aware of their somatic markers, and thus their feelings, than others. "*Impaired input of the right-sided*

sources of somatic markers would functionally lead such individuals to be consciously unaware of their bodies' response. They would therefore not be able to know easily how they feel" (p. 146).

Shock is a somatic marker that is rarely recognized or named unless the sufferer is wandering around in a daze after a car wreck or other medical tragedy and is noticed by trained medical or psychiatric technicians. Otherwise, shock goes largely unnoticed, especially in children. Terr (1990), a child psychiatrist who came to specialize in acute trauma, was amazed after the Chowchilla kidnappings of a school bus full of children to hear the children described, not just by the media, but by child psychiatrists, as doing "fine." Those children were not fine, will never be fine again. Probably many were not even "fine" before the incident.

Thinking and reading about shock is a bit like entering the Twilight Zone. Those readers who grew up in the 60's will recall the fine job Rod Serling did of preparing us for what we were about to experience: a sense of the topsy-turvy, of things not making sense, of horror and nightmare and things that go bump in the night. I hope I can live up to Rod's legacy by being your narrator, inviting you to temporarily immerse yourself and your imagination into a new, uncomfortable zone of experience: the shock zone. In this paper we will review fivedimensions of attachment shock experience that create hellish states of mind – a misnomer, really, states of brain would be better – that come with a lifetime guarantee. "Cephalic shock" (Lewis, 1981,1984, 2001) is the experience of knowing that the world is not a safe place to rest your head, and that you and only you are responsible for keeping yourself "okay." The consequence of this "state of mind" is chronic tension, particularly in the neck and shoulders, and a sense that "peace of mind" is ever elusive. "Limboshock" is the state of mind that unexpected radio silence would bring to NASA astronauts circling our planet: confusion and an ominous dismay that all is not well. When we were learning about contributions to disorganized attachment relationships in the last chapter, we looked at separation and loss as contributory experiences in addition to a parenting style of momentary or prolonged "abdication" which leaves the child in a state of feeling abandoned and unprotected. This state of feeling abandoned and unprotected is the essence of limboshock.

At its worst, "Shattershock" is the state of mind of a torture victim who just breaks down and surrenders to his captors, with little left but a shattered psyche. In families with patterns of disorganized attachment, a similar shattering experience can occur in the developing self of a vulnerable child. We will see how an agitated child with a parent who feels helpless, rejecting and/or out of control can result in an escalating negative "resonance" which overwhelms the child's capacity to adapt. "Soulshock" is the trajectory of tragedy that ensues when a child has to make sense of bizarreness, malevolence and madness in the parent. The Red Queen of Carroll's (1865) Alice in Wonderland was a model of dangerousness, paradox, and disorganized attachment; she was intrusive, bizarre, and served arbitrary rules up ala carte. Our patients who in childhood had to tolerate bizarre paradox and arbitrary randomness have now to rely upon us to help them navigate the monstrous mindlessness of their cosmos. "Potential shock" is the anticipation of inescapable shock, that feeling we describe as dread. As our

brains scan for familiar landmarks of potential danger, our nervous system, our musculature, and our visceral register the toll. Dread dwells in the body, casting shadows of doubt and foreboding onto our minds and psyches.

Cephalic Shock: Frozenness and Static Tension

When babies have parents who go in and out of rhythmic attunement or just never quite get it right, the infants are forced to adapt to the shock of being handled rather than being able to relax into the safety of being securely held and understood. These infants are thrown back on their own immature nervous systems to maintain balance and homeostasis instead of being able to rely upon their parents in a relaxed fashion. A bioenergetics therapist named Lewis invented the construct of "cephalic shock" in 1976 to describe the impact and the life-long consequences, of being handled instead of being held as a developing child. Lewis (1976,1981,1984, 2001) suggests that one of the results of constant disequilibrium is that infants sense their physical precariousness and the forces of gravity and prematurely struggle to pull their head and neck up and away, instead of relaxing into bliss the way their more secure counterparts get to. Cephalic shock preserved in the musculature is the result. Lewis observed in his bodywork with patients that certain patients carried lots more tension in their neck and shoulder musculature than others. When the tense patients gradually learned to relax their heads into his hands, as he sat behind them, they often would break into sobs of relief and talk about how they had never felt supported before; they had always to hold themselves up and could never just relax into a sense of peace. Another way to understand the dilemma of these infants is to imagine the difference between falling asleep in the familiar comfort and stability of your own bed, and falling asleep on a sling three thousand feet up the side of a mountain, tethered to the rock face by a few pieces of metal. Experienced rock climbers learn to sleep on such slings while ascending up a challenging mountain face! So, too, we learn as infants to accommodate to the kind of parenting we have, no matter how ill suited it may be to our developmental needs.

"*The infant grows up trying to learn about life and itself from a half- blind (in the emotional sense), half-numb person, who cannot sense the separate life force, and unique rhythm in its offspring. …The infant…will have to find a way to hold on, hold together and hold against the parent who cannot provide it with auxiliary ego, a parent who is missing big pieces of its own ego. If anyone questions this, study the films by Brody and Axelrod on mother-infant interaction: one is stunned and barely able to sit through these films in which the infant is chaotically assaulted by dysrhythmic, gross mishandling at the hands of mothers who love their children and are consciously trying to do their best by them. What must be registering, for instance, in many of the infants in Brody's film, is that they are in danger, they are being handled in a manner that is at the limit of what they can tolerate biologically; THEY ARE NOT SECURE."* (Lewis, 1976,V-VII).

Lewis postulates cephalic shock to describe severe falling anxiety, a chronic state of disequilibrium physiological shock due to an immature nervous system exposed to unempathic handling, as it recognizes that "*contactlessness is intermittent and unpredictable*"(p. X). He notes that the child literally relies upon cephalic bracing to

support itself gravitationally before it has the ready musculature to easily do so. Lewis (1981) reminds us that Winnicott believed that failures of holding brought infants to the brink of unthinkable anxieties," one of which was a sensation of infinite falling. A newborn infant will first flinch backwards then rapidly throw out his arms in a desperate grasping motion whenever he senses himself about to fall; this motion is termed the Moro reflex. The evolutionary purpose of this reflex is to enable the primate to fully grasp onto it's mother's body, by first opening the chest and arm musculature in a flinch which facilitates the grasp motions which immediately follow. Thus the baby can be observed to scream in alarm, flinch and grab towards the mother in a nanosecond. Lewis (1983) notes: "*An infant will startle i.e., exhibit a Moro reflex, whenever a subtle change in its equilibrium occurs. The reflex will be triggered by sudden movement, noise or temperature change or even by its own energetic crying. The handling to which a borderline parent inadvertently subjects an infant creates a chronic state of disequilibrium or shock, if you will, that is far beyond the shock that the infant can discharge via the Moro reflex. This is the unique shock of unempathic handling, a daily occurrence repeated perhaps hundreds of times a day in the course of feedings, diaper changes, etc"* (p.8).

Lewis further notes that neuropsychophysiological research data is beginning to document what happens to infants who experience traumatic overrarousal. Schore (1996) reports that patterns are laid down in the infant's immature nervous system, which become part of its hard wiring. Structure which is both neural and at the same time psychological becomes imprinted into the circuits of the infant's cortex and limbic system as a state of frozen fear. When an infant is at the limit of what he can tolerate biologically, (e.g. what Lewis would characterize as cephalically shock), the state of threat registers and moves through brain stem, midbrain, thalamic, and eventually cortical areas, apparently engraving long lasting damage (Perry, 1997). Lewis(2001) points out that daily cephalic shock during holding, changing and feeding in earliest infancy renders the developing infant vulnerable to other shock trauma later in the developmental cycle:

"*The same caretaker who cannot respond to his infant in a well-attuned, emotionally responsive way in the earliest months of life, will tend to have long term difficulties with the child as he matures. The child will not be well-attuned to on a core bodily level, or genuinely engaged with on an intersubjective level"* (p.7).

Lewis notes at lest phenotypic similarity between the stunned infants on videotapes from the 60's who he labeled as suffering from "cephalic shock" and the similarly frozen, disorganized youngsters presenting with disorganized/disoriented attachment behavior (Main and Solomon, 1986). In the presence of frightening or unattuned parental behavior, the children present with prolonged freezing, slowed, underwater movements. Schuengel et al (1999) described an unusual infant observation example during their attachment research that seems to fit both these models: "*Oddly enough, although apparently frightened by her infant, Mrs. R treated her in a cold and harsh manner, perhaps as a way to control her fearfulness. Deborah reacted with disorganized behavior. On one occasion, she heard her mother approach and displayed an asymmetrical facial expression by pulling one corner of her mouth down. ...When Mrs. R*

stood before her, ready to pick her up, Deborah looked up with a fearful facial expression. Her eyes bulged, her mouth was open and her shoulders were tense. ...4 months later, Deborah did not show disorganized behavior and she was actually classified as secure. There was unusual behavior at the second reunion, however. Deborah cried and signaled weakly to be picked up. After being picked up, she stopped crying, and Mr. R. kneeled and held the infant in an awkward position. Because her mother put Deborah in this position, it cannot be coded as disorganized behavior. But it is odd for a secure infant to stay immobile when in an uncomfortable position on her mother's lap. Normally, secure babies sink in comfortably " (p.84). This description of infant immobility reminds me of the stunned behaviors of birds just after they crash into my window, or animals cowering before a predator.

Limboshock:diffusion into non-existence

Have you ever been stood up? Remember the feeling as time crept by and the dawning horror that your friend, date, whoever, *wasn't coming* ? There's a moment of wondering "Do I belong here? Have I misplaced myself?" As an adult this experience is but a momentary flicker, a wink by the Fates reminding us that we exist at their whim. But as a developing child, the experience of no longer existing in someone else's mind, is devastating. Limbo is by definition a state of being neglected, left in oblivion, utterly forgotten. Our brains are wired to be in resonance with other brains; this is why solitary confinement and shunning are such devastating punishments. Infant studies show that a mother's immobile face (under research instructions to remain impassive to her infant for a few moments) is among the most frightening of stimuli. A "live" video feed of a mother playing "live" with a video feed of her baby allows the baby to stay in relationship with her. Contrast this with playing the same video feed from one minute earlier, the same "good mother," only not a good mother in relationship with the baby's mind causes the babies to collapse in despair within seconds. (Mary Sue Moore, 1992, dissertation videotape). Put the mother on live feed again, and the baby recovers. This was a brilliant dissertation: art imitates life. What happens, then, when a mother simply goes through the motions of parenting, and isn't really "there?" When I describe the videotape to my patients, or let them watch it, they are typically touched and moved by the sensitivity to mind to mind resonance apparent in the bodies and faces of these infants; it is difficult to describe the profound impact of abrupt limboshock in mere words.

Limbo shock is the frozen keening of the bereaved, mimed in silence by confused, disoriented actors moments after their stage has collapsed, their director among the missing. Sorescu, (1996) a Romanian poet, captures the leaden frozenness of limboshock:

The Tear

I weep and weep a tear
Which will not fall
No matter how much I weep.

Its pang in me
Is like the birth of an icicle.
Colder and colder, the earth
Curves on my eyelid,
The northern ice-cap keeps rising.

O, my arctic eyelid. (pp. 225-6)

What makes the tears freeze invisibly on the artic eyelid? There are many different pathways to nowhere and non-existence. An absent or inattentive mother, extended separation from the mother, acute loss of the mother, or being threatened with rejection for needing or clinging to the mother can set up limbo shock in the child. If connection arrives and disappears randomly and unpredictably, or abrupt severing of relied-upon connection takes place due to death, illness, physical withdrawal or emotional constriction, babies are traumatized and experience limboshock. "*Constriction appears to be a 'desperate' mental strategy that prohibits segregated attachment models (simultaneous vertical splits) from becoming activated and, thus, blocks painful attachment material from flooding consciousness*" (George et al., p. 339). For infants, a constricted parent means the absence of a soothing, reassuring, solidifying presence.

Bowlby (1980) conceived of the attachment system as integrated with physiological homeostasis. Once a maternal bond has been solidified, the mother is the first line of defense against stressors of all denominations. Actual or threatened loss of the mother then becomes a source of acute distress. Once searching, calling, and crying fail to recover the absent mother, the child is faced with the threat of both emotional and behavioral collapse. When parents do not respond favorably to attachment behaviors on the part of the child, the youngster has to find some way to achieve proximity even if not soothing is forthcoming. Research on disorganized attachment demonstrates that the frightening or frightened attachment figure is an inherently paradoxical stimulus: because any cause for alarm will activate the need for protection and thus the attachment system, the child is compelled both to approach and withdraw from the same person. Main and Hesse (1990) have proposed that the infant's unresolvable conflict is reflected in the tortured approach/avoidance/freezing behavior that is at the core of disorganized attachment behavior. The limbo shock lies in the realization that no soothing can be had despite the desperate yearning. The "soothing mommy" that might periodically be available has temporarily been displaced by a "scary, rejecting mommy" and no matter how hard the mother later tries to soothe the toddler, the toddler's brain cannot shift rapidly enough out of the "scary mommy" model to allow soothing to take place. The "soothing mommy" is gone, for now.

A more everyday source of limbo shock in the child is traditional separation anxiety. Limbo shock runs the full gamut between the toddlers furious "you lost me!" at the grocery store (duration 90 seconds) to the more serious variety echoed for me in the following television story. In 1962 the television show Twilight Zone had an episode "Little Girl Lost" that frightened me severely. The episode depicted a young girl who disappeared into another dimension in the wall behind her bed. She found herself in an

eerie kaleidoscopic emptiness of Picasso-like topography, peopled by no one but herself. Disoriented, she could occasionally hear disjointed calls from her frantic parents and they could hear but not see her. They sent a pet dog in after her, in the hope he could lead her back. If my memory serves, she crawled from angle to jutting angle with her dog, trying to locate a way back to her parents' voices. As the hole behind her bed slowly began to close up (presumably forever), her father somehow got hold of her ankle and yanked her back. No doubt my memory has distorted this episode somewhat to conform to my own personal nightmarish experience of limboshock: when I was a toddler my mother became gravely ill and nearly died after elective surgery; my surrogate caregivers had little warmth, compassion or calm to spare. My father reportedly walked the floor with me sobbing each night when he returned from intensive care, which went on for months. I was 15 months old, entering a critical period for separation distress. Despite being perfectly aware of the relationship between the Twilight Zone episode and my own circumstances at an early age, and all its implications, I was unable to "check behind my bed to make sure the wall was really solid" for several years after watching it at age 8.

(Author's note: after writing this I looked up the episode to see how true to life my memory was of this television episode from 41 years before. Interestingly, the only details I altered historically were (1) my age: I saw the episode at age 12 instead of 8, 8 being the age at which I had a life-altering accident of terrifying proportions; and (2) the visual topography: instead of being "hard", sharp-edged angles, the other dimension was like a "soft" set of inter-nested bubbles, concave, convex, vaguely blurry and luminous. I suspect I shifted the story set to conform to my own memories of "hard," agitated surfaces predominating in my early life instead of "soft," soothing ones.)

Limboshock is the horror of going under the water for the third time, life's ebb bubbling madly, while no one is watching. A friend of mine who felt she was in impasse with her therapist had the following dream just after she began therapy with an analyst who, she felt, understood her better. She was lying on the bottom of a swimming pool, terrified. Adults (including her former therapist) sat in lawn chairs around the pool. She clawed her way to the surface, waving frantically and screaming "help" but her therapist kept talking about his investments and neither looked her way nor heard her. After hearing her analyst commented that he suspected she had been drowning for a very long time, and she burst into tears. Her first therapist related to her on the basis of her precocious and highly developed false self, her life accomplishments and social position, but never grasped the level of desperation she lived with as a constant companion.

Child, adolescent and adult patients have reported to me the chill of being "forgotten" while waiting to be picked up, until slowly and agonizingly it dawns on the child that no one is coming. The securely attached child "knows" that the car broke down, there was some communication problem, but that it will all be worked out in a little while. The avoidant and ambivalent attachment children all worry to varying degrees depending on their previous experience, but the disorganized attachment children panic. From worry to panic, each moment brings fresh opportunity for the silence of limboshock. "Waiting to be picked up" is of course only one of many possibly landscapes of separation anxiety. so limboshock can relate to repeated failures of reliability of the

"*container/contained*"(Bion,1957) relationship. The question so popular in the 60's:"If a tree falls in the forest, and there is no one there to hear it, is there really a sound?" was only partly ever about physics. To restate it more clearly: if there is a sound, and no one to hear it: does the sound really exist, or does it fade into nothingness? Do I really exist if noone is there to confirm it?

States of limboshock bring to mind the desolate and devastating poverty of post-war countries: freedom to choose, to rebuild exists, but there is little infrastructure to support growth. Individuals who endured massive doses of limboshock while growing up are at a loss when it comes to forming deep, authentic connections with others. Theirs are not the life-long friendships based on intimacy and mutual regard; often their friends are precious to them because they remind them that they exist, that they have shared history, at least with someone. We are really talking here about emotional deprivation. If a parent was never consistently "there," the infant and developing child have to endure a kind of primal absence of mind to mind resonance, a human variant on the wire or cloth monkeys of Harlow's(1958) research. Even if you have read his article, *The Nature of Love* before, it's worth checking out again; in the context of limboshock and disorganized attachment: the pictures alone are enough to make you cringe in comprehension of the ravages of deprivation.

Imagine a tiny, newborn monkey, taken away from his mother, placed in one of many stark environments. Behind Door # 1 are three different empty cages, which the infants are placed in. The wire cage babies die within 5 days; if a wire mesh cone is introduced, the babies do better. If the cone is covered with a cloth, the babies survive and appear to be healthy; although not normal; they have contact comfort at least. Behind Door #2 are the Wire and Cloth Monkey Mothers, perfectly proportioned with one breast. The Wire Mother is simply a wire frame shaped to support nursing, with radiant heat provided. The Cloth Mother is the same wire-covered frame, heated, with foam rubber and a changeable terry cloth cover on top. Both Mother Surrogates have faces; the Cloth Mother face is more lifelike, with bigger eyes. Pictures sprinkled throughout the paper show tiny infants huddling desperately against this Cloth Mother, which they vastly preferred over the Wire Mother. The baby monkeys used the mother surrogates much like they would use real mothers, as a secure base of operations. When frightened, the youngsters would vocalize and rush to cling onto their Cloth Mother's torso. If the surrogate mother was temporarily removed from the room, the baby monkeys became inconsolably agitated. One heartbreaking picture shows a disconsolate baby huddled at what would be the feet of the surrogate Cloth Mother, collapsed into a tiny ball. Monkeys who were raised without any surrogate mother for their first 250 days were initially alarmed when a Cloth Mother was introduced, but rapidly began relating to her as a source of security and reassurance, like the monkeys raised with her did. Pictures show these juvenile monkeys desperately clutching their new Cloth Mother, lying across her torso. If you can bear to check out these pictures, the website is: http://psychclassics.yorku.ca/Harlow/love.htm the search words are wire monkey + Harlow plus Nature of Love.

The infant who falls and falls into limbo shock may grow up into a person that never was really there, drained of vitality and juiciness. "*Do not go gently into the night; rage,*

rage, rage against the dying of the light" (Thomas, 1952) could as well be written about early childhood limboshock as about fear of death and obliteration. Let's look at a clinical example. Lisa is a 44-year-old woman in group psychotherapy with a formidable false self. After six years of individual work, she still found herself mostly blank. She had adhesively pursued a series of unsuitable relationships with empty men, hoping that in the child they might give her she might find the vitality missing in her life. In group she had mostly been vague and empty over the many years. At first she was skeptical about whether anyone in group cared about her or her feelings. She worked through her painfully empty relationship with her parents in the group transference, and then confronted her unhappiness as a businesswoman. She dropped out of twice a week individual therapy and group therapy to become a spiritual director. After completing her training and discovering that the life of a spiritual director was not for her, she returned to group, where she continued to explore her unsatisfactory dating relationships and lack of deep friendships. She was pleasant with other group members, asked a lot of questions, but remained largely superficial. Occasionally she would painfully and silently squeeze out a few tears, collapsing her face into her hands, horrified, humiliated, and saying she wished she could disappear into a hole so no one could see her. A few minutes later she would have completely reconstituted her defenses and was again vague and pleasant.

Finally one night in group she said she was thinking of leaving because she could never figure out what it was she was supposed to be working on. Her group therapist, after asking permission, "shadowed"(Moreno ,1991) her inner voice, standing behind her and giving voice to the limboshock he suspected was there. " *You left me to fall and fall and never helped me understand what I was feeling, it was like I was a building collapsing into itself, nothing was left, just the dust and cells of my body, like the World Trade Center buildings, all destroyed inside my head, I never got to exist*." Nodding vehemently, Lisa broke down into the first loud sobs she had ever shed. She mused that she was always falling, and that no one had ever caught her before. "*It's like I was a silent movie that had no actors, just annoying music. There was no me to tie to the train tracks, and no one would have heard me if I could have screamed, anyway. The music just kept playing in my family while mother silently smoked her cigarettes, they hated each other and wished I had never been born to imprison them together. Mother was too young to have a family, and certainly didn't love him. I'm not even certain now that she even loved me. I don't think she loves anybody.* "

In the months after this group, Lisa began to come to life. She became deeply interested in other group members in a way that had "heart" instead of being primarily cerebral. She visited her idealized mother and confronted her mother's malignant narcissism and destructiveness to the rest of the family. She took up jogging and began to develop activities and interests with other women that were more genuine. She formed a circle of friends that went camping together, cooked meals together, and the like. She bought a new house that she thoroughly enjoyed. She broke off her desperate pursuit of men for "attachment to anyone's sake" and became curious about the kind of man *she* might really be interested in, a novel perspective that she had never considered before. While in the midst of a triatholon she met a man who appears to be in love with *her;* she is taking

it slow with him. In short, it seemed she is developing a self that had been largely short-circuited over 43 years earlier.

As Lisa showed us, the forces bound in limboshock are fearsome. Like a drowning infant or toddler, she simply sank to the bottom and died inside, without dramatic and obvious struggle. The collapse into wordless meaningless despair endured by Lisa and others like her is captured by Grotstein(1986) in his description of "black hole" experiences of cumulative trauma. He describes the paradoxical power of limboshock in terms of "*surging powerlessness, of implosion, of disintegration, of disorganization into non-organization, in short, the decimating, annihilating power of nothingness*; *…tormenting nothingness paradoxically mixed with 'nameless dread,' the decathected chards or residues of abandoned meaning*."(p.267). Grotstein (1990) described this slow implosion into the silence of oblivion, of abandoned meaning: "*A violent, implosive pull into a 'black hole,' one which is experienced as spaceless, bottomless, timeless and yet, paradoxically, condensed, compact, and immediate, yielding suffocation anxiety"*(p. 281). Grotstein hypothesizes that the traumatic state itself dissolves the holding-containing matrix of the internal and external world with a dissolution of figure ground distinction*: "As the patient experiences descending into the 'black hole' there often is a 'white out,' a 'blank psychosis,' which corresponds to shock-induced frozenness of the whole sensory apparatus.*"(p, 281) Like an avalanche descending a mountain face to obliterate all traces of its passing, Lisa's feelings would pass through her, leaving behind nothing but blankness until she finally faced the depths of her childhood shock.

Patients who have experienced this state early in childhood report a particular relationship with time that becomes accentuated during periods of chronic pain and abandonment such as that following bereavement, a breakup, etc. Time appears to be unrelentingly persecutory and undyingly endless. Perhaps reminiscent of a containerless infancy, in which time unfolded to reach infinity itself, structureless time haunts patients who struggle with limboshock. Like the monkeys in a room without a mother, there is nothing to hold onto. As such an altered sense of time stretches out, reality gets distorted. Most of us are familiar with the experience of waking at 2am worrying about something. As the long night drags on, we toss and turn trying to stop thinking; our worries intensify and still we don't fall asleep. Until we do. The next morning, we wonder why we made such a big deal out of a small worry. We were in the zone of limboshock.

One patient, Amy, struggled with limboshock over weekends. If she had no good book, no plans, or if a friend cancelled a plan at the last minute, Amy would disappear into nothingness. She tried to go to a movie by herself and fled the theatre in tears, certain that the world could see that she was all by herself. She would call me up in panic on Friday afternoon, unable to figure out what to do with herself over the long hours until her job started Monday morning. The sound of my clock ticking drove her nearly mad, as it reminded her of weekends with her grandparents. Her parents were quite depressed, and left her for long periods at her grandparents. A pioneer woman, her maternal grandmother ran away from Missouri at 14, lied about her age and taught at an Indian village in Alaska before meeting Amy's grandfather, a gruff timber captain who also was a runaway. Being neither conversationalists nor interested in Amy's inner life, her grandparents structured

Amy's visits to their house with chores, the (for Amy) dreary sounds of golf and baseball tournaments, and long mandatory naps in a guest room that had only a Bible, a bed and a ticking clock on the bedside table. There were never any toys, books, interactive games, or children's television shows to watch. On the rare occasion Amy got to stay with her paternal grandmother, it was a different story. Her paternal grandmother delighted in her granddaughter's presence. They had constant interaction, played all sorts of imaginary games, read books together; naps (which were optional) were spent cuddling up with two affectionate cats. Amy grew up dependent upon others to help her feel alive. Books were her constant friends, the more imaginative the better. She was delighted when she finally bought her first decent television/videotape machine and learned to rent videotapes to entertain herself with. She was becoming self-reliant, and no longer dreaded empty spaces of unscheduled time. Time had changed from enemy to benefactor. The poet Simic (1996) captures the essence of Amy's limboshock-dominated passage of time:

Squinting Suspiciously

I was watching time crawl roachlike
Shuddering and stopping
As if some of its legs
Had already been plucked.

It still had the whole of infinity
To climb like a kitchen wall.
The very thought of it,
In all likelihood,
Causing these jitters,
These eentsy-weentsy doubts.

It must be the chill, I told myself.
Neither one of us can get warm
Even on a hot night like this.
O cruel time, you need someone to throw
A blanket over you, and so do I. (p. 72)

Even individuals who grew up with secure attachment experience limboshock in the severe grief of sudden bereavement. Jill, a 53-year-old woman of enormous emotional range, has just been broken up with by her boyfriend of a year's duration. She had grown up the beloved child of two Irish parents. At 12 she had been burned badly in a house fire, and had been in a burn unit for a while. She and her lover Westin, whom we met earlier, had been talking seriously about marriage. His intense terror of intimacy had surfaced in a couple's session, over a discussion of how she would like to be able to touch him more tenderly, and make him feel less alone, and he broke off contact with her abruptly. He frequently disappeared into "the bunker" to process profound pre-verbal issues, but usually maintained some kind of contact with her during these periods of alienation. On this occasion he was traveling due to his work commitments, and used this hiatus to avoid contact with his individual therapist as well.

Usually during a "bunker" period he relied on his therapy to keep his alienation from becoming too ego-syntonic. This time he avoided calling his therapist to set up a long-distance appointment. This time after three weeks of silence she wrote him an e-mail requesting some emotional contact, and this time he responded in chilly reminiscence: "I think fondly of your heart but I cannot think of what to say right now." When he resumed his individual work he could not seem to remember what it felt like to be in love with her, only irritation that she was pushing him to tolerate tenderness in touch, and that he was relieved to be "away from" the relationship. He could not decide whether to contact her to break up, or to continue to avoid her until she handled things for the both of them. He had some vague fantasy that his love for her might return if he just waited long enough. His indifference to her welfare was quite non-characteristic of his typical demeanor towards her, but her could not work his way out of the icy, protected indifference towards her. Several weeks later, still frozen by the limboshock of his abrupt departure from her life, Jill went over to his house in grief, demanding some closure to his silence. He declined to work on the relationship further; he had too much terror, he said. (We will examine this terror more deeply in the section to follow on potential shock: dread.) Several weeks later, she wrote about the shock of his decision to turn away from love and attachment in her journal; she noted that he reminded her of Anthony Hopkins in the movie "The Remains of the Day;" this character also turned away from the promise of love because it was just too overwhelming a possibility to contemplate.

From Jill's journal:

I'm just writing with the prayer and intention to release the pain…grief seems easy compared to the shock…its really more than that…

In all my life I've never felt this much trauma…I live such a rich life…filled to abundance with love and an amazing faith that saves me and nourishes me and always, leaves me grateful…but there is a shock around my heart that aches beyond measure. very much like a child's first experience of betrayal and visceral abuse…

And although I am a woman and not a child, and I truly felt present and not naïve or wearing blinders, nothing prepared me for the way Wes treated my heart…I knew he was frightened, even at times terrified…but regardless of his injuries, I feel horrified. At times I think "this can't be real…Wes could not have treated me with such cruelty…a complete disregard of the golden rule…for my heart, it's recovering from shocking abuse from a soul I knew and loved…

At times it's excruciating to bear…it's been over a month…I connect in the heart to each person I see, both in my practice and my life. There is weight of it when I am alone…I cannot find the way out of the deepest and most shocking disappointment of my life…
And then the way opens and for a time, I feel my heart opening more with a strength that is more than I have ever known and a certainty of love beyond measure, always available.

I know already some of the learnings…they have come quickly and vividly to comfort and reassure me, that I continue to be very alive and fully committed to my path of the heart, there is no doubt…

And then there are times, like now, when I remember him…and for a moment I wished he'd never come, never walked up to my door and I saw him…and recognized his soul immediately

There were so many ways he could have left me – with dignity, love and respect for us both…I would have understood letting go…I would have been left with such a different memory…this memory of this last month is the harshest landscape to navigate…I know I will and I know that choosing love in every moment I can will be the compass. But at this very moment, regretting trusting him with the tenderness of my heart.

I can't quite see the horizon, or the sun.

This poem by Hafiz (1300's) expresses JILL'S dismay and consternation at Westin's turning away from love:

A Great Need

Out
Of a great need
We are all holding hands
And climbing
Not loving is a letting go.
Listen,
The terrain around here
Is
Far too
Dangerous
For
That.
(p. 165)

Shattershock: disorganized torture and the fractured container

Shattershock is the psycho-physiological sequela of a break or fracture of the child's emerging mind/body psyche after an inadvertent experience of near-torture at the hands of a parent or other loved one. Shattershock is attachment shock in the extreme, when the psyche actually shatters under the impact, like the glass in a windshield when a rock glances off of it. Most of the time the windshield remains outwardly intact, but tiny spiderlines of shock fracture and radiate throughout the glass pane. Meerlo(1973) coined the term menticide to describe the breaking of the mind into capitulation and submission/surrender when the captive or victim's psychological needs are exploited by threatening and hostile caretakers from whom there is no escape. At first, under

conditions of torture, the needs for solace, rest and oblivion are evenly balanced by needs for defiant self-expression, loyalty to others and refusal to yield, surrender or submit. Ultimately everyone can be broken down. Stover and Nightingale (1985) write about "the breaking of minds and bodies" in the context of deliberate, organized political torture: "*although infliction of…pain is integral….the purpose of torture is to break the will of the victim and ultimately to destroy his or her humanity"* (p.50).

The conditions of torture at least superficially resemble the childhoods of children with early childhood attachment disorganization: total dependence upon the captors; unpredictable switches between harsh and lenient conditions rapport, good cop/bad cop, as it were; timelessness; rough handling; intrusiveness into the personhood of the captee; unpredictable and random sensory assaults on the senses; perpetration of meaninglessness. Suedfeld(1990) reviews the Report of the APA Subcommittee on Psychological Concerns related to Torture and concludes that central characteristics of torture include: (1) the individual is in the control and power of some group or individual; (2) the suffering may be mental or physical and (3) the pain is inflicted deliberately.

Disorganized attachment and the shattershock of childhood are not usually created deliberately, by an intentional and organized perpetrator group or individual, but by a *disorganized individual with no particular motivation.* Unfortunately there are a small number of children who actually grow up within malignant criminal families and are actually deliberately pimped out for child porn and other awful experiences. Nonetheless, even in relatively benign families shattershock comprises a state of mind of "lived" torture "lite" unknowingly perpetrated by parents who are unable to contain or process intense affects when their children need emotional attachment. Much like growing up in a war zone, these children never know when a bomb blast is going to go off; they have to pick their way carefully through the land mines of their parents' emotions.

As a practicing child analyst Bloch(1978) studied the terror of children who believed their parents were bent upon killing them. This is a difficult thought to think, as we take parental love as a given, a backdrop. For example, commenting on the "ordinary" parent child relationship Bollas(1995)says of "basic trust": "*it precedes reflective consideration, almost a thoughtless assumption, derived from parental care of a child. We know, don't we, that this is the infant's and child's trust in the mother and father who look after the child, who certainly withhold any violent or murderous response, and who bear the child's greed, omnipotence, empty-headedness, and jealousness"* (p.186). Yet in the Oedipus legend, Freud downplayed the first part of the myth of Oedipus in formulating his theory: the parents of Oedipus, frightened of his power and destiny, conspired to arrange his death as an infant in order to defeat the prophecy of the oracle that he would grow up to kill his father and marry his mother. Thus at the legend or archetypal level, from birth parents and infants are in life and death struggles with one another.

Grotstein(1991) asserts that predator/prey anxiety exists as an inherent preconception in the human species and appears in young children from the beginning of life, so it is not unusual that witnessing or experiencing violence would be terrifying at a biological as well as psychological level for an infant. Physical and emotional violence were not

rarities in the homes of the children Bloch analyzed. Bloch noted the bottomless feelings of humiliation and the unalterable sense of helplessness many of these children endured. Her conclusion was that in order to resolve the parallel attachment systems (my words) of terror and yearning, these patients embarked on a life long struggle to win their parents' love as a primary defense against their fear of infanticide:

"…(*they)attempted to explain and justify their perception of their parents' hostile and aggressive feelings by blaming themselves. Their implicit hope, since their worthlessness had provoked those feelings, that whenever they changed and became worthy they would be loved can be found even among the children who attempted suicide and the abused children who later committed murder. This delusion both sustained them and perpetuated their suffering. My treatment of adult patients frequently revealed that it invested their entire lives and eclipsed time and reality. In its service, infancy remained the anchor of their being, life was made to seem eternal and age meaningless…..Their security demanded that they seek within themselves the causes of the parents' anger or hatred or their wish for infanticide"(p. 226).*

Bloch goes on to share a patient's description of herself in a terror state after witnessing scenes of violence in her family: "*When I let everything frighten me…I lose myself in a panic that comes out in wildness and screaming and laughing and feeling sick and empty, and everything looks like papier-mâché and I can't trust anything…"* (p.228).

The shock zone of shattershock is the legacy of parents who were never themselves parented in a secure fashion. Lyons-Ruth et al (1999) hypothesize that *"If the caregiver has not experienced such comfort and soothing in relation to her own past losses or fear-evoking experiences, however, the infant's pain and fear will evoke her own unresolved fearful affects, as well as her helplessness to know how to find comfort and resolution in relation to them…"(p.38)* "*...Therefore a hostile-helpless infant-caregiver relationship should be viewed as a primary source of dysregulated fearful arousal for the infant, one that holds little promise of resolution over time in the absence of significant changes in the caregiving environment or significant new relationships(Egeland et al 1988)*" (p. 45*).*

Both the caregiver and the child are sucked up into a containerless spiral filled with the intensity of an emotional twister, The forces acting on and within a dyad caught in an attachment disorganization maelstrom meet no shock absorbers or brakes to slow momentum. When there is no container to hold the forces of terror, panic, desperation, raw need, hatred, dissolving and disappearing, eating and being eaten, and the other intense negative affect states that babies and young children sometimes generate in their parents, mayhem ensues. Grotstein(1990a) describes this experience mayhem as the black hole state:

"…*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,*" (p.257) "*..Nothingness within a container…is healthy because the later affords a meaningful context for the former, whereas 'nothingness' without a container*

constitutes the 'black hole'…and approximates chaos or randomness and may invoke the participation of 'no-thingness in order to fill it. Ultimately, I seek to nominate nothingness and meaninglessness as the most dreaded nadir human experience. I believe that they constitute the fundamental traumatic state. Thus "space" is not an area within which human relationship might be allowed to develop but rather it is the presence of an inhuman and malevolent absence that must be blotted out of awareness at all costs." *A manic variant of this 'black hole" experience is that of explosive expansion or even of splintering"* (p.281).

Bick (1968) described to Meltzer (1975) a mother/infant attachment pattern during which mother and infant were sharing and amplifying negative emotional states mind to mind, presumably because the mothers lacked the internal resources for self soothing required to sooth self and infant in the face of distress: "*…she had observed in her work of direct observation of mothers and infants, something that had to do with states of catastrophic anxiety in certain infants whose mothers seemed somehow unable to contain them. When these infants got anxious, their mothers got anxious too and then the infant got more anxious and a spiral of anxiety tended to develop which ended with the infant going into a state of some sort of quivering and a kind of disintegrated, disorganized state that was not even screaming, not a tantrum, just something that one would have to describe as disorganized. Mrs. Bick began to observe this phenomena also in certain patients, generally patients who, on the whole, did not seem terribly ill, in candidates; in people who came because of things like poor work accomplishment, unsatisfactory social lives, vague pathological complaints; in people who are somehow on the periphery of the analytic community and wanted to have an analysis and couldn't quite say why. She began to observe that these patients in their dream life and in their waking life were subject to states of temporary disintegration very much like the infants. ….She discovered …that they weren't properly held together by a good skin, but that they had other ways of holding themselves together ….She began to call these secondary skin formations…" (p 295-6).* One wonders how often therapeutic failures have been influenced by this type of uncanny and disconcerting negative limbic resonance, with panic spiraling out of control in the therapeutic dyad.

A patient, Tasia, brought to me the following written material (excerpted) to articulate her shattershock. Her mother had transitory psychotic episodes but functioned primarily as a high-level narcissist. Tasia describes shattershock as "the particle accelerator experience." When I read her the above paragraph about Bick's observations, she sighed with relief and said: "I thought I was the only one who had this experience."

"My mother and I and my husband and I both share this awful pattern I call the particle accelerator experience. Neither one knows anything about emotional connection so if I am upset at all, all hell breaks loose unless I just go away and dissociate, self soothe, whatever. There is a feeling that just keeps flying back and forth between us like a particle in a tube at an increasing acceleration, propelled by some force. A failure of maternal containment…it just keeps on escalating tension and speed in a visceral way until I explode. It's never the other person who explodes, at least on the outside, it's always me. This isn't a metaphor, or a mind -thing, it's in my body. I hear it as a steadily

building whine, which climbs into a shriek, maybe me screaming in my head, I don't know. I experience this as a visceral sensation; next, being hurled away violently, away from the tube against the wall, then fracturing into a thousand pieces like a large glass container would, I feel the impact, hear the shattering, then I feel a mess, all jagged pieces inside. I do have those unexplained healed hairline fractures on my pelvis, who knows? I've seen her slam her head into the kitchen counter – maybe she got violent with me when I was little. She had so little patience with me when I was crying for her, she hated it; she used to say she'd pretend to be dead so I would just go away and leave her alone. She couldn't bear it when I needed her. Like, the time I was home from college with a 103-degree fever, something called Hong Kong Flu. I couldn't eat Thanksgiving dinner, and she got so furious at me for not eating, even though she knew it was my favorite food in the world. She ended up screaming at me and I was crying and saying I'm sorry and it got so weird, I tried to leave the house, but I was too sick. Somehow everything was always my fault. She never admitted to any issues. It was almost a relief when my mother screamed a few years ago: "What is this thing called soothing you always wanted? I never had it and I turned out fine. That was always the problem between us, this ridiculous thing you say you need. Go get it somewhere else. I haven't the faintest idea what you're talking about." After that meltdown she wouldn't talk to me the rest of my visit; then she died suddenly the next month. Sometimes it's like the particle accelerator with my husband. He hates it when I am crying and trying to tell him what I am feeling. He flips into his childhood, when his parents were going at each other shredding each other to bits. I'm not like that, I don't want to hurt him, I just want to tell him about my desperate feelings, I'm trying to help him understand me but he can't listen. Anyway, when he storms away from me and won't listen to me, I end up huddled onto the floor, grabbing on for something stable to hang onto and sobbing, a total mess. It's embarrassing."

Tasia and her husband John are working hard to contain shattershock between them and to learn how to nurture each other when the other shatters. Although Tasia has the more obvious meltdown, actually each of them shatters with escalation of tension. Neither one knows how, yet, to restore equilibrium to the relationship once it has spiraled out of control. As Tasia feels more desperate, her voice gets louder and shriller, more closely approximating a distress cry. John, hearing the loudness, flashes back to his childhood experiences of listening to his parents tear at each other instead of communicating. If either one can get calm enough to observe that the other feels shattered, use active listening to each other's feelings, or become vulnerable enough to ask the other for patience, then the spiral reverses. Tasia, hyperverbal, prefers that words be used to reconnect; John, more nonverbal, prefers to try and reach out for safe, reassuring touch. Thus far, Tasia rebuffs John unless he acknowledges in words his vulnerability, instead of pretending that he is being a caretaker for her. The two of them are slowly developing the tools they need to resolve the terror each has of being in the presence of danger from the other. We will read more about Tasia and John in a later chapter.

This poem was written by Simic, the man who was blown out of his bed by a bomb explosion at age 3. He grew up on the streets, foraging for food, and immigrated to the

United States as a teenager. In this poem he gets up close and personal with the shattershock experience.

BLOOD ORANGE

It looks so dark the end of the world may be near.
I believe it's going to rain.
The birds in the park are silent.
Nothing is what it seems to be.
Nor are we.

There's a tree on our street so big
We can all hide in its leaves.
We won't need any clothes either.
I feel as old as a cockroach, you said.
In my head, I'm a passenger on a ghost ship.

Not even a sigh outdoors now.
If a child was left on our doorstep,
It must be asleep.
Everything is teetering on the edge of everything
With a polite smile.

It's because there are things in this world
That just can't be helped, you said.
Right then, I heard the blood orange
Roll off the table and with a thud
Lie cracked open on the floor (Simic, 1996, p.52)

Soulshock and the structure of evil

Siegel's (1999) work on the nascent sense of self suggests that it is in mind to mind emotional limbic resonance that we learn who we are, how to feel, and how to regulate how we feel. What happens when an infant, a child, is in mind-to-mind resonance with malevolence, madness, deceit, corruption and ruthlessness? The adult has superior available intelligence engaged in the service of cruelty, superior mobility and physical resources, superior reasoning and language skills, possibly superior street smart and people-reading skills, and the ability to deceive if he wishes to. The child has a trusting heart, an open innocence and an engaging presence. I suggest that even casual everyday interactions between the two people, because of spiritual and emotional toxicity are going to at minimum taint the child's open innocence and trusting heart, draining away some of his vitality; even this positive outcome is predicated on the child not being a particularly attractive target for predatory violence on the part of the adult. Should the hapless child be the intended target, and survive the encounter physically, I believe his soul will be shocked away from his body for some time, his body trapped in traumatic processing, his heart constricted, his vitality squashed, and his innocence lost.

Terr (1990) discusses the uniqueness of this variety of traumatic fright: The fright from (soulshock) trauma is so unique that we don't even have a 'right' word for it in English. Helplessness? Terror? Horror? One little boy after being kidnapped for ransom told Terr: "*I already know what it's like to die – to be killed. You can't breathe.* " On a few rare occasions adults will give such eloquent words to their own terrors from childhood that we can better grasp how traumatized children feel. Terr tells us that a novelist Naipul said in 1981: "*I have two very early childhood memories of my father being mentally ill and of waking up in a hospital room and being strapped in a bed. ...I have always been fighting a hysteria that plagued me as a child, the old fear of extinction and I don't mean dying. I mean the fear of being reduced to nothing, of being crushed*"(p. 36-7).

Terr notes that being psychologically overwhelmed, the sensation of being "reduced to nothing," is such a hideous feeling that the victim seeks never to experience that sensation again. Fear of further fear, the immobility response, keeps victims from trying to escape even when their chances seem good. Children and adults who have been kidnapped and held hostage have long puzzled FBI authorities because the authorities literally had to drag the protesting hostages to safety. In collaboration with Terr and other child trauma experts they came to understand the role terror of fear itself plays in the dynamics of shock paralysis.

Authors and movie directors have spent a lifetime trying to teach us about soulshock, about what it is like to be touched by darkness. Soulshock is the horror of nightmares come true, finding betrayal and malice in your bedtime story along with hot cocoa. Soulshock is telling your mother your father abused you and getting slapped in the face for disrespect. Soulshock is finding out lies make up the threads of your family's tapestry. Soulshock is discovering that Alfred Hitchcock and Stephen King wrote the screenplay of your life.

I have never met a psychotherapist who has not been touched by evil in some way; even if we specialize in the "worried well," we are bound to run across the occasional unspeakable horror. We struggle to frame the concept of evil within familiar boundaries, to pin it down for further study by surrounding it with words that name its essence. "*There is a place called nowhere, a country where (evil) lives and from which he strikes. We know this place. Even if it is beyond our perception, we know it exists. It is the place of the split-off unknown, where actions with unanticipated consequences originate, where sudden destructiveness against or from the self arises, a zone of darkness that weaves in and out of selves, preserving darkness and nowhere in the midst of vibrant mental life and human relations*." (Bollas, 1995, p. 190) Peck(1983) defines evil as that which kills spirit; Erich Fromm as that which desires to control others, to foster dependency, to discourage capacity to think for themselves, to diminish spontaneity and originality, to keep them in line, to rob them of liveliness and humanity. Goldberg (2000) argues that to understand evil requires us to uncover the destructiveness bred within attachment relationships, especially the family. "*People who are living destructive and/or disturbed lives…have a marked incapacity for intimacy and caring*"(p. 204). Humiliation,

contempt, neglect, "do what I say not what I do," and deception within the family structure itself are some of familial corruptions he cites.

Lewin(1996), Peck(1983) and Bollas (1995) have taken the subject of evil on directly, by writing about it. While the topic of evil is almost too unnerving to think about, they urge us as therapists to open our minds and hearts to its effects: "*We often wish to close our eyes and close our minds and close our hearts so that we do not have to meet the challenge of evil. We all too readily can be led down the dangerous path of trying to make the world a better place to live by pretending…intelligence in the service of cruelty is evil …Each time we reduce a person to the status of a thing,*(underline mine) *ignoring the crucial dimension of the other's inner experience, hopes, strivings, and need for love and respect, we put ourselves in proximity to evil...The horror of differences that we see as located outside ourselves bespeaks a horror of our inner diversity, our sense of the plenitude of our own potentials as a nightmare….When we speak of evil, compassion knows that we speak of a process by which people misunderstand themselves, make themselves morally misshapen, and wreak havoc not only on the world around them but on the world within then, compassion knows that evil is a set of existential mistakes with dire consequences* " (Lewin, pp. 292-3).

Being reduced to the status of a thing by a person significant to you, such as your parent, spouse or therapist, is one of the most horrid affect states possible to experience. Kristeva (1982) and Mitrani (1996) describe this state of feeling reduced to the status of a thing as being a state of the ***abject****:"* …(this is) *felt as a totally catastrophic collapse or as a dreadful sensation of being ripped- off and thrown away. In a sense, the latter is an experience of total and irreversible dejection. It is not an experience of the loss of the object or even the presence of the absence. Instead, it is an experience of the presence of what Kristeva (1982) termed "the abject" .She suggested that the "abject" - a jettisoned object –retains only one quality of the object it once was – that of being opposed to or separate from the subject*" (Mitrani, p170). Abjectness is a visceral experience rather than a mental concept; I believe it is an essential aspect of what Balint (1952) termed "*the basic fault.* " This essence of being treated as/seen as/felt to be utterly despicable or contemptible becomes installed as a neural map in the core sense of self (Siegel,1999) when the infant is violently repudiated and metaphorically jettisoned by the primary object, with resulting ruptures in the infant's psychic skin. An awful enough circumstance this is indeed, when abjectification of the infant occurs because of simple misfortune and ignorance in the parental dyad. How, then do we expand our minds to encompass the fate of the infant who encounters genuine evil – however we think of this – in another?

Bollas(1995) writes compelling about the structure of predatory evil as a complex perversion, a transformation of early childhood trauma into a source of excitement. *The trauma is represented in transformed disguise, and it is continually enacted in dramatic space with the other as accomplice"* (p. 210). This drama is presented to "show" elements of awful preverbal experience that eludes the realm of words, to somehow transcend the perpetrator's own early "soul death " and live again by passing that death on to some "other."

"The person who has been 'killed' in his childhood is in unwilling identification with his own premature mortality, and by finding a victim whom he puts through the structure of evil, he transcends his own killing, psychically overcoming his own endless deaths by sacrificing to the malignant gods that overlooked his childhood...the shocking harm erupting in the midst of a benign texture of the real (as opposed to our imaginary transformation of reality into something alarming) is deeply disturbing, and it preys upon a certain kind of fear we have that is so great we cannot even experience it as fear: a dread that reality will cease to support us in safety and will do us harm. Some people who were victims of a childhood trauma that occupied their subjectivity – in effect displacing the imaginary with a kind of theater of the real, capable of infinite repetitions but no creative variations – realize that even more shocking than the content of what happened to them is the trauma that the real in the first place actually did something profoundly consequential…something happened which never should have"(p.291-3).

Bollas' *structure of evil* (p. 211) has six phases. Although Bollas writes of serial killers engaged with the structure of evil, we do not have to look to the esoteric or diabolical to find applicable case material from our everyday psychotherapy practices. I am sharing the following example to illustrate how common everyday evil is in our clinical practice.

I see Frank twice a week. When I first met him he was wary and skeptical about how I could help him. He came to me at the urging of his wife, who knew some other men I had worked with. He told me his wife was worried about him because he had never felt anything about his childhood. He wanted to learn how to feel his feelings like other people did. A goodhearted man and doting parent, he stayed a bit distant, especially with his wife, whom he told me he secretly adored. However, he could not talk with her about how important she was to him. As it turned out, he had been raised by two wealthy but emotionally remote invalid parents. His mother had declining health all of his life; in a wheelchair due to multiple sclerosis, she was addicted to morphine. He remembers her room as dark, silent, and scary. His father had more pizzazz but was out on oilrigs much of the time, so Frank was raised primarily by a succession of nannies and housekeepers. When Frank was 12, his father fell to the floor from their shared bed: he was having a stroke in front of him. The family had to move while the father was in a rehab hospital, and when the father eventually came home he was still seriously brain-injured. Frank's mild mannered father transformed from Clark Kent into Godzilla: after the stroke, he was prone to rages and angry outbursts. The metaphor Frank and I developed for his childhood is that Frank was treated much like a pet hamster: he was fed regularly, his cage was cleaned out, and whenever the family moved, he was dragged along in his cage. Otherwise, he was left to entertain himself. As Frank worked on himself he came to grieve deeply about the sadness of his life. Waves of feelings would suddenly come over him and he would tear up with me for one or two minutes, then flash me a cherubic smile and quip: "I so love therapy! I can feel!" On one such occasion he was at home instead of with me; he threw himself on his bedroom floor and just sobbed and raged with his wife about how nobody was ever there for him.

Frank's extreme wariness about therapy, as it turns out, was due in part to two intense soulshock experiences that occurred at age 10 and at age 20, which he had never

processed with anyone. In his chapter "*The Structure of Evil*" Bollas (1995) talks about the process of transferring deadness from one person to another. This process involves seduction, the promise of a false potential space, the development of a stupefying dependence that empties the mind, the creation of a shock experience for the innocent other, the transfer of psychic death. Frank had undergone two such ordeals which resulted in destruction of his capacity for trust and optimism, At age 10, some older boys had lured Frank and a friend into their basement to play "spaceship," with an unfortunate outcome. At age 20, a close friend had taken him out into the country to drop some kind of hallucinogen with him and, purportedly, guide him on his first "trip." I call this second experience "the Psychogenic Menticide."

Frank's Space Ship Adventure

1. *Presentation of good to the other.* Two older boys said they had had cool space ships in their basement and were somehow interested enough in Frank and his buddy to offer them an interesting opportunity. What a compliment
2. *Creation of a false potential space* Spaceships in the basement and two older boys too – it sounded almost too good to be true.
3. *Malignant dependence.* Once Frank and his friend followed the boys to their home, it was a done deal. Frank was asked to sit in this odd chair with straps and wires, which was just part of the space ship apparatus they were told. The other boy was told to watch. Once strapped in, there was no way out.
4. *Shocking betrayal.* The wires hooked up to an old wall phone and the older boys sent 220 watts jolting through him, terrifying him and making him sick. The idea that boys could/would do that to other boys was not a possibility up until it happened, and Frank's world view shattered and cracked. Cruelty and betrayal had entered his world.
5. *Radical infantilization.* Now Frank couldn't have run away if he wanted to. The fear of the fear was more frightening than anything. He was unstrapped and told to watch while they strapped in and shocked the other boy. All he could think of was how glad he was it wasn't him again.
6. *Psychic death.* As the older boys whooped and hollered in glee, Frank experienced "the murder of his being." The self that was in need, that trusted the world, that believed in a good fate, was suddenly killed.

Frank does not remember if he and his friend discussed what had happened. His own mother "absent" on morphine, his father away on an oilrig, he believes he never told anyone about his terrifying experience. He never saw those older boys again. While we discussed Bollas' structure of evil, his eyes got wide and he cried. While telling me about the shock experience he said the hair on his arms raised up as he "felt" the shock again course through his body with me.

Ten years later, a new friend who he had been smoking marijuana with in college, offered to let him try something more fun called "acid."

The Psychedelic Menticide

1. *Presentation of good to the other* A man in his middle 20's, a regular at the frat house, pretended to be a friend to gain Frank's confidence, and supplied him with marijuana, forming a drug buddy relationship and meeting him at parties.
2. *Creation of a false potential space.* The offering of a special experience that would be really fun, different and special: a guided trip on "acid." Like before, Frank felt really special that an older guy would show an interest in him.
3. *Malignant dependency* Once Frank swallowed the pill (the friend did not, so he could "be there for Frank" and agreed to be out in the country alone with his "friend,", he would be totally dependent upon him for the next 12-24 hours for a safe "trip."
4. *Shocking betrayal.* On the drive out to the country the "friend" began to make contradictory orders: drive slower, no I said drive faster, no I said drive slower. At first Frank thought the drug he had taken was blurring his judgment. But then gradually he became aware that his "friend" was intentionally playing with his mind to terrorize him.
5. *Radical infantilization* His companion proceeded to pretend to read his mind, suggested frightening hallucinations to him, laughed at his terror and suggested even more frightening hallucinations that to Frank's horror would actually seem to begin to happen. He told Frank that he had a direct link to Frank's mind and could do anything to and with him he wanted. Somehow the experience ended and back at the fraternity house Frank saw him one more time, confronting him. He just shrugged and laughed and disappeared forever. In therapy we have processed this excruciating experience as a rape experience. It lasted for somewhere between 12 and 16 hours, with violent flashbacks for years afterwards.
6. *Psychic death* Frank lost his faith in heaven after this incident. In an odd trick of the mind, Frank "knew" with certainty that he had been to hell already during the drug experience, and that all life after death had to offer was more of the same. On several occasions while single, he broke down when alone in his apartment and thought he was going mad. He thought he was in hell, and called his mother insisting that she repeat the words " I love you Frank." She did so, and Frank collapsed to the floor, relieved because the flashbacks stopped.

Frank discovered that he had avoided therapy all his life because he had vowed "no one will ever mess with my head again." When we first processed the shock and horror of these two soulshock experiences, and how they understandably made him fearful of therapy, he broke down and wept in relief at things making sense. The shock and confusion had been in his body all these years and had blocked him from really being intimate, from taking the kinds of chances he needs to take in order to be who he really can be. In actuality he takes to therapy like a duck to water now that he understands that it is not about mind control. He has made rapid strides in intimacy with his wife and children, and is establishing friendships. After we untangled his traumatic thinking about hell during the flashback experiences, he rediscovered the possibility of faith and began enjoying church on Sundays with his family.

Soulshock comes in all sizes and shapes. Frankl (1959) once compared suffering to the noxious gas(of the chambers): it fills the room no matter the size, so there's no point in comparing sufferings. From the wife who discovers her spouse has been embezzling her money by getting her to sign it over to him, free and clear; to the son who discovers his father has been cheating on his mother: soulshock rocks the soul, shatters assumptions about who we are and who our loved ones are. Soulshock is part of coming to terms with life, disappointment and mourning in adult life: but what are the consequences of soulshock in infancy and later childhood? Certainly, deep confusion will result about questions such as real/unreal; safe/unsafe; truth/lie; solid ice/thin ice. A psychic house will be built on a foundation of a floor lined with psychotic tile, 2 by 4's with shock holes throughout; meaninglessness blown into the walls as insulation, with a rooftop of suspicion and cynicism.

Tori Amos is a popular musician whose music resonates with the painful dissonant and discordant experiences of attachment shock. In the following cover song from Eminem about soulshock, she makes explicit a toddler's horror, confusion, awareness of "wrongness", confusion, disorientation, and inability to set anything aright as she is dragged along, while her father in a bizarre singsong voice talks to her while disposing of her mother's murdered body in the middle of the night:

Bonnie and Clyde 97'

Baby your da da loves you.
I'm always gonna be here for you,
No matter what happens.
You're all I've got in this world.
I'm never gonna give you up for nothing!
Nobody in this world is ever gonna keep you from me!
I love you.

Come one hey hey we're going to the beach!
Grab a couple of toys,
And let da da strap you in the car seat.
Where's momma?
She's taking a little nap in the trunk.
Oh that smell?
Must have runned over a skunk.

Now I know what you're thinking:
It's kinda late to go swimming.
You know your momma.
She's one of those type of women
That do crazy things.
If she don't get her way,
She'll throw a fit.

Don't play with da da's toy knife, honey.
Let go, hon.

Don't look so upset.
Why you acting bashful?
Don't you want to help da da build a sand castle?

Momma said she want to show you how far she can float.
Don't worry about that little boo boo on her throat,
It's just a little scratch.
It don't hurt.

Her was eating dinner while you were sleeping,
Her spilled ketchup on her shirt.
Momma s messy isn't she?
Let her wash off in the water.
Me and you we can play by ourselves can't we?

Just the two of us

See honey there's a place called heaven and a place called hell.
There's a place called prison and a place called jail.
And da da's probably on his way to all of then except one.

Cuz mommas got a new husband and a stepson.
And you don't want a brother do you?
Maybe when you're old enough to understand enough a little better,
I'll explain it to you.
But for now we'll just say:
Momma was real real bad.
She was being mean to dad and made him real, real mad.
But I still feel sad that I put her in time out.
Sit back in your chair honey quit trying to climb out!
I told you its okay-ay.
Pappa take a night night, goo gooo ga ga da, change the diapy…. Clean the baby up so I could take a night nighty…
Dad will wake her up as soon as we get to the water.
'97 Bonnie and Clyde; '97 Bonnie and Clyde…..
Me and my daughter; me and my daughter……..

Just the two of us; just the two of us; just the two of us

Wake up sleepy head we're here!
Before we play were gonna take momma for a lit'le walk
On the pier.

Honey, don't cry honey.
Don't get the wrong idea.
Momma's too sleepy to hear you screaming in her ear.
That's why you can't get her to wake.
Don't worry,
Daddy made a nice bed for mommy,
At the bottom of the lake!

Here you want to help daddy?
Tie a rope around this rock.
We'll tie it to her footsie,
And we'll roll her off the dock.
Ready now here we go on the count of 3:
One….Two…Threeee!
Wheeee! There goes momma!
Splashing in the water!

No more fighting dad…
No more restraining order…
No more stepdad …
No more brother…

Blow her kisses Popeye.
Tell mommy you love her.
Well go play in the sand ,
Build a castle and junk,
First just help dad empty the stuff out of the trunk. (Tori Amos, 2001)

Clearly the father in this situation hasn't a clue what a lifelong horror and shock template he is setting up for his daughter. He is going through the motions of shielding her from shock, much as the father did in "Life is Beautiful," although his reasoning is entirely and creepily self-centered. The father is creating a horror movie in which his daughter is the only living co-star, and she will be inhabited by horror for the rest of her life.

The psychic envelopes of traumatized children such as this toddler are fated to be torn, ripped, damaged, or obliterated. "…*Traumatized children lack a theory of mind in the sense that they have difficulty in seeing others as having feelings, intentions and desires, any more than they can accurately define their own inner world. Faced with aggressive or sexually intrusive parents, the normal process of secondary intersubjectivity, in which a child shares her experiences of the world with her caregivers via visual cueing, imitation, and so on, is inhibited. Leiman(1995) sees this in terms of inhibition of the normal mediating function of the parent, who under favorable conditions helps to create shared meanings in the transitional or interactive space between the child and her objects. To perpetrate his cruelty, the abuser has to remove from his consciousness the knowledge that the child can experience fear, pain, disgust, and so on. The child grows*

up in a world in which his feelings – and meanings – are discounted or obliterated. " (Holmes, 1996, p. 15-16)

We have looked at cephalic shock, shattershock, limboshock, and soulshock, No matter what dimension of shock experience is involved, shock states are devastating to our past, our present, and our futures. Terr(1990) discovered that traumatized children have an altered sense of time. Their time sense had gone awry after profound physical trauma; in a sense, they had already "died" in their past. These traumatized children "knew" that they were going to die young, say, in their 20's. Like Winnicott's "fear of breakdown (1974), what is anticipated in the future is actually something that has already been survived in the past. Kalshed (1996) speaks movingly of the animating spirit at the center of healthy living, which is compromised in severe trauma. While never annihilated completely because this would mean literal death, he makes room for the possibility that the spirit may be shocked into cold storage and fail to re-root naturally in the embodied person without the tending of a devoted gardener, like a bulb that has been harshly uprooted and then needs to be tenderly re-planted when the ground is ripe, fertile, and no longer quite frozen solid. Solomon(2003) calls this "earned" secure attachment: it takes several years of a consistent, reliable relationship for the hypervigilance of disorganized attachment to fade within the relationship. This hypervigilance contributes to brief paranoid states, meltdowns, and difficulties fully engaging in relationship because of the amount of dread involved. The human capacity for dread is a heavy burden, even though its counterpart anticipation is a delight. Remember, Siegel(1999) called the brain an "anticipation machine", which constantly scans the environment to determine what will come next (Siegel, 1999,p. 30). Let us turn now to examine the role that "potential shock" plays in relationships.

Potential shock: dread

Dread is a complex feeling, as it collapses the space between past, present and future; and between reality and fantasy. If Winnicott is right, and the "fear of breakdown" is a fear about something we have already endured, then the examination of our dreads about the future illuminates our understanding of the self from long ago. Dread is a visceral experience; the body braces, the musculature tenses, and the stomach registers queasiness. I believe dread is the psychological equivalent of the body's memories about and preparation for inescapable shock. As we explore our patients' experiences of their dreads, we may have a temptation to urge them to change their attitude, their expectations, to avert a self-fulfilling prophecy: "Quit being such a pessimist and give things a chance. Focus on the positive, not on your negative predictions about what may happen." However appropriate such a cognitive/behavioral intervention may be for some people who wallow neurotically with doom and gloom, the thoughtful examination of dreads may prove to be a passkey out of kingdoms of unvoiced anguish.

Dread of invasion Consider, for example, the dreads of Susan, an oncology patient who also experienced a back problem for a number of years. Susan dreads check ups with her oncologist, bone scans, physical pain, meeting new doctors, asking for help, medical and dental procedures, and above all, going to the hospital. How does she characterize her

dreads? " *Every time I go in for a yearly checkup, I dread hearing the news that the cancer's back, that it's spread after all. I can't help but remember the shock of that first diagnosis, when there was a distinct 'before' and 'after.' My world as I knew it crumpled in an instant, never to be the same again. When I go in for that bone scan, my body is on high alert, poised to run from catastrophe. Whenever I notice a new pain or tenderness somewhere in my body, I literally shake with fear that it's metastasis*." Her dreads about doctors and physical pain are re-creations of her period of absolute dependency upon an unattuned, unempathic mother, and the shocks of being dropped, rejected and in unbearable circumstances: "*When I'm in pain I begin to feel desperate, like it will never end and I can't get away. I hoard pain medication because it's so awful to risk asking for more: what if the doctor says no? I'm so totally dependent on him to understand what I'm going through; he has the absolute power to grant me relief or withhold it. I am so ashamed when I need to ask someone to help me carry something; I should be able to do things for myself and only finding out the hard way that my physical therapist was right about me not trying to do some things on my own was able to get me past my dread of asking for help. I'm afraid they'll look askance at me, think I'm weird or disgusting*." It comes as no surprise to learn that Susan's mother treated her neediness with contempt and disparagement, even on such occasions as asking for help with her homework, or when she was in the throes of stomach flu. When Susan reports to me about medical procedures she has to endure, such as radiation, chemotherapy, IV's and the like, she evaluates the experience based on how she was treated by the medical professional: "*I am so afraid they will be brusque and just treat me like a piece of meat to be shoved around, sometimes they don't even act like they know I'm a human being with fears and vulnerabilities. It's like I'm having to brace against being handled roughly, and I'm always startled that there isn't more compassion in their manner. Tears leak out of my eyes involuntarily on those occasions, I just hate showing how vulnerable I am to someone who doesn't honor my experience. Sometimes I luck out and get someone who has lots of warmth and empathy, and then I don't have to brace and can relax: then it's like being held instead of being handled."* Indeed, Susan's parents spoke frankly with her about not having held her during her infancy. "Oh, we picked you up for feeding and changing and bathing, but Dr. Spock said not to coddle babies with excessive holding." It became evident that Susan had been handled as a child, not held in such a way that she could relax. "*My mother told me that I came into this world a prude, that it was an ordeal to pry my legs apart to clean and change me. She didn't seem to realize that she was revealing to me how roughly she was handling me; the tension in my little body had nothing to do with prudishness but everything to do with feeling unsafe*." How does Susan understand her dread of hospitals? "*I'm trapped, unable to get away. The only time I ever felt emotionally safe while I was growing up was when I could go out for a walk or a hike. When I'm in a hospital, there's no getting away from the people who have absolute control over me and my needs. The environment is so inhospitable, almost antithetical to healing. All those interruptions, intrusions, lights and noises make it almost impossible to relax or get any sleep. There's nothing familiar to hold onto*." Susan was born seven weeks premature and had been adopted at birth. She was rushed to a neonatal unit and spent her first two months in an incubator, with intubations, frequent heel pricks and all the noises and intrusions of a neonatal unit. Her biological mother never got to hold her. She also was not held by her adoptive parents until the day she

came home from the hospital. Thus, she was separated abruptly at birth from everything familiar to her: her mother's voice, her rhythms, her body. No wonder Susan detests hospitals. Indeed, when Susan was told she needed to have an endoscopy evaluation, she became hysterical, panic-stricken, and begged for me to be present with her during it, even though she knew she would be asleep during the procedure. She couldn't figure out why she was so terrified of the endoscopy, but she spent the week leading up to the procedure in a state of heightened anxiety and dread. Years later during a body therapy session she began to cough in an unusual way and felt frightened for no apparent reason. Her body therapist had previously been an obstetrics nurse and recognized the sounds as the peculiar coughs that intubated preemies make. Her body relaxed instantly upon hearing this information, and she felt she understood her dread of the endoscopy.

Dread of attachment shock Many of our patients with insecure attachment talk openly of dreading cocktail parties and holiday visits with their families. It seems likely that their dread relates at least somewhat to remembered and anticipated attachment shock. Consider the experiences of Beth, a sensitive intuitive who is also a bit of an introvert. She dreads being surrounded by lots of people "and their energetic fields," and "having to make chitchat instead of having real, meaningful conversations." Exploring further, we discover that she spent endless hours in extended family get -togethers with relatives who had no warmth or emotional connection to her: "*All the grown ups wanted to do was criticize, correct or compare all of us kids to each other; there was never a sense of fun at these gatherings. As for all of us cousins, we couldn't find any common ground to relate on. No one wanted to talk about feelings, or ideas, like I did, just about their latest exploits and vacations. It just felt toxic. I couldn't ever find a way to fit in; they all played together all the time and I was the outsider, the only child. I would reach out and reach out only to meet with gruffness or sharp edges of character*." She speaks of those occasions as emotionally bereft, "hard edge" experiences without any softness. Being married to a politician has posed some challenges to her marriage. Beth, an artist, has learned to eschew the "schmoozing" and "gladhanding" that are so integral to her spouse's profession. She explains she is so sensitive to disingenuity, inauthenticity and power plays that her skin literally crawls when she is talking with someone who is trying to "make a good impession on her" due to her husband's prominence. On the other hand, she believes she has good radar for people who are genuinely interested in herself and her family's welfare, and arranges their private social life accordingly. She assiduously avoids the press.

Or consider the following holiday "family" experience of one married couple. Ted is a 55 year old illustrator and computer whiz. He is married to Chris, a pediatrician who felt actively disliked by her mother but beloved by her father. An only child, Ted learned to self soothe by being creative. He has a vivid imagination, earnest vitality, and a robust sense of humor. When Ted is faced with visiting his family he describes a sense of foreboding settling into his body. He falls into deep dreads of emptiness, deadness, harshness, craziness and soul-numbing nihilism: all feelings that he associates with being around his parents while growing up. His mother had been an infantile character who perpetuated an atmosphere of joyless martyrdom and perpetual complaining. Ted's parents never had friends over or did any entertaining. Ted and his father Bill had

experienced a deepening of affection since Ted's mother had died a few years ago. For the first time in memory, Ted's father regularly initiated hugs with Ted and seemed less dour and dismal in demeanor. He had recently gotten remarried to Anne, a woman who radiated creativity, warmth and aliveness who lived in another state. Anne had created a full life for both of them by including Bill in friendships and church activities that had pre-dated their relationship.

Ted and Chris's first Christmas visit to their in-laws had gone badly. Interpersonal disaster had ensued around the issue of refrigerating cooked turkey. Anne and Bill, both early risers by nature, had gotten the turkey in the oven, by 6 am, and it was due to come out around 12:00 pm. Dinner with several guests was not planned until 7 pm. Finding the cooked turkey sitting on the kitchen counter at lunchtime, Chris suggested that the turkey be refrigerated until dinnertime so no one got sick. Bill, Ted's father said no one would get sick, and that the turkey didn't need to be refrigerated, since Chris's concerns about illness were old wives' tales. Ted and Chris went to the internet to find information on salmonella, which Chris presented to Bill. Bill erupted in rage, shaking his fist at her: "You won't tell me what to do in my own house, I don't want to hear another word. The turkey stays on the kitchen counter!" Chris held her ground and eventually the turkey got refrigerated due to her mother-in-law's intervention. When the guests arrived, Bill sat in the far corner and appeared to be sulking and uncommunicative. Tolerant of his eccentricities, the guests humored him until his bad mood passed. At the end of the visit, Ted and Chris found themselves happy to escape back to their own city. Throughout the ensuing year, Anne commiserated with Chris and Ted about her new husband's odd behavior, and talked with Bill about the joys and responsibilities of being a host. Through e-mail, Ted and his Dad corresponded about the visit, and Bill promised to work at doing better. He wrote Chris a letter, apologizing.

Chris had vowed never to visit at Christmas again, as Bill's tirade and glowering had triggered old memories of feeling disliked by her mother. However, as the next Christmas drew near, she and Ted reluctantly agreed to suck it up and go anyway. Both Bill and Anne were elderly, and had had many health crises during the intervening months. Ted expressed apprehension in therapy about visiting his father again. He recalled countless occasions of his father's explosive tantrums and rude behavior during his childhood. It was almost impossible to stand up to him. The last visit had been dreadful; except for conversations with Anne, the hours had just dragged by. Chris and her mother in law got along great, but Ted was always monopolized by his father in dull conversations. Their visit this year promised to be a bit more fun, as Anne's adult children would be visiting as well. In fact, they were totally taking charge of Christmas dinner. Ted and Chris discussed bringing the game "Cranium" with them this year. Anne, an active bridge player, was planning a dinner party for 12 of her friends and neighbors but was worried about whether there would be enough to "do" at the party besides just sitting around and talking. Chris proffered that having a game to structure activity around might enliven everyone's mood and create opportunities for a little laughter. Anne, always up for something new, was delighted at the idea of an interactive game. Ted and Chris brought the game with them as an early gift. In a practice session the night before the party, his father and stepmother became acquainted with the game and said they'd

give it a try, expressing relief that the game is played in teams so that no one is forced to "take a turn." After dinner, while his stepmother and guests were setting up the game and dividing into teams, Ted's father gruffly insisted on doing all of the dishes. His guests entreated him to join them for about ten minutes, and Chris offered to do the dishes. His Dad gruffly threw her and one of the guests out of the kitchen, snarling "stay out of my way," and stubbornly proceeded to finish the chores alone. When Anne confronted him in the kitchen, he could be heard yelling at her to leave him alone. When he finally joined his guests, he played grudgingly and grimly, refusing to laugh along with the general hilarity the game engendered amongst the other players. The next morning, Chris was dismayed to find the game tossed in the garbage, irrevocably ruined. Bill denounced the game to her as "inappropriate," "boring," and "stupid," and insisted that Chris had been self centered and manipulative by bringing it. He told her it was high time she was put in her place. Despite her entreaties he continued being rude and righteous.

Chris told Ted she wanted Ted to cultivate a relationship with his father while he was still alive, but that despite her love for Anne she was contemplating never coming back for anymore visits. Ted understood completely, and they tried to make the best of a difficult situation. When Ted tried to talk with his dad about how he had been rude to Chris, and to both of them by throwing their gift in the trash, Bill refused to engage in meaningful conversation. On Christmas morning, Ted and Chris unveiled their surprise: a digital video recorder for Ted and Anne. Anne was thrilled but to everyone's consternation. Bill said he didn't want it and to send it back. Dinner went smoothly, but during the clean-up Bill insisted on putting all the turkey leftovers in an ice chest with four blue ice bars. Anne's children told Bill to be sure and add ice on top, but Bill muttered something about interfering relatives and left the room. Chris, Ted and Anne's children had a private discussion over whether or not to remind Bill about salmonella, but decided to see what happened instead. The next day at lunchtime, Bill went to the ice chest to get out the turkey leftovers for sandwiches. Of course, the leftovers were not even chilled anymore. As Bill went about making sandwiches, everyone declined to eat them, including Anne. Bill reluctantly threw out the leftovers, and the family went out to lunch.Ted and Chris endured the last few days of their visit by listening to music, reading, and taking walks. Ted had frequent desultory conversations with his father about finance and investments while Anne, her children and Chris played bridge. Once he returned home and to therapy, Ted agonized over his inability to stand up to his father, his disappointment that they couldn't have meaningful conversation about feelings, and his dread about visiting his Dad in the future without the comforting insulation of Chris. Both of them had been immersed in their own private hells of attachment shock during this visit: Chris felt actively disliked and rejected by Bill, and Ted felt that his fears of noxious deadness had come to pass.

The French have a term for Ted's dread: *le néant,* which roughly translated, means nothingness and emptiness, a vacuum or black hole into which all aliveness disappears and evaporates. Unlike Susan, who dreaded being jarred and jolted from the outside, Ted feared being swallowed up by a monster vacuum of toxicity. His mother had experienced a post partum psychotic break after his birth, from which she never truly recovered fully, and his father had recoiled from his wife's vapid neediness and melancholy by immersing

himself in work and chores. Over time, Ted's father's horror and disappointment in his wife's mental status had devolved into an undertone of bitterness from which he never truly recovered during their 48 years of marriage. He titrated his resentment by withdrawal, drinking and a relentless work ethic. With his new wife he seemed able to let go of his bitterness and enjoy himself for one of the first times in many years, but he apparently couldn't tolerate the burdens of being sociable. Anne's children observed that Anne was happier with Bill than they had ever known her to be, and wondered if Bill's antipathy to Chris had to do with Bill's wish to keep Ted all for himself now that he saw him less frequently. Ted had had high hopes that Anne's warmth and vitality would provide an antidote to the oppression of le néant and that Bill had turned over a new leaf. He planned to try one more time to confront his father, but had to postpone these plans indefinitely. Shortly after the Christmas visit Bill developed a spot on his lung, and is being followed closely by a thoracic surgeon.

Dread of intimacy Adult patients have described a variant of frozen body experience, what Hedges (1994,2000) terms "organizing experience": a visceral, "let me out of here" reaction to the presence of too much love. We read earlier about cephalic shock (Lewis, 1981, 1984, 2001) stemming from awkward parenting which marks the musculature with frozen tenseness. As cephalic shock gets structured into the brain, I wonder if that frozen "stunned" feeling doesn't manifest also in our adult patients who are frightened of the mind-to-mind contact involved in tenderness and intimacy. Whereas most of us fear abandonment, abrupt severing of attachment ties and the sense of lack of safety that ensues, a certain group of patients, possibly those who suffered from extreme cephalic shock as infants, seem to have developed hard wiring that runs counter to "mother as protector from predator." Instead, mother "is" predator. Thus aloneness has somehow become hard wired as the ultimate safety, and it is the continuous presence of the "other, the I-Thou relationship" (Buber, 1957) that shocks, summoning up images of mother/predator. Thus the relaxation of "being alone in the presence of the mother" (Winnicott,1958) never can occur, except paradoxically, in the presence of silence and solitude and the Older Self who ministers to the child within. The relentless dread that suffuses the qualitative experience of "being together with another" in deep intimacy, is suffocating; nothing less than survival anxiety is at stake during this panic state. At this level of vigilance, getting away is the highest priority and supplants any memory of the good times in the relationship.

In my experience this transference is more likely enacted with a lover rather than with the therapist because getting away from the therapist is so much easier, and the focus is more on the patients needs. The intensity of the death spiral of the panic state cannot be overstated. I have seen relationships destroyed at all costs no matter how precious and life affirming, because they threaten to upset the applecart of homeostasis (Mitrani, 1996) that has kept the patient reasonably high functioning. In the early days of a romantic relationship Westin, whom we have met earlier, found himself longing for sexual contact with Jill, the woman he was falling in love with. He had been celibate by choice for a number of years prior to meeting her. As they made love and she cried out his name in joy during the moments of orgasm, he found himself afraid he would die on the spot. He rapidly developed a mysterious proctitis that rendered him fortuitously impotent for a

number of months. When he tried to re-institute sexual relations with Jill, the woman he believed he was destined to marry, he found he could not unless he got high. His anxiety was too great. He began to dread even the possibility of a lovemaking session with her. As he became increasingly phobic about physical and emotional intimacy with his partner, he found himself entering paranoid states to break off contact. After a particularly moving couples session in which she professed abiding love for him and longing to touch and be touched by him, he found himself compelled to break off the relationship altogether, without knowing why. For months he was unable to mourn the loss of his love, to whom only weeks earlier he was considering proposing. Indeed, he was unable to even recall the good moments in their relationship; he felt he had narrowly escaped a dangerous situation by escaping the threat of intimacy. "*She was too much for me; I felt that I would die in her presence."* Only a year later was he able to comprehend the depth of his fear of vulnerability; he then began for the first time to mourn the loss of the love of his life.

At core there was a terror that could not be withstood: "*It is too much for my brain, this is in my body not in my mind, this is not a thing of choice but of survival, I am shaking with terror. I know I wanted to marry her three weeks ago, but I cannot. She wants me to surrender my heart to her; to make love to her, not just make sex; to see her and be seen. You say my face grimaces oddly in ways I do not even know when I think about this. I know surrender is not really dying, but it is like dying. It is the most frightening word in the English language. I am terrified, terrified, terrified. I cannot do this thing, it is too much."*

When the person that stands between me and danger –
    is the danger
Her well-intentioned reach towards me
    has clumsy fingers of ice
Her gaily-wrapped surprise
    of terrible loneliness
Tickles me with freedom (Westin, 2003)

Westin has learned to tolerate contemplative eye contact, during which we gaze into each other's eyes with the intent of establishing an intimate connection. Early on it made him weep with both inconsolable longing and an unbearable franticness to escape. He is currently in the process of deep mourning for all the lost goodness he has evacuated because it "hurt too much to keep." He is noticing that he breaks moments of intimacy with me, in group and with his friends: "love burns." However, another part of him is vibrantly alive and dances in relationship with the other like a flower garden blooming in spring. Unlike a conflicted neurotic, Westin develops two different, parallel relationships with love: one based on the deepest of contact; the other, vertically split relationship, is dangerously immature and phobic. He realizes that a young emotional part of him believes that risking the love of another is terribly dangerous. Surrender to the power of merger kills, this part of him believes, and he is ready to fight to the death to preserve the little corner of heaven his younger self calls the bliss of solitude. When he thinks about dating again, he shudders with dread, recognizing that he has grown too much to have

empty, unconnected sexual relations, but as yet lacks the ability to sustain sufficient emotional and sensual intimacy for a real emotional relationship with a woman. He also weeps with the longing to partner, to rejoice with a soulmate. In his art therapy he is learning that he alternately repudiates and treasures the feminine aspects of his heart: his sensuality; his capacity for tenderness and nurture; his ability to meet others at any depth and hold them safe, his boundless container for joy and beauty. An "old soul," he instinctively recognizes the other at the soul or spirit level, although he dares not linger in a soulful plane for fear of getting lost. Our thrice-weekly connection is all he can handle at present, but he is determined to grow past this point of stuckness. He is working actively to build a tolerance for intimacy so that he can partner someday. He now knows he will forever regret destroying the love of Jill, his soulmmate, the woman who said she "would have loved him forever."

The long watch. How do we keep alive our own vitality and sense of connection to loved ones when we walk in the shadows of death and torment? Keeping the home fires burning for a family member who is seriously ill is a unique landscape of anguish all to its own. So many dreads creep into the emotional landscape of doctor's offices, into ICU waiting rooms and into the halls of nursing homes: dread that the loved one won't get better again; dread that they will; dread that the pain will worsen; dread that their loved one will be incoherent again; dread that the doctor's won't provide pain relief; dread that insurance won't pay; dread that the mean spirited nurse will be on duty tonight; dread that the doctor won't return frantic phone calls; dread that the surgeon will bring more bad news; dread of a relapse. Families who have lived through countless "this is it!" phone calls develop an exhausted numbness; adrenaline fails to command their attention the way it used to. Yet the dread of past and future shocks float throughout waking and sleep, implacable and tormenting. Chronic illness in a family member creates it's own private circle of hell, tainting our hopes and dreams of the(a)future, ever-threatening to rupture the ongoing nature of daily life with shocking intrusions into the rhythm of relationship. The following excerpt from Stephen White, psychologist-turned novelist, captures the exquisite dance with dread that a couple endures when they have to wrestle with the ravages of relapse:

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A different kind of dread is unique to the late 30's mother who has miscarried in the twelfth week and finds she is pregnant again. To hope or not to hope, to bond with the life inside or hold one's breath, waiting until some inexorable intuition commands faith and maternal hope. The loss of a child one has carried is shocking, sudden and always unexpected, no matter what the odds. The challenge of re-opening one's heart to the fluttering of new life inside is fraught with remembered peril. Each successful ultrasound brings welcome reassurance but still the body does not forget the silent horror of loss and utter, wrenching bereavement. In mere seconds cherished dreams and the certainty of a shared "our baby" is no more. No deeper attachment shock exists than the keening of a mother-to-be over her lost child. How do she and her spouse find the inner courage to risk trying again? How do they work around the potential shocks of statistical

probabilities without losing their hope, and most importantly, without dulling their vitality with each other? Katie and Scott are a vibrant young couple in their late thirties with a precious two year old they adore. They endured two early-term miscarriages on their journey toward their beloved son Brad, and realized that it was "now or never" if they wanted to try again. Katie became pregnant on their very first try, and with hushed excitement they awaited the passing of their first trimester. By week fourteen, Katie and Scott felt that they could relax vigilance enough to share their joy with trusted friends. Just after the sixteenth week, they were holding hands during an ultrasound when they realized something was terribly wrong: the baby had no heartbeat. After the heartwrenching shock of the D and C(the doctor asked if they wanted to know the sex of their dead baby), Katie plunged into a grief that was seemingly bottomless, while Scott pursued work with a vehemence. They began to focus on remodeling their house, a project which consumed all the space that a shared grief might occupy. Ensconced in a rented apartment, Katie and Scott found themselves preoccupied with the minutia endemic to remodeling; neither one noticed that they had stopped talking with one another. After about four months Katie emerged from her remodeling trance and began to embrace her grief with gusto. She grew bewildered when Scott would try and cheer her up by changing the subject. Was she supposed to be "over it" by now? She lamented that she wasn't taking as much joy in her son as she usually did, and worried that she was depriving him. I reminded her that her own mother had been wrapped in grief while Katie was an infant, due to the untimely death of her own mother. Grief was etched into Katie's cells, taken in with mother's milk. Her own child, by contrast, had tasted nothing but joy until these past few months; he was resilient and sturdy. I reassured Katie that her own mothering would rebound rapidly enough. I encouraged her to honor her grief and to invite Scott to join her despite his misgivings. She began to reach out to Scott and helped him reclaim the feelings he had misplaced. Once again they began to talk, to play, and to rejoice in one another. Finally it was time, and they got pregnant again. Both Katie and Scott held their breath during that first crucial trimester. All proceeded beautifully, and they decided to place their new child in the hands of God, whatever the outcome. The other day they told Brad that Mommy held a new brother in her tummy. Brad, who knew all about sisters from his pre-school class, decided that he would be his new brother's sister. And so we pray.

Infertility treatment poses the same challenges to couples. As one woman pursing fertility treatment put it: "Every time I get my period, it's another death." She and her husband prayed, and prayed some more, and eventually were blessed with a wonderful son. Other couples break under the storms of loss

Shock can serve as a doorway, a portal to soul-searching and depth of experience. Although shock carries the weight of an imperative, in that we are forced to confront circumstances beyond our capacity, we always have a choice about whether, and how, we allow shock to serve us in our growth. We turn now to examine issues of choice, resilience, and grace.