

THE ABJECT SELF: SELF-STATES OF RELENTLESS DESPAIR

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ABSTRACT

Early childhood deprivation, attachment chaos, repeated medical traumata and abuse set up neural networks of dread, shame, worthlessness and hopelessness: the phenomenology of abject experience that resides in implicit memory. Abject interactions with others condense yearning and despair into complex enactments of abject suffering. Working in abject subgroups dilutes the intensity of abject material as ownership of toxic affects is broadened. Affective engagement and a relational perspective facilitate the management and transformation of self-abjection into more optimal relatedness in combined group and individual treatment.

Sarah drags in 30 minutes late for group. She freezes outside the group perimeter, hovering anxiously as if to beseech the group's permission to enter. Arms wrapped around an enormous tote bag, she imagines herself as a hermit crab, toting her security around with her. She has been repeatedly late to group recently. The group knows she is being harassed by her boss and dares not leave the office with work unfinished. Still, her hovering is annoying. She is a seasoned group member and knows the ropes of group protocol. I bite back two competing urges: to snap at her to sit down already, and to smile in welcome. Doing neither, I ignore her, until someone else growls in exasperation: "For God's sake sit down." Sarah flinches and whines piteously that she hadn't wanted to interrupt what was obviously an important conversation. She adds that she wasn't sure whether she should come in or slip away. As she creeps into her seat she whispers "Please don't look at me, I'm trying to be invisible." Someone quips "You couldn't have found a more effective way to bring everything to a halt than to make a big scene." Sinking more deeply into a slump, she murmurs "I was so looking forward to being here, I'm really sorry." Within a few moments, Sarah had recovered her aplomb and launched into the back-and-forth of the group process, seamlessly inserting herself into the fray. Most of the time she presents with a beguiling smile, a rapier wit and wicked repartee, yet her alter-ego resembles a timid, confused young girl who expects to be rejected, speaks in a mumbling whisper and inspires contempt. The group has just witnessed Sarah in a moment of self-abjection, a form of diffuse, unformulated enactment of dissociated traumatic affects that can be baffling.

SELF-STATES: SIDE-BY-SIDE

Sarah had a foot in two worlds. One part of her was able to negotiate conflicts with her siblings, colleagues, clients, and many close friends as well as within therapy settings. A second, less well-functioning side of her would emerge periodically at moments of embarrassment, yearning and acute vulnerability. During these episodes Sarah would present in a self-state which was markedly tremulous, browbeaten and collapsed. Sarah's description of her self-states is "side-by-side" co-existence of two selves. Sarah is a high-functioning dissociative patient who can be triggered into "low-road" functioning (Siegel, 1999). When she loses her typical self-possession she feels young, whispers, and becomes frozen in dread and uncertainty. Dissociative defenses are easily mistaken for resistance and character pathology (Adams, 2006; Hegeman and Wohl, 2000). While many such patients present with a history of abuse, others grew up under conditions of chaotic attachment and emotional neglect; recent findings from developmental psychology underscore the prevalence of subclinical dissociation in these populations (Liotti, 2004; Adams, 2006; Bromberg, 2009)). Despite the existence of an apparently strong therapeutic alliance, aspects of attachment disorganization (Solomon and George, 1999) and dissociative defenses may complicate the course of group and individual treatment. Many therapists are unaware that their groups may contain a fair number of mildly dissociative patients, since even severe dissociative defenses rarely manifest clearly until many years into treatment.

Low-road functioning is initiated by the fear center of the brain, the amygdala. According to Le Doux (2002) "...different components of the self reflect the operation

of different brain systems, which can be, but are not always, in sync...allowing for many aspects of the self to co-exist”(p. 310). Therapists may frame enactments of preverbal primitive states as signs of conflict, character disorder, untreatability, and/or masochism but if we view the enactment through the lens of traumatic attachment theory, therapeutic attention to preverbal trauma, contingent communication, attachment disorganization and dissociation may be more helpful. Early overwhelming experiences are encoded in preverbal form as procedural memory and not in narrative memory (Siegel, 1999) and thus are likely to be enacted before they can be metabolized and explored by the conscious self.

The notion of self-states is gaining purchase in many psychotherapy circles with the confluence of perspectives from traumatic attachment theory, interpersonal neurobiology, affect regulation science and relational and neo-Kleinian psychoanalysis. Self-states are a form of self organization which recur over time, involve a core affect or collection of related affects, a sense of identity, “somatic sensibilities” (Chefetz and Bromberg, 2004), cognitive patterns including a view of how the world works (internal working models), and somatic patterns which affect breathing, muscular bracing, postural rigidity and/or collapse, and muscle tone (Aposhyan, 2004; Keleman, 1985).

ABJECT STATES: NOT JUST SADOMASOCHISM

In her opus on the powers of horror, Kristeva (1982) delineates a realm of preverbal experience permeated by affects of meaninglessness, dread and horror. Her constructs of abject states and self-abjection are complex amalgams of identity, attachment disorganization, affect and enactment. Although Kristeva’s

conceptualizations are no doubt highly relevant to the treatment of borderline spectrum patients, in this article I hope to facilitate the recognition, understanding and management of abject self-states as they manifest in high functioning individuals who bring this complex material into their group psychotherapy settings. Self-abjection in these individuals only superficially resembles the behavior of the masochistic character. Defining hallmarks of masochism such as self-defeating behavior, passivity and martyrdom, inability to empathize or make partial identifications (Holmes, 2009), moral masochism, denial and idealization are largely absent in this population whose overall character structure is more depressive and dissociative than masochistic or narcissistic. Whereas the masochist suffers to gain nurture, the abject self suffers in the certain knowledge that he/she is beyond help. Therapeutic technique with masochists prioritizes tactful confrontation over empathy, but effective therapeutic technique with abject self-states is more like that with depressives: “The predominantly depressive person needs above all else to learn that the therapist will not judge, reject or abandon, . . . and will be particularly available when he or she is suffering” (McWilliams, 1994, p 275-6).

Individuals like Sarah who grew up under conditions of intermittent chaos and intrusion develop attachment strategies that disorganize under stress. The younger a person is when flooded with disintegrative affects, the more likely he/she will fail to integrate attachment strategies (Liotti, 2004) and will manifest dissociative features. The more a young child is unable to forge a meaningful and consistent bond with his or her parents the more desperate, alienated, bereft and *abject* he or she is likely to feel. Sarah is not particularly masochistic, borderline or manipulative. She is aware

of other's needs and is emotionally responsive to them. She is not plagued with abandonment anxieties nor filled with sadistic rage towards herself or others. Rather, like many others in this paper, she regresses to a wordless domain filled with the preverbal certainty of catastrophic annihilation. The patient in an abject state writhes outside the perimeter of safety in affects of horror, isolation and dread that are fully embodied (Chefetz & Bromberg, 2004). At such moments, no safe base exists.

When the abject self is present, the patient simultaneously pleads for connection yet abrogates intimacy; all that is life-enhancing is perceived to be in the Other, for the abject self was overwhelmed or emptied out, by active violations or terrorization early in life (cf: Bollas, 1987). Under stress, the patient's abject self stills in apprehension and falls into silent misery, oscillating between staring with longing at the unattainable object of safety and turning away, gazing off /or down. During these enactments, therapists frequently experience counter-transference feels of aversion, exasperation, helplessness or contempt. These complementary countertransference reactions may represent the patient's projective identification of internalizations of the original rejecting caregivers. The patient's acute vulnerability and dependency may also trigger idiopathic reactions in the therapist based on the therapist's comfort with primitive material. The patient (via the abject self-state) is left holding an unbearable affect for which there is seemingly no resolution. In attachment terms, these affects represent "fright without solution" (Hesse & Main 1999, p. 484), a form of attachment disorganization characteristic of people who experienced misattuned, unpredictable, and frightening or frightened parenting, along with little or no emotional repair of distress. The abject enactment therefore constitutes "psychological performance art,

complete with absorbing sensorial reality” (Chefet, 2008), a performance art that powerfully conveys the patient’s insecure attachment status. Therapists unaccustomed to working with dissociative processes may write off the abject enactment as masochistic character; alternatively, they may hope for the bizarre phenomenon to pass, preferring to work with the more functional selves of the patient. However it may be more useful to explore this phenomenon as a communication of something important, in order to set a context for linkages between the various self-states of the patient, as well as between group members. Group therapists especially are in a unique position to support the thawing and opening of frozen self-states. By proxy, one person’s breakthrough can become a breakthrough for the whole group.

Abject States: A Neural Network

Abject states are not easy to sit with. “The presence of the ‘abject’ causes us to flinch away, recoil and reject; it is the black hole, the abyss, the place in which all meaning collapses” (Adams, 2007). In the grip of abject feelings one feels unworthy, unlovable, and in utter despair about the situation ever changing. Implicit memories of helplessness, dread, horror and rejection are activated neurologically and communicated in posture, voice and words. Abjection is a powerful neural network combining cognitive and behavioral components, sensory images of past experience, recollection of strong aversive emotions and over- arousal (Folensbee, 2008).

Self-abjection is an interpersonal communication, an enactment of impossible need. Whereas projective identification can partially control unbearable affects by placing them into someone else, self-abjection conveys and preserves unbearable affects in complex enactments without achieving relief. Self-abjection represents a

simultaneous enactment of need, rejection, horror, impossibility and worthlessness that is closer to notions about the basic fault, hostile dependency and the black hole, than to pure object hunger.

The underlying world-view of abject self-states is based upon the realization that one's being was formed in the face of the impossible, the unnatural, the unthinkable and the unspeakable. When abjection is embodied within the self as an identity equivalent, "the impossible constitutes its very being" (Kristeva, 1982). Abjection of the self repels the other as ardently, and adamantly, as it simultaneously seeks proximity and connection; the abject individual defines himself by his certainty of unbridgeable space between himself and an unattainable object. During enactments the object of attachment is perceived only as a movement of rejection/dejection through the self, "like the wind through trees... the intangible ghost of a profoundly familiar [rejecting] other who inhabits the self and becomes indistinguishable from it" (Bollas, 1999). Past blurs with present as helpless yearning and embodied recoil from old rejections oscillate in a rhythm of doom. Implicit memories of abject, desperately insecure attachment are unanchored in time and lived out in the body, along with early working models of how life works that predict catastrophic rejection.

When Sarah crept uncertainly into group, she revealed abjection more powerfully than she could have in words. At core, Sarah has always described herself as a lost soul, metaphorically cast down upon a barren tundra, besieged by a blizzard, convinced that all hope of life being different is illusory. She experiences life as a series of one unendurable shock after another, echoes of a chaotic, frightening childhood. She has struggled from childhood with the worry: "What if there is

nothing except the frying pan and the fire?” Part of her longs to sink silently into the snow’s frozen embrace, to give up the futility of struggling for hope and vitality; yet another side of her is a vibrant artist and powerful professional who clings to life with ferocious tenacity and feels in harmony with the world when she is painting, befriending neighborhood children, practicing her profession, and gardening. Like many of my patients, Sarah slips in and out of abject states.

ABJECTION, BOUNDARIES AND THE BODY-SELF

Abjection damages not only the identity-self but also the body-self. Children who grow up under conditions of neglect, abuse, attachment chaos, medical challenges and/or sexual assault not only develop a skewed sense of self, but their very experience with their bodies is compromised from the outset. How can they come to value visceral and kinesthetic aliveness when the body is a permanent repository of raw vulnerability, when the body has survived on toxic nourishment, a veritable garbage dump (Eigen, 1996) for psychic and physical predation? Unspeakable terror involves the dissolution of the very boundaries of the self, the debridement of core self from psychic skin (Anzieu, 1989). “It is as if the skin, a fragile container, no longer guaranteed the integrity of one’s ‘own and clean self’ but, scraped or transparent, invisible or taut, gave way before the dejection of its contents” (Kristeva, 1982, p. 53). Kristeva elaborates how the abject person comes to reject his body: “The abject “presents himself with his own body and ego as the most precious non-objects; they are no longer seen in their own right but forfeited, abject” (*ibid*, p. 5). These patients rarely feel good about their physicality and are not truly embodied; their minds have become the only refuge they can depend upon (Corrigan, 1995).

Intrusive Medical Procedures and Peritraumatic Dissociation

Chronic medical procedures can isolate children from their parents and peer group and tax their nervous system with overwhelming pain and helplessness. Jill was born with a hole in her brain that twisted and compromised her left foot and leg. She had to endure ten brutal surgeries throughout her adolescence on orthopedic units where she was inundated with the constant screams of other panicked youngsters in pain. Almost no parental visitation was allowed, and Jill was often on display in the teaching hospital as a fascinating case of pathology, which she found humiliating. Her parents were stoic intellectuals who encouraged toughness. Her adolescence was difficult; she could not run, play and dance as others did. She felt always that her face was pressed to a glass divider between herself and people who knew nothing of deformity or handicap. When discussions turned to to sexuality and physicality, she put up the same glass wall between herself and the rest of us by cringing and complaining about how we ‘normals’ had gotten the better deal in life. She hated having a body at all; what pleasure had it ever brought her?

One session Jill revealed that she had been having dreams about a self-state called “Yuk” who pronounced that Jill was mousy, wimpy, totally lacking in pizzazz and mostly dead. A series of self-portraits emerged in art therapy, with handwritten notes indicating that Yuk thought Jill disgusting and weak for having been a crybaby in the hospital. The group embraced the Yuk side of Jill and urged her to share strengths with Jill instead of berating Jill for being human; everyone felt different in some ways. As the group and Jill/Yuk worked the abject issue together with compassion, Jill began to realize that she had gifts that others did not. She began to connect through laughter instead of simply through tears and empathizing with others’ suffering. She transformed over a two-year period into a lovely woman full of

warmth and wit. No longer did she whine about how deformed she was. As the Yuk self-state began to integrate, Jill developed the confidence to date, leave group and finally fulfill a cherished dream of adopting a baby from China.

Bollas (1999) argues that turmoil intrinsic to transference suffering *is* the presence of the object, and I agree that self-abjection preserves original abandoning/horrifying objects. Yet he further asserts that suffering patients are resistant to treatment because quiescence leaves behind an intolerable void. My clinical perspective privileges implicit memory and dissociation over resistance, and intersubjective attunement/affect regulation over interpretation. I believe that the quiescence following attunement to the affective distress in abject states can constitute successful affect regulation, strengthening the attachment bond while dissociated unformulated experience (Stern, 2003) is processed. The abject self state needs a treatment situation that is “dense with the feeling of safety” (Badenoch, 2008, p. xvii).

ENCASED IN DEADNESS

Psychic death is the shadow of abjection, haunting many individuals who have wrestled with horror. Psychic deadness presents clinically across a wide spectrum, ranging from characterological listlessness and anomie (Eigen, 1996) to the dissociated dead selves of individuals who have splintered under the pressure of unbearable childhood experience.

In her core, the trauma survivor remains solitary in the moment of her own extinction. No one knew her in the moment when she died without dying: no one knows her now, in her lived memory of annihilation. This place where she cannot be known is one of catastrophic loneliness...it is an area of deadness strangely infused with a yearning for life...Death has possessed her in its impenetrable solitude. But life makes her desire to be known in that solitude...(Grand, 2000, p. 4).

Boulanger (2007) introduces another dimension of the dead self: the collapsed self. Adult-onset trauma survivors, and children like Jill who endured repeated exposures to terror after they

developed a sense of self, experience dissolution of the baseline sense of self, the psychobiological substrate that one normally takes for granted. The universe on which the self depends is obliterated, fractured into ‘before’ and ‘after.’ Whereas catastrophic psychic trauma in early childhood usually results in the dead self being cloaked and sequestered in shards of “Not-Me” dissociated self-states (Chefet & Bromberg, 2004) leaving the rest of the personality relatively free from knowledge of trauma, in adult onset trauma (and traumatized adolescents like Jill) it is the ‘Not-Me’ living self that is dissociated from the parts of the self that are suffused in deadness. The self collapses rather than fractures. Memories of a non-traumatized self become blurry and unreachable. It is never clear that the trauma has been survived until the full impact of psychic annihilation has been witnessed and turned into narrative, by assembling all the bits and pieces of self experience and giving them meaning. It is “...the death that happened but was not experienced” (Winnicott, 1974, p. 106). ~~The following material illustrates how the dead self states of various group members were exhumed from oblivion in a group working with abject experience.~~

Dead Voices in the Group

~~All the dead voices....~~

~~To have lived is not enough for them.~~

~~They have to talk about it.~~

~~To be dead is not enough for them.~~

~~It is not sufficient (Beckett, S., 1954).~~

An earnest, vulnerable and resentful young man named Jacob joined a group. Leigh, a previously stable and committed member, careened into crisis upon his entry. Leigh was startled by the intensity of her panic. Whereas group had previously been her safe space, now group felt ruined and dangerous. She felt she could no longer tolerate staying in the group

because Jacob was about the same age as her young adult daughter, who had terrorized Leigh several years ago with bipolar rages. The mother/daughter rift had largely healed, but Leigh felt as if the group atmosphere was as poisoned by the new group member as her home environment had been by her daughter. She was furious with the group's therapists for their empathic failure in not anticipating this development. Horrified by Leigh's intense reaction to him, the new member offered to leave the group and go elsewhere for his therapy; the group challenged him to explore his own brushes with terror. Leigh offered to quit in his stead. The therapists consistently intercepted projections and interpreted that the group as a whole was ready to deal with fight/flight, paranoia and annihilation anxiety.

The night that Leigh processed her paranoid reaction to the new group member, James (about to become a father) instinctively recognized Leigh's abject terror and paranoia as parts of himself. Shaking, he asked for help in putting what he felt in his body into words. "How deep can we go, and still get back?" he asked. "I think I'm feeling the abyss for all of us. I'm at the bottom." He described feeling terrified, nauseous, and on the verge of throwing up. When I asked him "what was in the throw-up" (Griffin, 2008) he said: "You are, and all the violence of my life and the terror and abandonment and hopes and despair and your damn vacations and the paranoia and love and hatred that we feel in here...the abject stuff too, I want to puke it all out before my daughter comes. I am shaking with the violence of this."

The group deepened over the next few weeks as the maw of the pit that James and Leigh had opened up was metabolized. Although Leigh continued to maintain that she might have to leave because she 'could not work in this group anymore,' her threats to leave felt specious and paradoxical, for she was more present than ever before. She brought in sculptures and paintings she had done of the traumatic years with her daughter, her reactions

to Jacob, terror and paranoia. James also brought in abject art. The group worked with the art as they would a dream. One night Leigh announced it was her last group, and burst into tears of grief. We were all speechless: her departure didn't seem real, or possible. By the next session she was back, announcing that she had returned to group because she realized she was caught up in a profound enactment. Group as she knew it had to die in order for her to be able to live. She was not coming in as the same member who had left; she was a different Leigh, she insisted.

Over the next few months we were able to piece together the fragments of this enactment. Leigh had grown up in a terrifying religious environment of hellfire and damnation. Despite the presence of several traumatized self-states, she had developed into a confident, relatively put together woman with deep bonds to her husband, children and community. She had struggled off and on with major depression. As a teenager Leigh's beloved daughter had spun out of control in a three year rampage of snarling contempt, malevolence and physical violence, all of which occurred when Leigh's husband was not at home. He sided with the daughter and blamed Leigh's depression. Leigh felt that her chemistry had been irrevocably altered during these years, not into depression (she knew depression well), but into a dissociative, numb deadness instigated by her husband's denial and her daughter's violence. In individual sessions and group she was frustrated with my attempts to link her adulthood trauma to her terrible childhood; I was proving to her that I did not truly understand her reality. In the face of her daughter's assaults, and emotionally abandoned by her spouse, she had actually experienced psychic death of the hopeful, loving and confident mother-self: "This disaggregated self experiences a chronic sense of paralysis, numbness, disruption of the sense of time, and a feeling of rupture with the self who existed

before the crisis”(Boulanger, 2007, p. 15). Recalling Boulanger’s book, I suddenly understood that I was dealing with a collapsed adult self, not a dissociated self-state from childhood.

Although she would not yet disclose what we were working on to the group, for several weeks a very different Leigh presented in group: her face took on a waxy, grayish pallor; her demeanor was wooden and unresponsive, and she appeared to be deeply dissociated. She reported amnesia for several group sessions. She was terrified to tell the group about her ‘dead self’ because she was sure they would think her to be crazy. Another group member told Leigh that her face had been looking so waxen and grey that she looked like a corpse. Leigh finally took a deep breath and shared about her dead self-state. She couldn’t breathe since Jacob had first walked into the room, she felt irrationally traumatized by his very presence. Group felt like it had died, and she had died, but at last she was grieving the deaths.

To Leigh’s amazement seven other group members immediately joined her in a dead self subgroup. James had been locked in a closet by his preschool teacher when his stay-at-home mother had returned to work; family lore has it that he became remote and withdrawn after this preschool year. He grew up in the inner city of a violent neighborhood, and was the only surviving member of a close network of high school friends who had died violently one by one. Leigh’s work galvanized him into creating a series of writings and paintings about his dead selves. Randall, a cleric, had lost a huge part of himself when his son nearly died from a serious suicide attempt, leaving a note blaming his dad. Grace Anne, a rape survivor, joined in with memories of life after catastrophe. Isabelle, whose father would collapse into diabetic rages, wondered if she had ever felt anything but dead. Jacob, the new group member who had triggered Leigh, identified two dead self-states: one, a terrified little boy whom his parents never understood or related to emotionally; and another, the sexually abused little boy

whom no one believed, because his abuser was the beloved star quarterback of the high school. Alister had turned to martial arts to restore vitality after his drunken father repeatedly tried to kill him, and had died inside after he sexually abused his own little brother. Lisa, whose childhood was blotted out by a loveless silence, felt that she had been dead since birth.

It should be noted that for many years this particular group had earned from me the weary moniker of being the ultra-boring, 'dead' *nice group*. The membership was selected on the basis of their relative discomfort with intensity, difficulty with self-expression, high level of functioning in their lives, the presence of neurotic conflicts, and a willingness to learn about feelings. The dissociated layers of deadness and abject terror catalyzed a deepening process that enlivened the group process. I have since learned to listen carefully for themes of dead states.

Death by Starvation

Like acute shock, the chronic shock (Adams, 2006) of failed dependency and emotional neglect can create encapsulations of deadness and annihilation anxiety. One woman's dream reported nonchalantly in a different group opened my eyes to the prevalence of dissociative self-states in a composed, avoidant high functioning patient:

A botanical garden had a rare and beautiful species of tree, lush with multicolored flowers and delicious fruit. The tree was slowly dying, however; unbeknownst to the caretakers, the ground beneath the apparently healthy tree was frozen. The roots beneath the tree were rotting, starving, and desperate for nurturing attention (ibid, pp 128-9).

This dream heralded a shift in my work with this particular group. Not only did this patient have a starving, dying baby self that had been almost entirely dissociated, but so did many of the other high functioning patients in this group. However, at the

time I completely missed the reference to the dead self in this dream; it took the ‘nice group’ to teach me to listen for deadness. Recurrent dreams and dream series sometimes bear useful clues to underlying states of emotional starvation and abject self-states, as the story of Mariah will illustrate.

Despite her liveliness and vitality under other circumstances, Mariah had wept wordlessly and silently in the group since her entry. Mariah had always felt desperate and alone. A history of early childhood deprivation and terror was activated most recently by the death of her cat just before she entered group. Her bonding figure had been a purring cat, as her mother had had intermittent psychotic states and was emotionally rejecting and chaotic. As Mariah listened to the ‘dead self’ subgroup, she finally began to understand about the dead part of herself; her face began to animate for the first time. She suddenly remembered a piece of history that she hadn’t thought about in years: she had stopped speaking for a year as a toddler; when her mother went away to a psychiatric facility. Mariah was left in the care of abusive grandparents for several years. Her vitality had withered on the vine, until the family cat began to share her crib with her. Of course she was now decimated since the death of her 20 year old cat; her psychic skin (Anzieu, 1989) had vanished along with him. Although her dead self did not vanish with this realization, she was able to make room for this part of herself without *becoming her*, or enacting her, any longer, and had compassion for the shocked silence of the toddler-within. This is a recurring dream series from Mariah that illustrates the prominence of her dead self-states:

In an early version of the dream I keep turtles in a terrarium. No matter how hard I try, the turtles turn black and I find them dead. I feed them the wrong food or too much raw meat and the water turns poisonous and murky

and they shrivel up and die. In another version of the dream, I reach into the china cabinet only to find a shriveled up dying baby on the plate. It is suffering so much, I can hardly stand to touch it or even look at it. I pick it up in horror and it looks at me, chastising me with its eyes, turns black and dies.... I am in an aquarium filled with giant sea urchins heedless of my existence. I am a little fish and try desperately to stay out of the sea urchins' way. No matter where I turn, there are more giant sea urchins bobbing about. There is no safe place.

SELF-ABJECTION: A BARRIER EXPERIENCE

Abject affects are so difficult to tolerate that they are often encased in encapsulations such as roles that interfere with intimacy. Roles are autistic islands of body/mind that partially insulate us from unbearable affects while communicating these affects to others. Self-abjection is a 'barrier experience' (Agazarian, 1997) that creates an impermeable boundary between self and other, as well as between the true self and the adapted self. "It is the role relationship with oneself inside the barrier experience that is the major source of human suffering" (p. 294). Inside a barrier experience one is pretty much trapped until one learns to question the tyranny of the role-induced beliefs. Suffering feels like *the* reality, *the* fate that others are too dense to understand, but actually when functioning from inside a barrier experience, one is cut off from any sense of destiny, from self-discovery and from becoming known by others. The spontaneous, true self is encapsulated away from the conscious self. Shame, outsider, cynicism, paranoia and omnipotence are common roles that defend against the helplessness, shattering and terror triggered by emotional vulnerability.

Relentless Despair: Barrier to Relatedness

Abjection is an unbearable preverbal state in which only need exists along with an active sense of being "jettisoned, repelled, and repellant" (Kristeva, 1982, p.1). Condensing

yearning and rejection, abjection is embodied in cringing postures and enactments of *ambivalence* : beseeching and disintegrating; desperation and recoil; raging against and pleading for understanding; worthlessness and demand. To feel abject is to plunge relentlessly into the horror of the black hole, of meaninglessness, of non-existence: “an awesome force of powerlessness, of defect, of nothingness, of ‘zero-ness’ expressed, not just as a static emptiness but as an implosive, centripetal pull into the void”(Grotstein, 1990, p. 257). The black hole of abjection embodies ‘relentless despair’ about the possibility of being helped or soothed. Since abject experience tends to be a closed loop, reiterative and autonomous from actual positive experiences (cf. Green, 1999), the challenge becomes timing and creation of a pathway inside. Therapists must weave their way through the maze of alienation and despair

Alienation and Estrangement

Psychotherapy narratives featuring themes of suffering-horror communicate powerfully the nature of traumatized existence. The perpetuation of abject states may stem in part from the inevitable gulf that spans the difference between the traumatized and the normal. Children who grow up under conditions of neglect, abuse or bereavement have an uncanny sense of how they are different from peers who have loving families.

[T]he essence of psychological trauma...[is] a catastrophic loss of innocence that permanently alters one’s sense of being-in-the-world. [Trauma] exposes the inescapable contingency of existence on a universe that is random and unpredictable and in which no safety or continuity of being can be assured. Trauma thereby exposes the “unbearable embeddedness of being.”... It is in this sense that the worlds of traumatized persons are fundamentally incommensurable with those of others, the deep chasm in which an anguished sense of estrangement and solitude takes form (Stolorow, 1999, p. 467).

The misery intrinsic to roles of abjection relates to feeling different and untouchable. Group therapy can be a powerful mediator of the chasm of separateness between the abject self and the normal self, but the therapist must facilitate the linkage between self-states. Group treatment protocols abound for survivors of disasters (Spitz, Danieli, Schein, & Burlingame, 2006), who can turn to each other for help in developing a sense of meaning. However the private catastrophe of childhood deprivation, abuse or attachment chaos is largely suffered in despairing isolation. Early in life, the personal meaning of abject experience is established in implicit (procedural) memory as essential truth, an internal working model of how things are (Badenoch, 2008): “I am utterly, wretchedly alone. This is the way things are, were meant to be, and will be forever more.”

Fate Versus Destiny

Abject individuals feel ‘fated’ to be denied the joys of being human that others take for granted; hence when positive moments do occur, they may flinch away instead of embracing them. Fatedness (Bollas, 1991) comprises projections of past experience into the future, manifestations of relentless despair and fear of breakdown (Winnicott, 1974). The fatedness of abject individuals keeps them from using the connections they have with others to build a self and a life. Destiny (Bollas, 1991), on the other hand, entails developing a vision of whom one might ultimately become, along with pursuing an active strategy for moving towards this end. Self-abjection entails an enactment of fatedness and doom, an interpersonal role of relentless despair. Hopper (2003) believes that such roles serve to provide the traumatized self with an identity within a field of chaos and turmoil. While no doubt each persistent maladaptation serves some survival function, I believe that self-abjection is first and foremost a complex preverbal communication of ‘the unthought known’: a mood or

physiology in implicit memory that we know intimately but cannot think about, or have not yet thought about (Bollas, 1987).

Isabelle struggled to recognize or share thoughts and feelings spontaneously; she experienced a formidable blankness that amputated any sense of internal experience.

~~Alexithymia is a condition linked to developmental trauma that manifests in difficulty identifying and describing subjective feelings in words, along with a sparse fantasy life and a literal cognitive style focusing on external input.~~ Her mother had a traumatic childhood and was depressed much of Isabelle's life. Isabelle's father was subject to diabetic rages when his blood sugar would drop. Isabelle would hide under the table as he screamed. Before entering group she had extensive neurological workups to rule out petit mal seizures or other brain abnormalities because she had difficulty forming emotional memories. She couldn't recount or even remember most of her life experiences. She felt utterly inept at life and would tearfully break into frozen panic whenever she tried to talk in group. She was convinced that her future will deliver only more of the same and that she would continue to fall further and further behind her peers in creating any vision for herself. She couldn't imagine what she might like to do over a weekend, much less what career path to pursue. She felt like hamster on a wheel, trying madly to get somewhere but ending up at the beginning.

Isabelle likened her panicky self-consciousness to that of a speaker hearing his own voice reverberate on a microphone; as she listened to herself speak her ideas began to dissolve and her words to lose significance, becoming random sounds devoid of meaning. Ogden (1989) describes anxiety states bordering on panic when the symbolic and binding power of language becomes dismantled, a state which leads to a sense of disconnection from other people who know how to share with each other in a meaningful system of words. Isabelle

was convinced she was boring and a total drag to listen to, and had no idea how to respond to other's affects except to offer hollow advice. She didn't feel she deserved to be loved or even liked since her insides were so empty of vitality. Traditional analytic therapy made her feel completely hopeless; she couldn't even do therapy 'right.' For the first few years, she experienced group as a great divide between normal people and herself. In our individual sessions I was unusually active and self-disclosing. We laughed a lot, and she began to look forward to her sessions instead of dreading them. Early 'homework' was to find three opportunities to say anything at all in each group. Slowly she began to experience moments of spontaneity that did not dissolve into meaninglessness, and to make connections between past and present. Her group validated Isabelle whenever she spoke from bodily experience instead of robotically from her mind. Instead of flinching away from bodily cues, she began to get excited when she noticed she might be feeling something.

Over the years I have observed the power of even a spark of the destiny drive to light up the darkness of abjection. Usually the trigger is some unexpected exposure to positive affect, a dimension of neural circuitry that is sadly underdeveloped in this population. Positive experiences have incredible power to awaken latent internal strengths. Sometimes the spark is kindled by a spontaneous musing on the possibility of innate potential that was smothered by indifferent or absent parenting: "I wonder what I would have been like had I been raised by different parents?" One woman with a history of severe abuse had her life turned upside down as she happened to gaze in the newborn nursery at a hospital while visiting a friend and was filled with awe. She realized that once, long ago, she had been innocent and full of potential like those babies. I have seen the acquisition of a kitten or puppy melt the heart of grim old codgers who were waiting to die. The matrix of group therapy provides multiple opportunities

for threads of destiny to interweave with fatedness to alter the tapestry of life experiences and choices.

Incoherence of Narrative

Incoherence of narrative, the holes in the story of one's life is one indicator of disorganized attachment and dissociative states. The narratives of individuals who struggle with abjection and relentless despair are replete with the tangles and confusion of unrelieved traumatization and chronic shock (Adams, 2006). These holes in narrative discourse and consensual meaning-making can waylay the therapy, creating a spiral of confused negativity (as occurred in the following example). After group one night Sarah waylaid me in my waiting room to bring up the issue of her bill again. It had been a long day and I just wanted to get home and relax. She had bugged my office staff repeatedly about wanting them to write out in long-hand the diagnostic and CPT codes on her bills. I didn't understand the purpose of doing this, and showed her that the codes were printed on the super bills, as were the diagnoses. She started to cry and said she would write them herself, but it was illegal to do so. I rationally replied "Ok bring them in, we'll do it for you" in the 'patient' tone I usually reserve for young children and the very impaired. As I struggled to understand what was going on, I told her I could tell she was frustrated with me and I just wanted to fix everything the way she wanted; what was I not understanding? She cried harder, saying that it had been like this all her life: she couldn't make people understand what she needed and had been stupid for even trying. Finally a light bulb went off for me: group statements were printed not on superbills, like other therapy sessions, but on my accounting system, which for some reason doesn't include CPT codes or diagnoses. Nobody else I saw in combined treatment bothered with sending the group accounting statements for insurance reimbursement. I asked

her if I had understood her correctly yet, and she tiredly nodded at me saying that she had been trying for a month to get this done so that she could pay me what she owed me, and hurried out of my office. We were later to discover that her elementary school experience had been a nightmare of misattuned communications like this.

Abject enactments are a way to ‘show’ rather than ‘tell’ about experiences with rejection, neglect and profound deprivation. Indeed, the ‘telling’ about abject experience is often incomprehensible because of cognitive interference, flashbacks and over-reliance on metaphor. Metaphor allows complex threads of nonverbal experience to be woven together and offers a road map to inner experience that is inscribed in a personal language. Yet if it is mixed in with chaotic narrative discourse deriving from a lifetime of trauma and disorganized attachment, metaphor can be difficult to follow (cf: van der Kolk, 1987).

Sarah would often break down in frustration when other group members indicate that they were struggling to understand her. Listening to her sharing in group was a bit like winding one’s way through a complicated maze; eventually one was bound to reach the exit, but it was difficult to sort blind alley from direct path. She would start in one place and end up in another, her words either captivating or confusing the listener, depending on their tolerance for right brain communications. Her words were eloquent with visual images and metaphors, always shared with earnest vulnerability and purpose, often laden with dialogue and scenes from classical books and movies. “I think in pictures...I can’t connect them until I tell you all the pictures.” When group members expressed their confusion about what exactly she was trying to talk about, Sarah would flinch and pull away, collapsed into an alienated humiliation that is all too familiar to her from her school days. “If emotional charges cause the return and re-enactment of scenes, the [traumatized] child is pulled toward predominantly visual and less

developed and interactive structures of thought. . . . Time sequencing is difficult because of the concentration on the here-and-now” (*ibid*, p. 99). Eventually Sarah learned to ‘get to the point’ or to at least ‘translate’ the metaphors for us.

THE ABJECT SELF IN LIFE METAPHORS

Although metaphor can sometimes be as difficult to follow as poetry, it can also capture and convey the essence of a dilemma in a way that straight discourse might evade. “I long for a time when clinicians routinely consider the potential for the existence of unspoken words, images, sensations, and more, that are the unwanted property of people rendered speechless by inescapable painful experience” (Chefet, 2008, p. 38). Life metaphors, which condense the thematic narratives of a life into poetic symbolism or concretize visceral implicit memory, poignantly articulate nonverbal experience. Life metaphors abound in personal narratives, but could easily be overlooked if the therapist is not alert. Metaphors describing abject experience typically involve a level of preverbal fear, alienation and/or deprivation for which there is no coherent language available (Chefet, 2008). Some life metaphors are quite straightforward: Marilyn talked of loving to read books and watch movies about survival after shipwrecks or other catastrophe, like Robinson Crusoe. Other life metaphors are difficult to decipher at first. Because of the gaps and tangles extant in incoherent narrative, metaphorically rich language can appear psychotic or grossly disorganized when it actually may signify abrupt changes in self-states and/or the underlying presence of dissociative processes (*ibid*).

Mariah experienced frantic anxiety states that tended to alienate her peers. She used to make up stories about herself in an attempt to coerce empathy from others, such as describing a time she nearly died in a house fire. In group she came to understand her compulsive lying

as abject enactments, attempts to bridge the gap between herself and others, to convey her life long suffering and horror. Even if the stories were not factually accurate, the underlying affects of desperation, terror and horror conveyed in these metaphoric stories aptly captured the nature of Mariah's emotional existence. Her life metaphors reveal traumatic attachment:

“I am blindfolded, stumbling through a cactus forest. I am stabbed by needles no matter where I turn. I am in the ocean, choking on water and pummeled by waves, terrified I am going to drown. I can't catch my breath. Then, I find myself collapsed on a beach. I cling to the warmth and solidity of the beach, digging my fingers into the sand to reassure myself I can stay put. But then the waves come and drag me out into the water again... Birds are flapping around and screams are trapped in my head... I was making chicken soup and was overcome by horror when the backbone of the chicken disintegrated in my hands; what was holding me together, would I disintegrate like that?... When my husband and I fight everything just keeps getting worse, we're in a particle accelerator chamber going faster and faster until we are smashed like atoms and then I hear glass break inside my head and we shatter into shards.

THE POWER OF WE

What keeps people mired in abjection is the utter isolation endemic to lifelong fragmentation and annihilation anxiety. Many individuals with backgrounds of deprivation, failed dependency and attachment chaos often have little sense of being part of a 'we' for at least the first twelve or thirteen years of life. These youngsters struggle to metabolize overwhelming experience for themselves in isolation, intuiting the futility of trying to raise themselves. They are forced to develop a brittle, precocious appearance of self-reliance because of premature awareness of their separateness and excessive vulnerability. Their misery is 'their' problem to solve. Even sibs in such families have such an experience of drowning in the muck, they climb upon each other's backs simply to survive. In adolescence

youngsters may turn to a peer group or romantic relationship to stabilize themselves, but invariably these relationships spiral into failure as abjection, scapegoating, disorganized attachment, and desperation intercede. If they can successfully rely on their intellect to get by, they at least can thrive in academic and work settings; they become high-functioning dissociative individuals who look like they have life figured out because they make a good income (Adams, 2006). Relationally, these individuals may be a disaster. Raising their own children to have secure attachment is a major challenge. By the time they arrive in our offices, they have endured many cycles of hope and collapse; they are worn out, and they wear us out.

The most powerful interventions a therapist can offer are intersubjective compassion and contingent communication. The transformation of ‘you have a problem’ into ‘we have a problem to figure out together’ is a profound difference in perspective that promotes attachment, affect regulation and neural integration. Overwhelming pain in early childhood becomes encapsulated within an individual’s implicit body memories (procedural memory) and cannot be worked through without affective resonance from a therapist who can tolerate immersion in primitive experience. When we are called upon to witness unbearable experience we sometimes put up a wall to protect ourselves a bit from the rawness of horror by using experience-distant language, describing from an outside perspective (Kohut, 1971, 1978), instead of using experience-near, intersubjective language (resonating from the world-view of the patient). The consequence is that our most vulnerable patients may feel more abject and alone. With patients who experienced little attunement or interactive repair in childhood, it is vital for the patient to discover that “someone is available who is capable and desirous of knowing what it feels like to be him or her” (Stern, 1985, p. 266). With chronically traumatized individuals, the core curative factor in therapy is the gradual

facilitation of earned secure attachment provided by a sense of safety, a holding environment and being 'seen' and 'met' (Schoore, 2003; Siegel, 1999).

Nonverbal Attunement

Soothing an abject patient is not unlike soothing a distressed infant: "the baby in the patient" (Mitrani, 2001) needs our nonverbal acknowledgement of, and attunement with, his distress. Words alone will simply not be effective. We are destined to fail repeatedly in our attempts to relieve our patients' distress, until we accept it as 'really real', and feel it from the inside out. It is helpful to approach abjection nonverbally at first, with especial attention paid to distancing maneuvers on the part of the therapist. On a good day I attempt to monitor my tone of voice, posture, gestures and facial expressions, trying not to back away despite my patients' earnest efforts to create a circle of hell meant uniquely for them alone. Engaging eye contact with a person in an abject state is crucial, as it breaks up the isolation intrinsic to the enactment. Shame literally begins to dissolve if the individual encased in shame looks slowly around the room and permits emotional connection with other group members. I talk about self-abjection and abject affects with my groups, describing how it feels and looks until invariably several group members join the discussion with personal examples. Therapeutic soothing of abject states is not by nature pre-emptive nor enabling, but contingent communication.

Really Getting It

It has not been my experience that interpretation is particularly helpful to many group patients in abject states. "As a primary factor in psychic change, interpretation is limited in effectiveness to pathologies arising from the verbal phase related to explicit memories, with no effect in the pre-verbal phase where implicit memories are to be found" (Andrade, 2005, p.

677). A mistimed verbal interpretation (left brain intervention) risks creating attachment distress (Schoore, 2007) and/or disintegration (Knox, 2008), whereas attuned emotional engagement (right brain intervention) promotes self-reflection and integration. Interpretation during turbulent and painful enactments of abjection is often an attempt by the therapist to dissociate away from affect, ground himself and resist the pull towards the primitive (cf. Bromberg, 2006).

Patients in abject states don't simply *want* to be understood, they *need* to be met and understood. While frustration of wishes may promote growth, frustration of real needs results in structural disintegration of the self (Akhtar, 1999). In abject enactments, patient and therapist are stirred up at the same psychic level: both are invited to endure the terror of annihilation. When our work begins to slide into the abyss despite our best efforts, we may fail patients in three primary ways (Van Sweden, 1995): dropping them, withdrawing from them, or trying to get them to stop suffering. "If a group therapist does not develop oneself with regard to his or her personality, the members of that group will only in a very limited way be able to broaden their identity"(Richarz, 2008, p. 158).

When we offer our reality of a problem, treating 'messes as mere potholes' (Bromberg, 2006) that the therapy must bump across (as I did with Sarah and our billing 'mess'), we ignore the abyss that the patient is falling into. Sarah's screams at me masked the desperation and shame that were being dissociated by both of us in the interaction. Understanding that the mess is an abyss and not simply a pothole requires us allowing the patient's abjection to enter into our psychic reality, to become "*really real*"(Bromberg, 2006) instead of just 'real for the patient.' Trying to talk 'about' or stop what is happening only makes the nightmare worse.

Being able to take on a trial identification with the abject patient is an essential step in being able to lead him out of the labyrinth: “There is an obligation to know intimately your own unique resonating pain in the quest to make the other’s pain coherent, livable... This is a relational matrix woven from threads of intense pain...”(Chefet, 2008, pp. 18-19). Yet, the temptation to withdraw, to jettison, to reject the abject patient is strong, as Richarz (2008) notes in his exploration of enactments in group: “I did not want to meet myself in her suffering” (p. 146).

Interruptions in the Rhythm of Safety

Interruptions in the rhythm of safety between patient and therapist sometimes cross the threshold between surprise and shock, the harbinger of mutual traumatization (Bromberg, 2006). In these situations Winnicott’s fear of breakdown (1974) is operative: we dread a terrifying future that has already occurred to us many years before. Implicit memory has no time stamp: the sense is of something happening *now*, with no awareness that the past has been triggered (Badenoch, 2008). The feel of a looming treatment crisis echoes that of any attachment ruptures from early childhood. The cycle of rupture, repair and the inevitable attachment distress that accompanies a treatment crisis bring powerful signals to the therapist’s soma that are helpful to listen to and acknowledge. For example, I knew my interaction with Sarah over the bills had made me feel a bit crazy. I realized something was wrong with what I was doing, but I couldn’t figure out what was happening. In our next group I asked Sarah what was going on inside her on that night we had the struggle about bills. She said she felt like she was drowning, going under for the third time, right in front of me, and that I didn’t even notice or care. It reminded her of being sent home from first grade with a demand from a teacher about needing a check for school pictures: “Just tell your mother she

needs to write a check first, before I can send them home with you” and then encountering the crazy making of her mother saying “You tell that teacher I’m not paying for pictures until I see them.” Back and forth between them she trudged, a ping-pong ball of chaotic confusion. As she cried about how hard it had been to make me understand what she needed, I was able to acknowledge how deeply my not understanding had traumatized her. No longer was I treating her abyss as a little pothole. The group responded by offering up other ways in which I had failed to understand them. Affective repair was underway.

Subgroups: The We in the Group.

Group therapy offers significant hope for individuals struggling with abject affects if they can work the feelings alongside several others who are doing the same thing. Empathic attunement from a therapist is necessary but not sufficient, because the abject patient may misconstrue empathy as pity. When peers join in the maelstrom with their own version of abjection, then the darkness of the abyss automatically lights up with solace. One patient likens this to being linked by a belay rope to another mountain climber who can stop the plummet should one person lose his balance. Working within a subgroup (Agazarian, 1997) allows for a deepening of the level of intimacy around an issue without one group member becoming the identified patient doing work for the entire group. It also allows room for group members who feel differently and are not trapped in a defensive role (perhaps they are feeling hopeful, or in a good mood, for example) to form their own subgroup, rather than being hijacked by suffering. Working an issue alongside others doing the same provides a sense of perspective. Subgrouping allows the barrier experience to be dismantled by the undeniable fact of joint ownership of a troubling affect state. As the perceptual field is broadened, fear is slowly supplanted by curiosity and study of the phenomena in others. When other group

members also acknowledge cynicism, despair, shame, deadness or paranoia, the unbearable aloneness of underlying abjection is abated.

As group members recognize themselves in the abject communications of others, they can by turn balance, confront and support each other. Randall and Leigh were adamant about reminding each other of their considerable strengths, especially when one or the other of them collapsed into a misery of self-recrimination over parenting difficulties. Sarah and Paul often supported each other during abject meltdowns. Sarah started off the group in tears of wonder one evening, reporting that Paul had murmured to her in the parking lot after group the week before: “Let’s agree to approach next week with courage, ok?” These simple words had changed her life. Not only had no one ever offered her the perspective of “*let’s*” before, but no one had ever suggested that she live in courage. “My friends urge me to be more self confident, but I can’t find a way to live in a world of confidence. The word means nothing to me. Living in courage, though: *courage* is something I can and will do.” As several other group members resonated to the concepts of “let’s” and “living in courage,” *the power of we* gained momentum.

TRACKING HOPE: HALLMARKS OF CHANGE

“One reason that therapeutic growth takes as long as it does is that the mind’s self-state organization is linked to the brain’s organization of neural networks” (Bromberg 2009, p. 352). As long as the *same* groups of neurons continue to fire and wire together in unchanged fashion, (as in abject states), it is difficult for other groups of neurons to wire into the neural network to allow new self experiences to integrate into the self-as-a-whole (cf. Bromberg, 2009). Because so many interactions in group involve safe surprise and novelty, (like Paul’s comment to Sarah), group therapy offers many opportunities for inspiration, self-

observation and skills acquisition. New skills such as self-soothing can support the destiny drive and facilitate identification with one's own growth potential.

Somatic Markers and Self-Soothing

Patients struggling with unbearable affects have learned to dissociate from their bodily experience; they have not experienced sufficient soothing to be able to calm themselves down when feelings surge. "In the dissociative mind, what is remembered...is a somatically lived experience of ripped flesh and disemboweled self-esteem ready for instant replay" (Cheftetz, 2008, p. 24). An important part of their therapy work is learning how to self-soothe. In combination with explorations and group discussions about the nature of self-soothing, the notions of fear of breakdown and implicit memory have been transformative. Self-attack, a response to early shame about dependency, is ritualized in abject states. When I introduce the notion of self-compassion to my groups, it meets with derision and incredulity. Yet the interception of self-attack is an important early step in the transformation of abject states into mourning. As somatic experience is the birthplace of affective awareness, affects frequently present first as physiological states. Learning to notice and ask about physiological states helps the therapist and group work with abject affects. Somatic markers are bodily feelings that normally accompany our representations of the safety or danger of a social situation. In other words, feelings *mark* response options to our felt sense of what is happening around us (Damasio, 1999). Most importantly, patients need to learn to *mark* positive as well as negative experiences as significant. Most self-soothing takes place in the context of remembered positive experiences that have been marked and noticed as calmative: laughter with a friend, appointment television, the rhythm of a walk, the purr of a cat, the soft fur of a beloved dog,

immersion in a movie, the burble of a brook or aquarium, the comical play of pets, the hum of a sewing machine, music, the smells and textures of a bookstore and its denizens, etc.

Asking group members about bodily experience teaches the group to track somatic cues about what they may be experiencing. By becoming more self-aware, hypervigilance and enactments can be replaced by self-reflection and curiosity. A paranoid patient may observe that things feel like they are going too fast again, or that she feels surrounded by enemies, and remind herself not to freak out; her terror is from the past. A panicky patient may share that he has an urge to leave, but delay the impulse while telling himself that exploration will help. A patient frozen in an abject state may notice that she covered her mouth and turned away just as she asked for connection. A patient in the midst of a shame attack may stop the attack mid-thought and ask for help instead. As the observing self learns to notice when self-abjection has just occurred, abjection begins to shift away from an ego-syntonic mechanism of communication, a way-of-being-in-the-world that feels entirely normal and familiar. Instead, patients begin to notice something “off” in the way they feel or think, and link their thoughts and somatic feelings with a familiar role. A shame-ridden patient may observe that her tears are forming a wall to keep others out again. An ‘outsider’ patient may ask for help in bringing herself into the group instead of stoically enduring alienation and blankness. Suffering can then be shared and explored, ‘talked about,’ instead of being endured and enacted.

I find it particularly useful to comment on subtle shifts the patient is making that might be outside his or her awareness. The work is so painstaking and difficult, every little step forward is a victory; I think in terms of years, not months, for changes to be integrated. Patients will protest that they still feel the same misery and therefore couldn’t have changed at all. No matter where we go, there we are; we can’t outrun our shadows. Light at the end of the

tunnel is imperceptible to us because it's a long, twisty tunnel; it is normal to despair at its length and darkness. Psychic growth occurs at a snail's pace. We need to envision our patients' future selves until they can actualize bits of their true destiny. In our feedback, we spotlight hope and perseverance; the patient is part of a 'we' that is paying attention. James used to chafe in silent annoyance with Isabelle, telling his individual therapist that Isabelle reminded him of a blank canvas with holes torn throughout. He refused to talk with Isabelle about these feelings in group because he sensed they would devastate her. As Isabelle became more alive, James finally was able to tell her about the canvas metaphor. As he noticed swaths of vibrant color replacing the empty holes, he observed multiple layers of depth developing within her, and was moved by what he saw. This feedback was the spark that catalyzed Isabelle's renewed commitment to growth. She might suspect my feedback of being motivated by positive bias, but she intuited that James was nothing if not bluntly honest. If he saw her changing for the positive, then it was the truth.

A watershed of critical mass in the growth process occurs when the patient notices himself saying or doing something constructive that he never would have said or done at one time. Raine, an entrenched skeptic about therapy, caught herself saying to a friend: "Just breathe through the pain, it will pass and you will be the better for it." Leigh noticed herself enjoying Jacob instead of fearing him. Isabelle laughs more, and has begun to open to her sexuality. Although the music of suffering may seem the same, the lyrics are actually different. We, and they, have actually arrived at a different place in the spiral that is growth. "So we sit, no longer only healer and healing, but two souls on one journey, each facing the Void, each alone and together" (Steele, 1991, p. 14).

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 (Hafiz)

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