TERROR IN PSYCHOTHERAPY

Lawrence Hedges PhD, PsyD, ABPP

Terror in Psychotherapy

The New Zealand Lectures

Lawrence E. Hedges

Clinical Contributors:
Catherine Morrill, Gayle Trenberth,
Sean Stewart, and Jolyn Davidson

e-Book 2020 International Psychotherapy Institute

Created in the United States of America

Cover image adapted from Käthe Kollwitz, *Death seizes the Children*, 1934

Adapted from keynote lectures presented to the New Zealand Association of Psychotherapists, *Te Ropu Whakaora Hinengaro*, March 19 and 20, 2020.

For more information about this title, contact Lawrence Hedges Director:

The Listening Perspectives Study Center
1439 E. Chapman Ave.
Orange, CA 92866
Phone/Fax (714) 633-3933
lhedges7@gmail.com
www.ListeningPerspectives.com

To the therapists in the New Zealand Association of Psychotherapists, *Te Ropu Whakaora Hinengaro*, who shared with me the first terrifying days of the Covid 19 pandemic as we relinquished our conference venue in favor of a Zoom teleconference for these lectures filmed from my hotel room in Wellington.

Table of Contents

Terror in Psychotherapy

Part I

Prologue: Terrifying Shrieks

Not long ago I was doing couples therapy with Mark and Linda. Her job with the Orange County Animal Shelter involved daily responding to calls reporting stray or distressed animals and bringing them into the shelter. As she compassionately described her work Mark rolled his eyes with impatience because, often enough, she would bring home some pathetic creature that she felt sorry for, to bandage or nurture, which left him totally nonplussed. One evening she came to therapy carrying a small covered cage and without explanation asked if she could plug it in. Of course. And our discussion began. After maybe ten minutes a rustling began coming from the

cage and she uncovered it to reveal a 6 inch long pup maybe only a day old, huddled against the small heated “rock” she had plugged in. She asked to use the microwave to heat milk which she carefully tested for temperature with a dropper against her wrist—all, needless to say, accompanied by silent facial expressions of disgust from Mark. She explained that the pup was found on a sidewalk abandoned by its mother to die because his esophagus was too constricted to suck. With medicine dropper in hand Linda worked to force milk down the pup’s throat. The animal squirmed agitatedly as the unswallowable milk ran down its cheeks and chin. Linda and animal struggled for a while until suddenly the pup opened wide his mouth and let out the

loudest, most God-awful terrified shriek I have ever heard. It filled the entire office and could be heard in other rooms all around. He died before morning. It was that terrified biological knowledge of death that shattered us all completely.

The Shriek in *Shadowlands*

I recently attended a South Coast Repertory Theater production of C. S. Lewis' autobiographical play, *Shadowlands*. You probably know the plot. C. S. Lewis (known as Jack), a celebrated British cleric and famed writer falls in love with Daisy, a recently divorced American poet who moved to England with her five-year old son, Douglas. As the love story evolves, she becomes diagnosed with stage 4 femur cancer and undergoes treatment, producing a remission during which the two experience an idealized honeymoon. Jack and the boy share deeply their love for Daisy and their shared fears for her life. The cancer recurs with prolonged suffering and

the certainty of death. The final scene opens with Douglas sitting sadly in the living room by himself in a corner of the sofa when the door opens and Jack slowly appears with the final truth written all over him. The two wordlessly embrace as Jack sits on a foot stool center stage and Douglas crawls into his lap. The two convulsively sob together until, at last, Jack throws back his head bellowing to the entire theater a blood-curdling death scream. As the curtain slowly drops the audience jumps to its feet yelling, screaming and clapping. Bravo, Bravo, Bravo. Jack had momentarily taken us all to the forbidden place of terror, the place of terrifying body and soul fragmentation! Not only had she died but a gigantic piece of

himself had died as well severing him asunder.

This place of soul shaking terror—the fear of pain, injury, dismemberment, death—is known in various ways to all of us, but we do our best to avoid going there. But now we are going to consider how this threat of death—so deeply buried in our bodies, minds, and souls—lives in all relationships and appears repeatedly in psychotherapy relationships.

Introduction: Relational Moments

We begin with a careful assessment of the impact of the sea-change in mental health care over the past two decades attributable to technological advances in neurological and brain studies, infant research, and relational psychotherapy as well as to a wide range of cultural shifts in the direction of diversity, egalitarianism, and social justice. What is absolutely clear is that we are a relational species, and that our brains and neurological systems actually form in the context of whatever intimate relational opportunities are available in early development and throughout our life-spans.

A recent task force of the Psychotherapy Division the American Psychological Association has reviewed thousands of empirical studies and revealed that the single most consistently important factor determining the overall outcome of all psychotherapies is the relationship between the therapist and client. [1]

What clients remember years later is not what their therapists said or did, but the relational moments in which they experienced emotional recognition from a very real person; their therapist.

On Relating

Professional work in any clinical setting demands personal relationship—whether the individual practitioner acknowledges the

force of relationship or not. Our professional choices manifest our personal ways of relating in how we think about and perform our work. Some therapists choose to ignore the relational dimension while other therapists choose to focus heavily on what's going on in the relational exchange. But all highly-skilled, seasoned professionals are acutely aware of what's going on in the relationship at all times and are carefully aiming their work into each relational matrix as it unfolds—no matter what theory or school of therapy they hail.

I think of family therapist Virginia Satir, a family systems therapist, whom I once watched conducting a family therapy session in front of a large audience bursting into tears and directly telling a sullen

teenager that her feelings were hurt because he thought she was ganging up against him with his parents when she was working so hard to find a way to let him at last speak what he needed to say to them.

I remember behavior therapist Joseph Wolpe telling a group of us about a little girl who had been to numerous therapists for compulsively cutting out paper dolls. After a few attempts to get her attention away from the dolls she was cutting, in exasperation Wolpe angrily yells at her at the top of his lungs, “Stop cutting out paper dolls!” And she did.

I once watched Alexander Lowen, father of bioenergetics body psychotherapy aggressively provoke a large burly man who

had in fact bare handedly killed several people in the course of his law-enforcement career to the point that everyone in the room was terrified Lowen was going to get slugged—until we saw the man crumple on the floor in deep sobs crying out to his father to stop beating him.

Each of these gifted therapists—working in their own way—demonstrates perfect relational empathy under the circumstances. Even one of the founders of Cognitive-Behavioral Therapy, Aaron Beck, after reviewing the neuropsychological research describes the crucial importance of relational context and asserts, "The therapeutic relationship is a key ingredient of all psychotherapies, including cognitive therapy.... Many of the basic interpersonal

variables common to other psychotherapy (i.e., warmth, accurate empathy, unconditional positive regard) serve as an important foundation for cognitive and symptomatic change" (Beck and Dozois 2011, p. 401).

Since it is by now clear that relational variables are an essential and unavoidable part of professional work at all levels, it behooves us to fine-tune ourselves to the relational question, "What's going on here anyway?"

The Intersubjective Perspective

While the topics of subjectivity and intersubjectivity have interested philosophers for several centuries, it has only been during the past few decades that the development of subjectivity and the maintenance of intersubjectivity have been scrutinized in a wide range of multidisciplinary studies, including neurobiology, infant research, and relational psychoanalysis. Simply stated, intersubjectivity amounts to: “I am a subject, an agent of my desires, thoughts, and actions. You are a subject, an agent of your desires, thoughts, and actions. When

we come together for an intersubjective engagement over a period of time, something else begins to happen that affects us both."

Intersubjective theories provide different ways of thinking about our shared intersubjective experiences and how the self develops through intersubjective exchanges. Formulations of intersubjectivity rest on the belief that the human mind emerges from and continuously exists within interactional processes, rather than being simply constructed or conditioned as a separate or isolated mind-self.

One of the clearest formulations of intersubjectivity holds the central theoretical construct of intersubjectivity

theory to be "the intersubjective field," defined as "a system composed of differently organized, interacting subjective worlds."[2] Robert Stolorow and his colleagues use intersubjective "to refer to any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized.....The concept of an intersubjective system brings to focus both the individual's world of [personal] experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence."[3] The main experience of intersubjectivity is one of being with rather than one of observing and interpreting. Sameness and difference exist simultaneously in the tension of intersubjective mutual recognition.[4]

The goal of therapy in the intersubjective view is for both participants in the context of a mutually-evolving, co-constructed intersubjectivity to come to recognize each other and to know themselves more fully in order to attain more creativity, flexibility, freedom, and passion in living and loving.

The Neuroscience Perspective

UCLA Neuropsychologist, Alan Schore, has skillfully analyzed the results of thousands of brain imaging and other neurological and infant relational studies concluding that the centerpiece of human development is the mutual affect regulation process established through right-brain to right-brain affective channels available to the infant at birth.[5] UCLA developmental neuropsychiatrist, Daniel Siegel, has

amassed research evidence demonstrating that human neurobiological development is guided by interpersonal processes from birth throughout the life cycle. [6] All of these studies make clear that *the human brain and neurological systems actually form according to relationships that are and are not available in early development.*

Addressing the issue of relationship from a somewhat different angle, neuropsychologist Stephen Porges introduces the concept of "neuroception" to indicate how the nervous system evaluates interpersonal situations as potentially "dangerous-painful" or "safe-pleasurable." Because of our evolution as a species, neuroception takes place in primitive parts of the brain without our conscious

awareness. The detection of a person as dangerous or safe triggers neurobiologically determined defensive or prosocial behaviors.

> A child's (or an adult's) nervous system may detect danger or a threat to life when the child enters a new environment or meets a strange person. Cognitively, there is no reason for them to be frightened....But often, even if they understand this, their body betrays them. Sometimes this betrayal is private; only they are aware that their hearts are beating fast and contracting with such force that they start to sway...For others, the responses are more overt....To create relationships, humans must subdue these defensive reactions [in order] to engage, attach, and form lasting social bonds....In the presence of a safe person...the active inhibition of the brain areas that control defense strategies provides an opportunity for

> social behavior to occur spontaneously,,,, In contrast, when situations appear risky, the brain circuits that regulate defense strategies are activated. Social approaches are met with aggressive behavior or withdrawal.[7]

Important in Porges' work is the idea that defensive strategies that detect danger are evolutionarily ancient and powerful. Only much later with the development of the polyvagal nerves in primates and humans can these automatically primitive defense strategies be inhibited so that prosocial pleasurable activities can occur. Thinking intersubjectively, we can see that our inner worlds of subjectivity—formed on the basis of a lifetime of interpersonal traumas—are highly likely to trigger our

danger-pain defenses in any intimate encounter.

Neuroscience on Fear, Anxiety, and Terror

Fear is generally thought to be of something specifiable.

Anxiety is understood to be a chronic state of diffuse unspecifiable fear.

Terror is the deepest form of fear—generally of pain, injury, dismemberment, or death.

The latest research in Neuroscience has startlingly upended the ways we have always considered—and even how (until fairly recently) Neuroscience itself—has considered fear, anxiety and terror. Let's take a journey with the foremost researcher who has coordinated thousands of brain and neuron studies having to do with fear,

anxiety and terror, Joseph LeDoux, as summarized in his recent book, *Anxious: Using the Brain to Understand and Treat Fear and Anxiety*.[8]

LeDoux points out that past thinking has been that we see a threatening stimulus and feel fear along with the characteristic responses of flight, fight and freeze with accompanying physiological correlates such as changes in perspiration, heart rate, pupil size, and so on. However, converging lines of recent brain research have led LeDoux, along with his mentor Michael Gazzaniga, to conclude that much, if not most, of what our brain does is achieved nonconsciously. Our conscious minds then construct an explanation of what happened so that consciousness can be thought of as a self-

narrative based on current perceptions and memories, as well as what we are able to monitor from nonconscious processes. That is, brain systems first respond to threat and we feel that response and then label it the feeling of fear. To experience the feeling of fear is also to know that this threat is happening to ME—that I am in a dangerous situation NOW. To experience anxiety is to worry about whether future threats may harm ME.

Thus, the upshot of recent brain research has been to establish that the brain and neurological system have, over millions of years of evolution, come to respond instantly to threat and to deploy flight, fight, and freeze strategies to ensure survival. (Some theorists add a fourth "f", fawn.) The

experiences we label fear, anxiety, and terror are our conscious mind's interpretation of the brain's survival responses to threat. That is, what we call feelings like fear, anxiety, and terror are constructed in early childhood through the tools of language and culture to interpret and label the information received from nonconscious threat responses.

The Experience of Terror

Webster defines terror as stark fear and as a running from fear. We may say we are terrified of being somehow disabled, helpless, diseased or trapped. We may feel a terror of not being able to move, to breathe, to think, or to speak. We may awake terrified from a nightmare in which we cannot pass an examination, cannot talk or

scream, cannot escape an approaching disaster, or are paralyzed in the face of the overwhelming and unavoidable danger. A "reign of terror" is a frightening, oppressive, and damaging political situation that cannot be escaped. Certain situations may elicit fear for prolonged periods of time until we find some escape, some safety, some relief. But for many people chronic fear and anxiety has been conditioned into their minds and bodies by the ongoing and frightening circumstances of their childhoods. Some people have experienced severe traumas and major disasters later in life that leave them perennially vulnerable to being once again seized by panic and terror. Terror, thought of as the fear of fear itself, the fear of ceaseless and unavoidable physical and

emotional pain or vulnerability—is a *universal* part of human experience, though clearly our past individual experiences with fear and with uncontrolled terror color the way we each anticipate fear and defend against it.

Most, but certainly not all, experiences of uncontrolled terror occur prior to the third or fourth year of life, by which time a child generally develops enough ego and self strength to master rudimentary forms of fear management. Fears of dismemberment, disease, death, incapacity, immobilization, fragmentation, and/or emptiness may at times be realistic to our personal life circumstances or may serve as images for representing or expressing otherwise unrepresentable or inexpressible mental

and physical memories or states. Archetypal themes such as abduction, ritual abuse, incest, out-of-body experience, dissociation, depersonalization, past lives, and multiple selves can also serve as expressions of preverbal and otherwise unrememberable agonizing and dreaded somato-psychic experiences. But since we now understand that human experience never occurs outside of some mental-relational context, we can also understand that memories of infantile traumas are inevitably attached to, paired with, and understood in some relational context, and that *later similar relational contexts tend to revive anticipatory fears, pre-defenses, and experiential modes that were once attached to earlier terrifying experiences*. Such fears, pre-defenses, and

experiential modes can be expressed in a variety of somato-psychic ways that serve to crystallize, concretize, and represent in conscious awareness many otherwise unrememberable and unrepresentable experiences.

In psychotherapy and psychoanalysis we openly invite people to remember through relating. Thus we expect an array of developmentally based fears to arise in the course of the intimate therapeutic relationship. In fact, it might even be said that the purpose of psychotherapy is to set up an intimate interpersonal situation designed to facilitate the arousal of previously experienced relational-fear responses so that their unthinking and automatic qualities can be brought to light,

examined, and to a greater or lesser extent, relinquished.

From conception forward, fetuses and infants are subjected to a series of unsettling, frightening, and, if uncontained, terrifying experiences. Whether from intrauterine causes such as toxemia and genetic aberrations or from psycho-physical trauma, fetuses and babies withdraw, constrict, and/or slump and wither when confronted with overwhelming stimulation. Infant researcher Selma Fraiberg (1982) has characterized the expectable responses to traumatic experiences of the mammalian newborn as the pre-defenses of flight, fight, and freeze.

Whether we conceptualize in terms of

—schizoid (withdrawing) defenses (Klein 1957),

—mammalian pre-defenses (Fraiberg 1982),

—or somato-psychic constriction and withering (Hedges 2012),

the infant's response to overwhelming stimulation is traumatic and is invariably experienced as relational—as occurring in the context of a relationship with someone present or absent. The psychological theory of transference predicts that traumatic experiences will be recalled in some way when later in life similar relational circumstances arise, prevail, or threaten. Consequently, in any ongoing intimate relationship, it is only a matter of time before a person begins to anticipate experiences occurring that have

characterized previously experienced dreaded and avoided relationships. *The psychotherapeutic relationship thus moves inexorably toward the re-experiencing of life's most primitive experiences of terror within the context of the relationship*. Whether such terrors are allowed to develop over time is a function of the willingness and ability of the therapist to relive the terrifying experiences with the client in the context of the current intimate relationship.

A critical skill of the therapist lies in being able and willing to welcome and interpret the resistance to re-experiencing the terror in the transferred here-and-now relationship.

The Underlying Fear of Death

> "All fear can be traced to the fear of our own mortality."
>
> Deepak Chopra

Our conscious fear of death is expressed in many obvious ways. We get preoccupied with terminal illness or we want to avoid all thoughts of it. We become afraid to drive on freeways or to venture into dangerous neighborhoods. We experience anxiety around situations that are even remotely life threatening. In response to our anxiety the deep, innate survival mechanisms inside us begin to operate silently. But the struggle to survive and the fear of death is far deeper than our conscious concern with dying or being killed. From the moment of conception the human organism experiences constant threats to its survival.

As the organism develops it acquires many ways of protecting itself. Mammals are entirely dependent upon the protective and nurturing environment in which they grow to keep alive. Embodied in the organism is the genetic "knowledge" that dangers to survival abound and that the environment is not completely safe. Anything disturbing the sense of equilibrium is likely to be experienced as a threat to survival. How can we work with this underlying fear of Death? And how, if this instinctual fear is the underlying basis for all relational fears, can we possibly overcome it? We must begin by recognizing and acknowledging the basic fact that there is a fear of Death inside us. And that it is terrifying. Then we can recognize another truth: that when, on

behalf of becoming more fully alive, we are reaching out, making contact, taking in, asserting ourselves, allowing ourselves to succeed, and challenging social expectations —we are creating change on a deep level. Change of this type always feels as though we are risking our lives. Our subjective choice is to experience the feeling that we are risking our lives—or to accept deadness as a way of life. We either risk the terrifying feeling of dying or continue to live with real deadness. The feeling of fear that we will die is not realistic. Our deadness is a reality.

The question as we move forward then becomes: "How do any two individuals work to override their relational fears in order to create mutually rewarding intimacy experiences—in or out of therapy?"

The Infant-Caregiver Interaction Perspective

The past three decades have seen the emergence of a community of baby-watchers, ingeniously researching every possible aspect of infant life they can define and observe.[9] Infant research has established that human babies at birth are already equipped—through genetically-driven processes of mirroring, synchrony, curiosity, and the capacity for affective resonance—to search out and to make creative use of various aspects of the inner (subjective) rhythmic and affective life of their caregivers.[10] The Boston Change Process Study Group has been particularly invested in ferreting out how early relational processes promote intersubjective development and the implications of these

change processes for lifespan development.[11] Attachment research likewise makes clear that the attachment motivational systems in humans are governed by intersubjective processes occurring between infants and caregivers.[12]

Infant researcher, Daniel Stern, sees intersubjective relatedness as a crucial step in self development as the infant becomes able to share subjective experiences, especially affective ones.[13] Further, Stern has come to consider the capacity and drive for intersubjective communication as innate and present from birth. Of special interest are the infant studies that involve both mimicry and affect-mirroring—that is, the parent's use of facial and vocal expression to represent to the child the feelings she either

mimetically reflects or assumes in her interactions that the infant has. Research indicates that the image of the caregiver mirroring the internal experience of the infant comes to organize the child's emotional experience.

Thus, the self is not merely open to environmental influence—*the self is constituted through its interactions with the mirroring social environment*. These relational processes are foundational for later intersubjective experiences that are reciprocally generated and shared.

The Relational Perspective in Psychotherapies

Heavily influenced by the feminist accent on the historically destructive male-subject/female-object

dominance/submissive split, the relationists emphasize that the human mind is not monadic but dyadic in nature. Vitalizing dynamic human relationships are seen as constituted by co-constructed intersubjective erotics—that is, by interpersonal interactions, dances, or idioms that are formulated as a "third" force or vector mutually created by and influencing both participants.

The Relational Perspective holds that: *through studying the affective transactions in the ongoing therapeutic relationship itself the establishment, resumption, and/or expansion of reciprocal affect attunement processes that are essential to all forms of relational intimacy can be restored.*[14]

The Relational Listening approach[15] outlined in Table 1. has defined four watersheds in the development of relatedness complexity with seven levels of relational fears that will help us contextualize the lower levels anxiety and terror experienced in transference and countertransference. The table reads developmentally from the bottom to the top and specifies an array of relational possibilities or potentialities that evolve in early development. Relational possibilities and expectations based on relationships that are and are not available in early life form basic templates that are used in later relationships. [For a fuller explanation of the issues covered in each listening

perspective and relational fear see the Appendix]

Table 1: Four Developmental Listening Perspectives and Seven Relational Fears[16]

IV. The Independent experience (3 to 7 years)

7. The fear of being fully alive
6. The fear of failure and success

III. The Self-other experience (24-36 months)

5. The fear of being unacceptable

II. The Symbiotic experience (4 to 24 months)

4. The fear of self-assertion
3. The fear of abandonment

I. The Organizing experience (+/- 4 months)

2. The fear of making connections
1. The fear of being alone

Considering the Terror Involved in Homicide and Suicide, as well as Serial and Mass Murder

When considering the psychodynamics of suicide and homicide there is a simple formulation and a more complex theoretical one.

The simple formulation rests on early life experiences—the rhythm of waking and sleeping activity of a fetus and neonate and the earliest emergence of consciousness out of non-consciousness. Both before and after birth the earliest sense of personal agency is deployed into encounters with sustained waking sensorimotor experiences of otherness that alternate with lapses into sleep—darkness. Vulnerable individuals

later in life may transfer this early retreat to peace and darkness when triggered by experiences of extreme hopelessness, helplessness, despair and psychic pain. Or they may transfer their chronic, destructive helplessness and rage murderously onto others. Babies vigorously protest intrusions into their need space and may kick, scream, cry, arch their backs, hold their breaths, bang their heads or flail wildly in pain until exhausted and then fall into sleep—the peaceful retreat of "darkness", the relief of unconsciousness (as in suicide). Or an infant can become arrested in chronic, destructive rage aimed at either the (m)other who has failed (murder) or the world in general that has failed (serial or mass killings). That is, the anticipation of an

otherwise satisfying interpersonal (or social) situation in the present may trigger a retreat or collapse into the relief of darkness because in infancy the original reaching hope resulted in a traumatic disaster. Or the possibility of satisfaction may trigger fantasies or enactments of murderous rage.

The more complex formulation to the question "Why Darkness?" relates to an issue Sigmund Freud worked over during his entire professional career from his earliest papers in the 1890's to his final papers in the late 1930's, a phenomenon he referred to as "the splitting of the ego." By "splitting of the ego" Freud meant that the earliest sense of agency, "the I" [translated into English as the ego], necessarily becomes split as it deals with the world.

That is, while one part of “the I” reaches explorationally into the world, another part of “the I” maps what it finds—that is, actively creates and then in some sense becomes an internal representation of what is out there. [17]

Hungarian psychoanalyst Alice Balint in an illuminating 1943 paper, “Identification” expands Freud’s thinking on the ego creating a perceptual-motor-affect identity inside that mirrors an object-affect identity on the outside—through the process of “identification”.[18] One might say there is a “me-self” and an “other-self” both in the ego, “the I”.[19]

Thus, in infancy when the “other-self” is experienced as frightening or seriously

depriving, then the quality of the internalized other is likewise frightening or depriving. In the Organizing experience (level I on the relational table above) when the traumatizing internalized "other-self" is triggered, an automatic shutdown is demanded and a retreat into darkness ensues—a flight from real or anticipated pain results in a loss of consciousness. Or an aggressive fight response aimed at whatever seems to represent that primordial "other-self."

In the Symbiotic experience (level II on the relational table above) when the internalized traumatizing "other-self" is triggered it creates a move toward compelling mutual affect regulation or interactional scenarios that are frightening,

neglectful or hateful. That is, the unique mother-child symbiotic (attachment or mutual affect regulation) scenarios are manipulative—of an *instrumental* nature—i.e., each person in the interaction behaves in a way designed to get her needs in the relationship met. These internalized instrumental Symbiotic scenarios reappear in later life as (usually unconscious characterological) interactional efforts to compel the other to meet my psychological needs according to my internalized expectations.[20]

Summary

Psychotic enactments that result in *actual* suicide or murder are traceable to the earliest relational experiences of hopelessness, helplessness, and despair or

to seemingly unending chronic and uncontrolled terror and rage—both responses to the earliest "Organizing" level of relational development. Enactments that *threaten* suicide (gestures) or murder (abuse) are traceable to the "Symbiotic" level of relational development and are often seen as manipulative or instrumental gestures seeking the fulfillment of early relational needs.

Whether the enactments stem from the "Organizing" or "Symbiotic" level of relational development, when threat is sensed by others they have an instantaneous neurological response that results in a subjective sense of "anxiety" or "terror." That is, in psychotherapy as clients move toward enactment of early dissociated

terrifying relatedness experiences in the transference, the therapist is likely to experience the threat of suicide (hopelessness and despair) or murder (abusiveness and rage) in the countertransference, and to react with her own terrifying dissociative defenses. Or the therapist may find ways to experience and move past her own defenses in order to experience *along with the client* the primitive threats as terrifying so that they can be worked through together.

I move at this point to give clinical examples of the kinds of terror-driven responses we frequently encounter in psychotherapy.

Three Brief Cases to Illustrate the Fight, Flight, and Freeze Predefenses

Three case examples highlighting what Selma Fraiberg (1982) has called fight-flight-freeze predefenses—primordial ways of avoiding connections—will illustrate how an Organizing experience can appear and how we as therapists can gain some grasp of the meaning of the Organizing transference experience.

1. Flight in the Organizing Transference

Ginger has been seeing Sally for three or four years. This client has been driving an hour and a half each week to her appointment (”So there's a long umbilicus,” the therapist says). Sally has presented as

tenuous in her ability to maintain relationships. In the last six months she has talked frequently about terminating therapy because of money and distance. She canceled her sessions in bad weather and during the winter holiday rush. On several occasions the therapist has empathically tried the following, “Well, okay, I can understand how busy you are and how far it is. You have accomplished a number of things in therapy, so if you want to consider termination, we can talk about that.” She has even suggested helping the patient find a therapist who was geographically closer. But that talk all became taboo. Sally was allowed to talk about termination, but Ginger was forbidden to talk about it.

On the occasion in question, Sally called during the Christmas holidays and, without any warning, canceled all future appointments. Ginger made several phone calls to contact her. She sent a Christmas card. She did everything she could to reach out to her. She thought, “Well, maybe it's best that she stop—and this is her way of stopping. Maybe I shouldn't pursue her.”

They finally did connect by phone, and Ginger discovered what happened. Sally said, “In the last session I was telling you about my friend Valerie, and you turned away. Then I knew you didn't care for me, so there wasn't any point in coming back.”

Her case consultant says, “She's found a way to live out the Organizing transference

of mother disconnecting and used the Valerie content to accomplish it. This is the window to the Organizing experience we are waiting for. We patiently wait for the moment in which the reenactment of the turning away, the breaking of contact, the rupture of experience happens in the transference."

As the case was reviewed, therapist and consultant located a number of such breaches in which the client needed to flee the developing intimacy of the relationship.

Ginger was fired up with these ideas because they seemed to make sense and to organize in her mind many past incidents. She is ready to talk to her client about all this right away. The consultant cautioned

her not to rush into verbal interpretations about something that is dissociated and perennially enacted nonverbally.

Ginger tunes in quickly and says, “I feel like where we're at right now is both lying down in a playpen, and I have to wait for her to come to me.” The consultant reminded her that the baby has to be allowed to find the breast, but it must be available to be found—not somewhere in flight and not through talk.

The transference to the psychotic mother will be reenacted again and again, so there will be ample time to discuss what is happening. But the therapist can use her new understanding to simply be with her client in new ways.

Interpretation at the Organizing level must be some form of concrete activity or some form of commenting or reaching out at specific moments when the client is in the act of pulling away from contact to communicate, “I know you believe you must break off our personal engagement in this way now. But it is not true. As a child you anticipated something terrifying but as an adult, you have the ability to stay here now with me and to experience your long-standing terror of connectedness. How can you manage not to leave me now? Can we find a way to remain in contact for just a few more minutes?” “Where in your body do you feel the discomfort, the anxiety, the pain?”

Clients needing to work on Organizing experience terror often deliberately conduct

the early phases of therapy at quite some distance from the therapist by spacing appointments far apart or arranging long and difficult drives. They often sit at a distance from the therapist and talk about seemingly unrelated things. They know that interpersonal closeness can only be experienced as traumatic. Thus, the invitation to sustain contact must be cautiously offered and episodes of flight anticipated and responded to appropriately.

2. Fight in the Organizing Transference

Georgia has been treating Judy twice a week for three years. An intense therapeutic relationship has developed. The client is a very bright and sophisticated professional. She lives very comfortably in the everyday world but suffers privately from what she

refers to as a “multiple personality”—that is when, without apparent reason, she goes into a rageful self.

Georgia sought a crisis consultation after she got a telephone call after their last session: “I'm not coming in anymore because there's something wrong with our relationship.” The therapist inquired about the nature of the problem. Judy replied, “I can tell you feel there's something wrong with my relationship with Naomi.” Naomi is a lesbian with whom the patient has developed an intimate relationship. She continued, “You don't think that it's right, or you think there's something wrong with Naomi. There's no point in our going any further so long as you think that way.” She was angry, shouting at Georgia over the

phone--and then she listed a number of other things, “You don't listen this way ... and you're not that way ...”—a tirade of complaints and accusations.

Georgia is in a state of shock, feeling she may never see her client again. She is not even clear about what might have been said to upset her. She tells the consultant that her client is basically not lesbian: she had three or four relationships with women, but ones in which she was looking for soothing contact with a woman, possibly in order to feel mothered. She cannot develop relationships with men because she does not know how to relate to men. She is confused and frightened by men.

Judy has said various times that, even though she is having a sexual relationship with a woman, she does not feel she is lesbian—she does not feel like other lesbians. She feels certain she is really not a lesbian. At one point the therapist had said, “I really don't think you're a lesbian, either.”

In consultation it appeared that the reflective comment the therapist made about her not really being a lesbian was used by the client in order to accomplish a rageful disconnect. The therapist reviewed the misunderstanding and learned from the episode that rage becomes the way of accomplishing relationship ruptures when interpersonal intimacy threatens.

Of special interest here is a screen memory in which the patient, who grew up in poverty conditions, witnessed her mother have an abortion and flush the fetus down the toilet. The mother's rage at having needy children appears to have been one of the sources of the rageful disconnecting mechanism.

In the countertransference, Ginger was able to report the passing fantasy of letting the patient go because her chronic anger promised to be so difficult.

This episode represents the patient's first tentative foray into working the Organizing transference directly with her therapist, though a series of parallel transferences with friends had been discussed extensively.

Now the therapist has a clearer view of the nature of the disconnecting transference replication.

The Organizing transference typically is worked through in a series of waves or episodes. The therapist will be more prepared to act quickly next time to deal with the disconnecting intent. The interpretation may be accomplished in the nonverbal or preverbal way; the therapist stays with her in her rageful self and invites her to stay connected and to live out her terror of being with the therapist together rather than to disconnect or rupture the connection with rage.

3. Freezing in the Organizing Transference

In the third example of how Organizing transference works, an emerging theme of an otherwise very-well-developed woman has been related to the Organizing level of relatedness. This example is from a much later working-through period of the analysis (with a male therapist) and occurs in a personality much more capable of verbal abstractions than the previous two.

Sarah's mother, during the baby's early months of life, was afraid to pick her up for fear of “breaking” her. The client actually believes she can recall her mother frequently lurking or hovering just out of sight so she would not beg to be picked up. In transference she would often lie on the couch absolutely motionless for long periods listening to the quiet sounds of the analyst

breathing, clearing his throat, or stirring in his chair. It has been discovered through several years of intensive psychotherapy that there were many strengths this mother was able to stimulate in this child, but at the deepest psychic level there remain connecting difficulties.

The emergent theme over several weeks to be reported was Sarah's silent rage that occurs on a fairly regular basis in social situations when she knows that the person she's interacting with can indeed do more for her and be more there for her, but somehow flakes out. In short, her frozen rage is mobilized at people when they have potentially more to offer than in fact the person is actively living in the current relationship.

In a key session Sarah develops the theme further. Early in the marriage, she says, her husband was far more warm, giving, and available than he is now, and she is angry that he is not more available when she knows he can be. She becomes exasperated to the point of feeling *utterly helpless and frozen*.

By the same token, she indicates that what attracted her to a close friend was that this other woman had so much to give. The friend is well-traveled and well-read. She is alive, active, versatile, a good conversationalist, and much more. But, in a recent example, when her friend had the flu and could not get out of bed to go to her son's very first baseball game: “Then I don't see her any longer as what she could be or

might be for me if she can't [even] be there for her own son. I become angry and disillusioned with her and withdraw into myself. Now I know what has been bothering me so much lately about her in our relationship: too often she cancels, flakes out, or blobs out when I know she doesn't have to, when I know she has far more to give but is choosing not to. I become completely *immobilized, frozen*, in impotent rage."

In the discussion of various examples that have occurred with her husband and her friend, Sarah said, "Now I'm finding that not only when I'm enraged at the other person for not living up to their potential do I not get what they have to offer me, but I also see that when I'm enraged I am totally

unable to take in, to get, to make use of that which they can in fact offer me." She referenced some examples from previous transference experiences in therapy in which she, in complaining bitterly about the therapist's seemingly endless unavailability over the holidays and weekends, was so preoccupied in her hours leading up to the holidays that she was unable to make use of whatever good experiences might be possible in the sessions.

Her comment is, "something always happens." The emphasis here is on the subjective statement of the disconnecting experience being impersonal. It's not, "I'm disappointed with the other," or "The other lets me down," or "The other fails to live up to his potential." It's, "We're interacting,

and then something happens, and the potential that is there isn't being lived out, and I fall into a lost state of sadness and grief, which is usually manifest in instantaneous but frozen rage."

At this point in the session the client realizes she has lost or repressed a further insight regarding her husband and friend that she was very excited about only a moment before when she connected to it. But just as quickly as the insight came, it fled and she was very disturbed for some time about having lost this insight.

After a few thoughtful moments, she said, "It sounds like a reason to break contact." The therapist quickly replied, "No, it's the *way* you break contact." The client

then said excitedly, “That's exactly what I lost. I was trying to formulate the problem with my husband and my friend in terms of how I break contact, but I couldn't quite get there. If I'm always living in what a person could give me but isn't, then several things happen: One, I have reason not to relate to them; two, I'm not relating to them at all but I'm relating rather to my fantasy; and three, they do have something to give or I wouldn't be relating to them, but in my distress and frozen anger I'm completely missing what they have to give to me. *I break the contact by being sad and enraged, complaining about what I'm not getting.”*

At this point she slowed down and indicated that she was emoting very deeply, that she felt she'd reached a very profound

point. “I know somehow that this can change my life if I can finally get hold of it. If I can find some way of fully knowing about this, I will be able to change many things.” Her therapist said, “It seems as though you have located the mechanism regarding how the contact is broken and how it relates to the early experiences of your mother who, much of the time, was there so that you knew full well what things she could provide. But when she was preoccupied, or not willing or able to give, or frightened about how she might harm you, she bowed out, leaving you stuck, knowing that she could give more but that she was not giving it. No wonder she reports that you were such a good baby and slept a lot! The content of the frozen transference is

‘You could be giving me more, but you're not.’”

“Now,” she continued, “I find I'm a little scared about knowing all this. Things keep clicking in my mind—more and more examples. It's like my whole life is built on this single mechanism. No wonder I wasn't happy when John, my supervisor, failed to tune in to me completely when I knew he could. If I finally identify this, I may be able to change. I am excited, but I think I'm mostly very scared. I think the scare is that I won't remember this, I won't be able to take hold of it, I won't be able to make it my own.”

The therapist said, “No, the scare is that you *will* remember it. You are in the process

of deep change, and as you are changing you are coming face to face with a terror you have avoided all your life. The terror of having to encounter a real live person who has some good things to offer but who may not, for a variety of reasons, be willing or able to give fully in all areas. Sooner or later in every relationship you encounter this situation, and it brings back the agonizingly sad and rageful reactions you had to your mother during your earliest months of life. So you have been unable to continue relating or you have given up the relating when the conditions are not met rightly.

What you are scared of is actually allowing yourself to negotiate the uncertainties of relationships and to survive the positive possibilities as well as the

painful disappointments which are bound to be a frightening and powerful consequence of fully knowing and living out what you are now discovering."

"I know you're right," she says.

Hedges Comments:

Each of these three examples illustrates how the rupture of the Organizing experience is repeated in transference. In each instance, multiple interpretive possibilities exist. The decisive moment of Organizing transference interpretation is not visible in any of these examples—in the first two because the relationship had not yet arrived there, and in the third because the in vivo interpretations had already begun and the client was in a later stage of

“owning” the interpretative work (though she expresses fear of losing it).[21] The presence of Fraiberg's (1982) three “predefenses” of fleeing, fighting and freezing is suggested in these three case vignettes and may be seen as the clients' ways of achieving a rupture of contact in the relationship that, due to transference projections, is threatening to become overstimulating.

Terror in a Marriage Relationship: Joan and Matt

Joan and Matt sought me out when they were considering having a second child—this time with a surrogate mother. Because of necessary radiation and a hysterectomy following the aftermath of breast cancer, doctors recommended that they freeze some fertilized eggs while they still could in case they ever wanted more children—which they did.

They are a strikingly good-looking couple who are highly intelligent, thoughtful, mutually respectful and very much in love. In the beginning there had been extremely strong chemistry between

them and their marriage started off wonderfully. Their now three and a half year old son, Sean, is developing well and both parents are invested in Sean's physical and emotional care. Unfortunately, in all of the trauma they have endured with the recurring cancer and the high odds of treatment failure, emotional distance slowly developed between them and sexual intimacy came to a complete stand-still—much to their mutual distress.

They want another child and a friend has offered to be the surrogate mother. New drugs have provided a "total cure" for the cancer but due to the exact nature of the cancer there will be a lifetime of medications required. Joan is justifiably proud of her courageous fight and her sense

of victory over the disease. Matt admires her achievements but is very much afraid for her, for himself, and for Sean should there be a recurrence—they are not past the five year safety mark yet.

Joan is frightened because when she was so overwhelmed with her treatment regimen, there were times when she experienced Matt's emotionally withdrawing and times when his preoccupations with work left the burden of household and child-rearing responsibilities to her. Will this happen again if they undertake having a second child?

Matt reluctantly admits that this indeed did happen and that emotional withdrawal in response to stress is a lifelong pattern for

him, dating to early severe emotional and physical abuse from his parents, especially his father.

Now is the right time to have a baby—the eggs are there, the surrogate is ready, the cure is in effect, Sean is of an age a sibling would be good, they want another child… but…?

Both Joan and Matt are frozen with desire and fear—towards each other, toward the relationship, and toward the possibility of family expansion. Could I help them decide what to do and how to do it? After all this trauma how can they get back to their loving intimate relationship that they enjoyed so much? How can they be assured

of a satisfying and enduring future family life?

Joan and Matt each wanted to tell me something about their families of origin and how each other's in-laws affected them. They were overjoyed to share their child-rearing experiences of Sean with me and I did some coaching around some issues that were coming up at pre-school lately. Unaccountably, Sean was being more aggressive with other children and had had a few accidents in his pants lately. We talked about how sensitive young kids are to stresses parents are experiencing and to conflicts that naturally arise when parents are considering more children that will change the love structure that exists in the family.

After several sessions in which we three had established some basic comfort with each other, Joan let out a string of discontents about Matt's emotionally withdrawn behaviors, trying her best to be understanding and not critical—but she was now recovered and wanted a restoration of their former interactions and intimacy.

Matt did some tearful work on his knee-jerk emotional withdrawals and re-arranged his professional work to be more present for Joan and Sean. He pledged not to let work get in the way of his family again and took some effective steps to make sure this would be so.

But his sex simply wasn't working since all of this began, and he hated to begin

something only to disappoint her and to feel humiliated himself. He's always been quite potent, but now he has no sexual desire at all for her or anybody else, he doesn't even masturbate. She's impatient. He's apologetic. They love each other. Neither wants to break up. They're in a pickle.

As the weeks passed by Joan relates a childhood of non-recognition by her parents and her having developed a strong, aggressive, no-nonsense, self-sufficient attitude toward life and problem solving. She had become a highly successful business woman with her own thriving firm and a number of competent employees to help her run it.

Matt's being soundly criticized and squelched by both parents throughout childhood left him with less than full ambition at several unsatisfying jobs until he found his present work which was exhilarating, but time and energy consuming.

I had several times posed the question to Joan of what it had been like for her after she was diagnosed and while she was going through protracted painful treatments. I got inspirational answers of how she had always put faith in herself, how she was determined, how good it felt to know she was on top of things, and a plethora of details about doctors, medications, procedures, etc.

Then came the night of trauma revisited. Joan got caught by one of my questions and her voice started cracking, she had never intended to say this to anyone, ever—and she started shaking and sobbing uncontrollably relating the utter helplessness, hopelessness, aloneness, and defeat she had experienced repeatedly during the whole ordeal—feelings she was too ashamed to tell anyone, even Matthew. She had always been ashamed of any vulnerability and had worked a lifetime to cover up any sign of weakness or insecurity.

Needless to say, both Matt and I were deeply moved with compassion to witness Joan's drop into traumatic re-experiencing before our very eyes. But we were relieved that Joan at last could speak her truth—like

some sort of boil was popping. We all three understood that this deep emotional outpouring wasn't just about the cancer (i.e., the secondary trauma) but about her whole life of emotional aloneness, struggle, and determination to get on top of overwhelming circumstances no matter what (i.e., cumulative primary traumas). And on top her terror of failure and humiliation. In the case of the cancer she had had to surrender to humiliating defeat by a powerful force greater than herself. But her good old spirit of determination did kick in like it always did and she had achieved the best possible outcome.

In response, the following week Matt dropped into his own shaking and sobbing and the humiliation and defeat he had

suffered repeatedly as a child from his abusive parents and how the only place that was safe was to hide, to become emotionally withdrawn, isolated and invisible but terribly alone. He had found Joan and for the first time in his life had a safe companion until the diagnosis when he found himself re-traumatized and once again very much alone with the prospects of losing her.

Matt knows she's "cured" but he's terrified something else might happen and he'll be all alone with two children and no support. The cancer experience had thrown him back to a terrible sense of failure and a lack of confidence in himself. Joan and I resonated deeply with his life-long trauma

and fear of more re-traumatization and failure.

From this brief account we can see that Joan and Matthew were hell-bent on doing the work they had to do to come clean with themselves and with each other about how the cancer trauma (i.e., the sets of secondary traumas) had affected them. They needed to know for themselves and for each other how this life circumstance tapped into the worst of their growing up experiences and how as children they had each learned to close off to fear of defeat, aloneness, and shame—she by active, aggressive, competence and he by withdrawal and isolation (i.e., their primary traumas).

The following sessions featured a cascade of painful childhood memories and more elucidation of the fears they were experiencing in their present life situation. How were they going to get things back together? How could they ever feel safe in love again? And if they couldn't restore the intimacy of their marital relationship how were they going to be good parents? Should they risk having another child?

I end the story here, with my main point about the importance of breaking through the current or secondary trauma to re-*experience* the original or primary traumas in order to establish more truth and intimacy in the present relational situation having been made. This brief story also illustrates *the importance of experiencing a*

retraumatization in the here-and-now with committed and emotionally involved others.

Joan and Matt were so relieved to restore honesty and to be once again working together as a team that, even with much relationship work yet to accomplish in order to regain lost territory, they felt confident to go ahead with having another child—hopefully this time a girl, but another boy would be great too!

We all know this experience. Some life circumstance traumatically triggers an emotional overload that needs to be ventilated with a relating partner. Usually when the conversation begins neither has the slightest idea what is about to happen,

but both sense some kind of highly-charged pressure present. And then, almost without warning, something starts to erupt—a deep energy impelling the overloaded person forward. It may start with an outpouring of frustration or rage over the realities of the triggering situation (secondary trauma). But out comes the emotional eruption and both people know something much greater is at stake, that something deep is emerging in the rapid-fire, jumbled, and irrational thoughts that tumble out. "Thank God this is private and confidential—I'm so humiliated and ashamed at what I'm saying, I don't even know if it's all true, but it seems important. I'm so confused, I don't even know where all of this is coming from."

A good listener remains low-key but facilitating and encouraging. “Keep going. No you’re not upsetting me. No it doesn’t yet all make sense but let it fly! You have to get this out. You have to get to the bottom of whatever’s happening for you.” And then the cascade of jumbled memories of similar past horrors and frustrations and how helpless, alone, frightened and defeated we felt at those times and in those circumstances (primary traumas).

“Now what’s going on for me in the present begins to make more sense.” This sense of trauma isn’t about just now, but about a lifetime of similar traumatic humiliations.

Metabolizing Terror Through Psychotherapy by Catherine Morrill

The following patient's name and case details were altered to protect his privacy. I called him Adam for years as I discussed his case in individual and group consultations with Larry Hedges. Upon recent reflection on my choice of name, I believe I named him Adam because he was the first client I worked with so intensely in the transference. Adam's desire and capacity to utilize our relationship for his growth created a dynamic transference-focused case, a proto-type of the kind of work I enjoy the most.

Adam is a Hispanic, cisgender male who grew up in poverty. From infancy onward, Adam had a variety of caregivers, many of whom were picking up the pieces when his biological parents were in jail or away for any number of reasons. He experienced neglect, sexual abuse, poverty and violence. His involvement in the arts and excelling in school helped him leave these circumstances to attend college.

I have been seeing Adam once a week for ten years, and in that time twice a week for about a year. Adam came to therapy at age 30 after he had some overwhelming experiences of dissociation during some intensive trauma-focused group work.

In general, Adam sought my help because he suffered from panic attacks and struggled in his relationships at work and romantically.

Adam began sharing feelings about his therapy very early on, reporting in the second session that he felt nervous coming to session because he was scared of vulnerability.

The third session he reported awareness that he had "performance fears about therapy." I sensed Adam's desire to connect with me yet I also sensed that he was terrified of interpersonal contact.

In our early work, in many sessions I had difficulty hearing him and I hesitated to "interrupt." When I sought clarification or

offered a reflection, he experienced it as intrusive. My job was to create as few moments of "intrusiveness" as possible.

From early on, the frame of therapy provided Adam a lot of security that he lacked in his early development. When the structure of therapy was interrupted, such as by my vacation, strong feelings of anger and neglect emerged.

He also had trouble negotiating reminders that I had needs, such as for vacation, or for payment. In his mind, if I had needs, that meant that I could take advantage of him or at least that he was going to be neglected.

Nine months into our work, perhaps not coincidentally the approximate time of

incubation of a fetus, Adam started seeing me twice weekly. We then entered a season when Adam experienced deep need for me and was also generally angry with me. Adam was angry that I was limited in my ability to be with him. That I had other patients who got parts of me. That I couldn't join him in his life outside therapy. That he couldn't be part of my life outside therapy. I was safe enough he could feel and talk about his longings and anger.

At this time Adam also talked about his sexual attraction to me. Adam did this carefully, testing the waters of my capacity to hold both his desires, needs and fantasies, while upholding the boundaries of therapy. He was terrified of the destructive power of sex he had experienced in his life,

both as a victim and as a perpetrator. At times, if I made a comment that he felt was intrusive, it would trigger his fears of my power in our relationship, bringing him back to incidents of being molested.

Other times Adam alluded to sexual fantasies about me. In time he shared that the sexual fantasies about me were rape fantasies. Being thought of perpetrator and victim were disturbing thoughts for me. But because he was careful, reticent to share his feelings, it was easier for me to hear his thoughts. I was able to minimize my fears as together we made links to his relationships with women outside of therapy, and to his history.

In time we came to understand them as an expression of his simultaneous desire for closeness mixed with the feelings of powerlessness and rage that come up in intimate connections.

One session Adam came in with a dream. This dream abruptly broke through my capacity to manage my feelings of fear. Adam said, “I think I must be mad at you. In my dream you were married and I felt like it was a ruthless loss. Then your face turned demonic and I was terrified, so I dismembered you. This felt weirdly validating of my pain. I felt dominant and somehow finally we were together.”

I didn’t feel scared during the session when Adam shared the dream. I felt glad

that he shared the dream. I held these images as useful ways for him/us to work through his feelings of terror. But when the session ended, and I reflected on the content, I started to have mixed feelings. Part of me remained feeling confident in the deepening therapy work, connected to Adam and curious. But another part of me "freaked out." I thought to myself, "we are talking about killing the terrifying mother, but that's also ME being dismembered in the dream."

I hadn't actually felt *unsafe* in the room, I reminded myself. But had I dissociated from the fearful feelings that were being evoked in me? Should I trust the sense of safety and objectivity I felt in the room? Was I missing dangerous cues? Were these

feelings of fear due to this being new territory?

I was reminded of when I, in my adolescence, volunteered for our town teen hotline. When my highly anxious mother found out that I fielded a call of a sexual nature, she forced me to quit the hotline work I loved. Was I out of touch with potential danger? Then? Now? My own anxiety felt overwhelming.

I brought the dream to my consultation group to help me make sense of the fantasies and dream. It was helpful that their response was concern for me. I appreciated the support. I can't imagine wading through these deep waters alone.

But I still felt alone. I still felt like I was losing my footing. And that was terrifying. At my core I felt I could trust the capacity of Adam to self-reflect and self-regulate, even as these young psychotic parts expressed their terror and need. And yet, there was a way in which these psychotic parts provoked feelings of terror within me.

If I could change anything, I wish I could have managed my anxiety those initial sessions after discussing the dream. Adam felt my anxiety. He felt disappointed in me, that I wasn't able to remain the secure container he hoped I could be. My own vulnerability was on full display as we struggled to understand and hold his feelings of terror and the impact of them on me, together.

In time, as Adam and I processed it, we talked about how my marriage in the dream represented his intense fear of losing our real and nurturing connection. I considered it a win, that he has developed a deep attachment to me, albeit an insecure one. And this earned security creates the safety to face the terrifying mother who lives within him and whom he needs to kill in order to survive.

Over time, as the terrifying mother slowly died, we could finally be together. Adam could find secure connection. For Adam, these images were very helpful in giving words to his inner world.

As Adam has worked through his trauma, finding ways to feel and talk about

his feelings as they have played out in our relationship – whether loneliness, disappointment, fear or sheer terror —has been central.

This process has helped Adam metabolize his speakable and unspeakable traumas. This work supported his relationships outside the room, helping him reach for connection despite his fears and to reckon with disappointment.

Terror in Psychotherapy[22]

Part II

Review of Part I

1. Recent neuroscience has established that our brains react instantaneously and nonconsciously to threat stimuli while our conscious minds lag behind creating an interpretative narrative of "feelings" based on the present perceptual field as well as information received from monitoring our nonconscious processes.

2. Neuroscience has established that we are first and foremost a relational species in that our brains actually form in response to whatever relationships are and are not available in utero and the first year of life.

3. Intersubjective and relational perspectives in psychotherapy hold that whatever is important in human mental life is established within and continuously co-created in interaction with others throughout our lifespan.

The intersubjective fields we form with others constitutes a special culture often called “the third” of the relationship.

4. The Relational Listening approach defines a dimension of relatedness complexity from our simplest relatedness potentials to our most complex relatedness potentials. The assumption is that we all experienced relational challenges at all level of relatedness complexity development. And that our responses to these challenges remain as relational templates to guide our later experiences.

5. At each “level” of relatedness complexity we can define universal accompanying relatedness fears related to personality and character development.

6. We concluded Part I by considering the nature of terror and its relation to the psychodynamics of suicide, homicide, mass murder, and serial killing.

In psychotherapy and psychoanalysis we openly invite people to remember through relating. Thus we expect an array of developmentally based fears to arise in the course of the intimate therapeutic relationship. In fact, it might even be said that the purpose of psychotherapy is to set up an intimate interpersonal situation designed to facilitate the arousal of previously experienced relational fear responses so that their unthinking and automatic qualities can be brought to light, examined, and to a greater or lesser extent, relinquished. But it can equally well be said that the therapeutic activation of "symbiotic" and "organizing" levels of relatedness in the therapeutic relationship will likely elicit disruptiveness and even

terror in transference and countertransference.

That is, as fundamental patterns or templates of early relatedness become stimulated and enacted in the therapeutic relationship, the dissociative defenses will likely collapse leaving the client—and often even the therapist—in a state of relational trauma.

We have all endured a lifetime of traumas, even though we may have ignored or attempted to deny or pass over their emotional impact on us. When most of us consider the kinds of traumas we have experienced and compare them with what victims of genocide, war, plagues, tsunamis, life-threatening diseases, disabling accidents, insurmountable poverty, racial prejudice, or severe childhood abuse have endured, we count ourselves fortunate.

Yet we know that we, too, have suffered greatly in the course of growing up and establishing a good life for ourselves. While we have no desire to cast ourselves into the

role of victims, neither does it help to pretend that we have not had our share of traumatic suffering—the impact of which lingers on to haunt our everyday lives and relationships in many ways.

Psychological and neuropsychological research over the past few decades into severe trauma and post-traumatic experience has fortunately given us many new insights into the nature of trauma and made clear that trauma and post-traumatic experience is not only universal, but necessary for normal and healthy growth! An entirely new paradigm is now emerging for our understanding of the universality and the normality of traumatic and post-traumatic experience. Thus the formerly pathological Post-Traumatic Stress Disorder

(PTSD) is now being referred to simply as Post-Traumatic Experience (PTE). We now understand there is a continuum of traumatic and post-traumatic experience—from ordinary and developmentally normal and expectable traumas and cumulative strain traumas to highly impactful extreme forms of focal and intrusive traumas.[23] Traumatic experiences can enhance our development by providing seemingly insurmountable challenges which we can find creative ways of meeting or they can devastate us at any stage of life. But the relational traumas that occur in early life are particularly devious in that they lay a faulty foundation for later growth experiences. But —whether earlier or later, whether mild, moderate, severe, focal or cumulative—the

essential nature of trauma in human life remains the same, and the universal after-effects are by now well-known and predictable.

Some Historical Notes

Sigmund Freud's seminal discovery was that, given a favorable relational situation, a person could gain access—through interpersonal mirroring processes—to the ways that her internal world of experience had become structured and to the ways that she could free herself from her developmentally structured bondage. While "trauma" has been defined and redefined many times according to different points of view, the bottom-line definition always goes back to Freud who spoke of the traumatic situation as a moment when the person's ego (sense of "I") is so overwhelmed by intrusive stimulation (passive or active) that it cannot comfortably or effectively process

what is happening at the time (Freud 1933). The overwhelmed (over- or understimulated) ego/self here is understood as the fetus', neonate's, infant's, child's, or adult's personally constructed habits of being that, due to internal or external stimulation, are strained, stretched, or collapsed to the point that some accommodative defensive response is required to shore up an otherwise helplessly disintegrating self in the throes of confusion, panic and terror. Over time what has slowly emerged is the central role of trauma in structuring each person's internal world of subjective experience. The foundational aspects of all mental development are essentially molded by traumatic experience! Freud understood

that it was the social nature of our species, and the gift of being able to pass socially-derived learning down the generations through the cultivation of emotionally-derived symbols and culture, that constituted the genius of our species. The socialization processes necessary for the mind of a child to enter the complexities of human culture necessarily requires learning, relearning, and reformatting and then learning again. This relentlessly required relearning and reformatting process is demanded by internal and external intrusions into the way the child and later the adult has structured her inner subjective world of experience at that point in time. A creative response on her part—using whatever resources she might have

available at the moment—aims at responding to that intrusion either by smoothly assimilating the new information, or by traumatically accommodating the demands of the intrusion by re-arranging the established patterns of her internal world. Thus, assimilation of and accommodation to novel and habitually overstimulating experiences are understood to be universal and normal developmental processes. Assimilation does not require a traumatic repair or reconstruction process but accommodation does.

Freud aimed his curiosity not so much toward the internal or external cause of the intrusion—the traumatic event itself—but toward the way the person's unconscious mind responded to or internally re-

organized a pattern of reparative, re-orienting responses. The relational patterns thus built might be developmentally enhancing or seriously inhibiting. Freud was the first to realize that *from a therapeutic standpoint* the intrusive event itself was not so important as the way the person experienced and internally organized the effects of that event. *Freud's focus as a therapist in creating a healing relational atmosphere needed to be not on the blow or the symptoms per se, but rather on the traumatic response—that is, on unraveling the complex web of personal internalized meanings generated by the intrusion.* Contemporary Interpersonal/Relational Psychotherapy continues in this essentially Freudian tradition of privileging personal

meanings over the facts of the traumatic event—arguably the most important therapeutic insight of Freud's life.

Conclusions

Only a century after Freud's pioneering work in trauma have we come to see the human imperative of the interpersonal or intersubjective field—that is, that the life of a human being is at all times immersed in a field of social (interpersonal) or intersubjective relations. And therefore, that all intrusions into individual psychic life requiring accommodation, whether extreme or more developmentally ordinary, impact the development of the individual human body and mind and must, therefore, be understood as traumatic and taken into account in therapy We can now appreciate

that “upper level” relational patterns can be understood through verbal and symbolic interpretation. But “lower level” relational patterns are pre-verbal and pre-symbolic so they must be understood by being enacted, replicated and understood within the therapeutic relationship..

As psychotherapists, every day we witness the distressing and disabling effects of life’s many traumas. As therapy progresses so that people have enough trust to bring to us—to enact with us—the terrifying relational traumas of their preverbal “organizing” and “symbiotic” periods of relational development, we ourselves become snared into their relational lives so that often enough our own dissociative defenses momentarily break

down. It is at these trying, anxious, and often terrifying moments in the countertransference that we must rely on support and consultation from our colleagues to help us safely through.

Case Studies: Terror in Psychotherapy

What follows now are a series of abridged vignettes bravely reported by practicing therapists describing moments in which their relational involvements with clients broke through their own dissociative defenses in the service of holding tight through enactments in the intersubjective field. These stories aptly illustrate the importance of seeking consultation in moments of countertransference agony and uncertainty.

In Search of the Intolerable by Gayle Trenberth[24]

"DON'T GO."

I was watching her eyes lose focus, shifting to the left and rolling up, her body tensing in an arch, one hand closing in a fist, the other pressing hard against her leg. My words startled her, her eyes darting to meet mine. I saw the longing in her eyes, and my body began to stiffen, my eyes began to close, my chest became tight, breathing shallowly. In a choked, panicked voice, she said, “Don’t go!”

This exchange occurred seven years into the therapeutic relationship. We were exploring the powerful effect of *trying* to stay in contact with one another. I could feel her terror as she made contact with my eyes. Resonating to that terror, I began to shut down my connecting senses: my eyes, my skin, limiting the common air we shared by

breathing shallowly. At this point in our relationship, she could express her longing for me to stay in the connection, but even as her words brought me back, she could not tolerate the contact, and broke it by shifting her eyes, and tensing her body. Carla's intense longing for contact, and her intense fear of it, became the core work of twelve years of psychotherapy.

I first heard about Carla when my office partner asked to have a short consultation with me. He revealed that he was treating a woman who had apparently developed a crush on me after seeing me in the waiting room. I was surprised to learn she was obsessed with me to the point of following me home. My colleague felt overwhelmed by Carla's stalking behavior, and brought up

the possibility of referring her to me. His thought was that her obsession with me might ease if she had contact with me. He reassured me that while she had developed these obsessions with women before, she had no history of violence.

As Carla came to her first session with me, she was excited and frightened about seeing me. As she told me about her issues and her belief that I could help her, I was aware of the longing in eyes that would not look at me, and of an overall extreme tension in her body. I was also aware of a repellent smell she had. She was a heavy smoker, and the smell permeated her skin. While she was confessing to following me home, speaking her obsession that I had some magic that could save her, I

simultaneously felt warded off, told by her body to stay away. She wanted to see me twice a week, as she felt she could not tolerate the time between sessions spaced a week apart. I felt a curious dread as I agreed to the schedule. Here was a woman who had stalked me, who seemingly had a crush on me. And in the first session, I felt repelled by her. I had fantasies of being engulfed by a sucking infant's mouth, whose smell made me nauseous. I questioned whether I could work with her while feeling so repelled, yet I was touched by what seemed like her need to find some meaning to her existence. Later, I was to discover that her need was to create enough of a "psychic skin" to be able to tolerate the contact with another she so

longed for, yet intensely feared would destroy her.

Esther Bick, a British psychoanalyst, first coined the term *psychic skin* in her 1968 paper, "The Experience of the Skin in Early Object-Relations." After observing infant development, she theorized that on a sensory level it was the mother-baby interaction that begins to bind together the experiences of parts of the nascent self and develops the primitive ego. The application of experiences of a physically and emotionally "holding" and mentally "containing" other to the surface of the infant's body allows the baby to move toward integration into a cohesive sense of self. Bick describes this as developing a psychic skin, a containing function that is

introjected from the external object. The external object *is* experiences of continuous interaction stimulating the sensory organs of the infant—particularly the skin—which, once introjected, creates a sense of containment. This containment allows the concept of a space within the self, and the development of a boundary between self and other.

Bick, along with Frances Tustin (1990,1991), and D. W. Winnicott (1960), assumes that psychic unintegration at the point of birth is a natural state of being, and that this state only becomes alarming to the infant if the holding and containing other is over- or understimulating. In the absence of a containing presence, there will be a breakdown of the continuity of sensory

dominated experience, and the infant will experience unbearable terrors of falling or spilling away forever (Tustin), or fear of going to pieces, falling forever, having no relationship to the body, having no orientation in space (Winnicott). To defend against such unbearable terrors, the very young infant may develop a *second-skin* formation (Bick 1968), a pseudo-independence, through which the infant attempts to hold him or herself together. This archaic defense is often manifested somatically as disturbances related to the skin, or to the experience of the skin, such as skin rashes or numbing of areas of the skin. In the adult, second skin formation can manifest either somatically or in preoccupation with bodily sensations and

symptoms. This can extend to compulsive behaviors such as eating and masturbation. These psychosomatic symptoms, preoccupations, and behaviors are attempts to create heightened experiences of a sensory surface in order to ward off feelings of loss of sensory cohesion, so that existence can be felt without the terror of falling or spilling into space, or going to pieces.

Hedges (1983, 1994a,c) has described the drive toward sensory and psychic cohesion as the *organizing level* of development. It is the infant's task to use all sensorimotor modalities to establish channels to the human nurturing environment, the interaction of which organizes the rudimentary sense of "I-ness." When there is an interruption of the

organization of channelings through over- or understimulation, there is a momentary disruption of the infant's internal harmony and continuity. The infant has a sense of disorganization that to it seems like breakdown, emptiness, or death, and experiences terror. All adults have had in their infantile pasts these moments at the organizing level of development, and to a greater or lesser extent, have needed to find ways to defend against the catastrophic anxiety of loss of cohesion.

In the consulting room, when working at the organizing level, the patient experiences a yearning for contact, but at the very moment of contact the transference memory of the over- or understimulating other appears, the fragile sense of self loses

cohesion, and there is an experience of terror.

The patient may break the potential for contact through splitting, obsessing, tangential affect or thought, somatic reactions or preoccupations, negativity, passivity, withdrawal, or more psychotic manifestations, such as delusions or hallucinations. Any defense can stop the threat that relationship presents to the fragile sense of "going-on-being" (Winnicott 1949).

In a recent session with Carla, she described this dilemma between the intense longing for contact, and the threat it represents to the vulnerable sense of self-cohesion. She was talking about her longing

to be wanted by a group of friends, yet observed herself “flitting” from one person to another so they could “never pin her down.” She then said, “I’m flitting with you right now.” I acknowledged that, and told her my reaction was to wander in my thoughts, to then come back to working on connecting with her, then wander again, and it felt exhausting. She commented that she wanted me to work hard to “get” her, then she would feel wanted

Case Study

Carla, a 43-year-old single woman, was in treatment for issues involving religious commitment, her attraction to a woman, and a sense of meaninglessness about her life. She lived alone, had never had a primary relationship, and had never had

sex. She was confused about her sexual orientation, and her gender identity. She had a muscular, boyish body, a masculine face, and wore her hair very short. Except for her breasts, which she hid in large shirts, one might have thought she was a man. Later, she revealed that she felt she should have been a man, and in regressed states, would feel she had a penis, or had lost the penis she had when she was born.

Carla was one of six children. She had a brother a year and a half older, and a brother one year younger. Eight years after the birth of her younger brother, her parents had the first of the next three daughters. Carla wanted to be like her brothers, going on boyish adventures and playing sports, but felt shunned because she was a girl. She

felt forgotten between the demands of her older brother, and the needs of her younger brother. She was sent to a Catholic boarding school in the seventh grade with the explanation that if she stayed home she would end up caring for her baby sisters. Her experience was that she had been replaced by cute baby girls and sent away. She felt ugly, short, and masculine. That first year in Catholic school, she developed a crush on one of the nuns, a pattern that was repeated over her years of schooling. She had no high school experiences with boys, and only superficial friendships. In college, she decided to be a nun and spent six years in a convent, but on the day of her final vows confessed to daily compulsive masturbation and was asked to wait on the

vows until she could stop. Disheartened, she dropped out and came to California, becoming a teacher in Catholic school settings for the next seventeen years.

Carla's recollection of her childhood was scant, and communicated mainly through impressions. Her mother seemed too busy for Carla's needs, her father, distant and critical. The overall impression was of a child surrounded by potential connections that were never made. Carla began seeing me as I was completing my training as a bioenergetic analyst and beginning training in psychoanalysis, and I brought both modalities to her treatment. Bioenergetics is the study of human personality in terms of the energetic processes of the body. The body's available energy, and how that

energy becomes constricted or expanded in the musculature is seen as mirroring the psychological defenses the individual created to handle the early childhood environment. In Carla's case, her body was short and compressed, with thick powerful muscles. She had a hunched back, a short, thick neck, flattened buttocks, and overdeveloped calves and quadriceps. Her skin was brownish in tone, yet her heritage was white. All these characteristics seemed an exact description of the masochistic character structure described by Lowen (1975). In his view, the masochist's body is fully charged, but the energetic charge is held back from expression through the overdeveloped, compressed musculature. This body structure mirrors the

psychological inhibition against being independent and self-assertive. As Carla and I began working together, I discovered that while masochistic themes and defenses existed, her musculature was a mirror of even more primitive defenses, those of the second-skin formation described by Bick (1968).

I began bioenergetic therapy with Carla by working on the muscular holding in her neck, assuming she had a masochistic character structure that needed to be decompressed. I asked her to hit a couch with a tennis racket, and as she began, her back and legs cramped. Again, thinking bioenergetically, I assumed this cramping was energy trying to move through chronically tense muscles. I asked her to

breathe through the cramping. She collapsed to the floor, rolled onto her back and began hyperventilating, while her whole body spasmed. Suddenly, it seemed I was looking at a newborn infant in intense distress. I reached out to touch her to provide some containment, and she responded as if she were electrocuted by my touch. Pulling back, I directed her to breathe slowly, and paced her on her exhalation to counter the hyperventilation. She calmed down, opened her eyes, but had no words for this experience.

Wanting to explore the meaning of her experience, we began a series of sessions with her lying on her back. As she attempted to relax and deepen her breathing, her body would begin to cramp and spasm. The

distressed newborn would reappear. Hyperventilating, her eyes closed, face scrunched-up, mouth and jaw alternating between locking and trembling, her arms and legs would flail, threatening to hit me if I did not keep my distance. It seemed she had no awareness of my presence, and often she did not respond to my voice. If I attempted a bioenergetic technique of contacting her head to provide a sense of containment, all the muscles under the surface of her skin would tighten, producing an impenetrable barrier. There were times when she would scream, as if into a void, "just love me!" Then she would startle, jump up, rush into a corner of the office, hands in fists, glaring, "No! Leave me alone!" In all these maneuvers, I felt nonexistent as a

person in the room. I was a painful stimulus or an absence of stimulation. I was often confused, trying to ride out the experience, looking for some moment when I could penetrate the autism.

This time between us was captured in Carla's journal when she wrote:

> You've helped unleash a monster with a thousand arms. All reaching at once a big hungry mouth—kicking legs, pounding, pounding, pounding—more, more, more—stay away from me—just let me reach—don't let me get you. Don't let me touch you. DON'T LET ME TOUCH YOU! I'LL GOBBLE YOU UP. GOBBLE GOBBLE FIST FIGHT—ENERGY—finger tips, toes, feet, genitals crotch/let me in/fuck you—penetrate—be part of you—inside you—warm secure.

I felt tormented by the intense need expressed in her fantasies, journal writing, and stalking behavior, yet the impenetrable autism in the session. At times, I felt sadistic, wanting to use stressful bioenergetic techniques to break that impenetrable barrier, and make me *exist* to her. Exist, be a person in that consulting room, yet I had my own terror that if I existed, I would be engulfed by the needy infant wanting to surround me, be in me. After working in a session to make some sort of contact, I would feel grateful that the session was over, and that little contact had been made. Carla would leave, opening to contact now that the possibility was over, and suffering that none was available. And so we did our dance. Working toward

connection, dreading it, being repelled by it, finding ways to avoid it, yet somehow longing for it. Again, her journal expresses the poignancy of the struggle:

> I'm crazy in love with Gayle. I want to be with her all the time. I want to call but have nothing to say. I came home twice today and my machine light was on. I was hoping there was a call but knew there wasn't because I hadn't asked for one. I was disappointed anyhow. I started to call again but said no. It's like—Let her worry and wonder if I don't call. Let her wonder why. I can't keep telling her I love her. I hate it that it's not reciprocal. I wish she'd tell me she loves me and misses me but I know she never will.

Carla, as she approached the nearly impossible task of trying to find a way to connect with me, would experience intense hunger for me, followed immediately by an

equally intense need to eliminate me. At the moment of potential connection, she would feel herself disintegrating or falling, and eliminating me would restore her fragile sense of being. She could destroy the connection, splitting off into a trance-like state, using intense and painful muscular tension to hold me out, as she held herself together. Her increasing self-stimulation at home was an attempt to create a heightened experience of a sensory surface in order to ward off feelings of loss of sensory cohesion.

At this point in my own training, I was being exposed to analytic formulations that led me to believe I needed to approach Carla's dilemma in a gentler way. I proposed that she come three times per week, but that we use the format of her lying on the couch,

where she did not have to look at me, and where she could "flow" with whatever might come up for her.

She was immediately frightened of falling off the couch. As she would begin to lie down, she had sensations of falling into space that at times would lead to the reappearance of the distressed infant, and at other times would lead to body motions that seemed like a reenactment of birth trauma and falling out of the birth canal. If my chair was too close to the couch, she would panic. She needed to find just the right distance that gave her a sense of my presence without overwhelming her. As these fears subsided, she began to experiment with streams of consciousness, verbalizing anything that came to her mind. If the

content of the verbalization exposed her needs or longings, she would become nauseous or need to go to the bathroom. She began wearing diapers, longing for and fearing the letting go. I again found myself feeling a curious dread. Would she vomit or urinate on my couch? What would I do with these "productions" if it happened? The repelled feeling reappeared. If I happened to touch her in session, I felt a compulsive need to wash my hands, as if some substance emanating from her was sticking to me. It was as though in trying to open a potential way of connecting, I was again being warded off by her body.

Eventually, she calmed, and we had periods of silence, breathing quietly together. She began to look at me from the

sides of her eyes, creating a halo effect where she could see the shape of my head, but not the details of my face. She would occasionally ask that I sit closer, and could tolerate the closeness if she did not look at me. Once in a while, we would touch the tips of our fingers together and she felt comforted, not frightened. The dread and repelled feeling began to leave me, and moments emerged when we had the same thought at the same time, indicating a more symbiotic level of contact was beginning.

As these moments began to build, a surprising event emerged. I began falling asleep! I was not sleepy before or after her session, but struggled to keep myself awake during her session. Hedges (1994a,c) refers to this phenomena as the therapist having

such empathy for the client's terror of contact that, as connection becomes possible, the therapist breaks the relatedness moment.

I shared my reactions with Carla, and suggested we begin to study the ways in which we were both disconnecting at the point of contact. She wanted to sit up and look at me. As we talked and looked at each other, one of us would note when the other was going away. I would watch Carla's eyes lose focus, shifting to the left and rolling up, as her body tensed, and one hand would close into a fist while the other would tap at her head. I would say, "Don't go." Other times, as I felt our connection, my body would begin to stiffen, my eyes would begin to close, my chest would tighten as I

breathed shallowly, and Carla would find some way to say, “Don’t go.” We would examine together the fears around the moment of contact.

In the world outside of the therapy, Carla had left her job as a teacher and after some searching developed her own retail business selling educational toys and books. She began attending gay bars and found one that became a community for her. She uses these new relationships to study her movement toward connection and disconnection, and brings the results of her studies into the therapy.

Carla recently had a dream where she had an appointment with a priest and with me at nearly the same time. She tried to

cancel the appointment with the priest by chasing him down with her bicycle but didn't reach him in time. Then she tried to get to my office but got lost in a construction site. She nearly had an accident but a construction worker helped her avoid it, and she ended up under a freeway where kids were everywhere. Now there were three people, Carla, a woman, and a priest. Together, they climbed out of this no-man's land. The woman and the priest got far ahead, and Carla was faced with a bridge with movable planks. She got up the courage and ran, almost falling off, but momentum kept her going across the bridge. She ended the report of the dream by writing, "Now that I think about it, it was Gayle and Father (the priest) who were with me. I missed

both appointments, but somehow we were together walking back. I was planning to go back to the convent to get my gifts."

Summary

Carla began her treatment with me searching for contact, and terrified of finding it. In the first years of the therapy, she existed in session in an autistic state, experiencing intense bodily sensations without any apparent sense that there was another human being in the room. Yet, it was important that I was there, that the room was there. The space was created to hold and contain the sensory experiences Carla was having. When contact threatened to penetrate, her fragile sense of sensory cohesion threatened to spill out into relational space, and she felt she would

shatter or fall forever. She used second-skin formation and intense muscular tension to form a hard surface to hold herself together, and used the pain of muscular spasm to counter the threat of contact with me. Over time, Carla was able to internalize the holding and containing environment enough to create some psychic skin that allowed for a boundary between self and other. There was enough cohesion so that she could begin to experiment with contact with me without the terrible sense of disorganization that occurred in the early years. She could study the way that contact needed to be broken when her anxiety began to be intolerable. Carla developed an ability to move back and forth between connection and disconnection without being

paralyzed by terror, and to use her awareness of her process to re-establish contact when needed. Her lifelong work will be around the terror of connection, but she has developed enough psychic skin to allow some contact to penetrate her internal world. As in the dream, she has attained in real life the courage and momentum to cross the moveable bridge of relatedness and receive her gifts.

Since the writing of this experience, Carla has been able to establish and maintain a relationship with a woman for two years. In the first six months of that relationship, she relived many of the terrors of connecting that she had experienced with me. Understanding them in her mind and

body, she was able to move through her terrors and into relatedness with a significant other. She has begun a one-year termination process with me, feeling she has accomplished what she came to treatment to find: relatedness.

Terrified by Disconnecting Rage by Sean Stewart[25]

Hedges' Introduction

A regular aspect of countertransference in response to organizing transference is the arousal or revival in the therapist of a fragmenting fear that *we* are not being heard, responded to, or being acknowledged as a real and present person in the therapeutic relationship. Our own deepest fears date back to infancy when we reached out hoping or needing to connect to our own

(m)others. And either no one was there or we were somehow painfully rebuffed. When the organizing transference is operating, we therapists find ourselves reaching out, struggling to be responded to, and collapsing or fragmenting in our own sense of despair and/or terror. The following is a transcript of a case conference that had everyone in the room on the edge of their chairs as the client created an episode of full-blown psychotic rage. It is a rare portrayal of two people living together in terror.

Case Study

Sean: Eddie and I are in our eighth year together now. I want to report an amazing encounter we recently had. Eddie and I set up a week when we were going to meet three times instead of our regular two—on Monday, Wednesday,

and Friday—and also have five-minute phone contact every night. The regular contact calls we've been having for some time now give us a sense of connection, even if they're just a couple of minutes. Eddie has seemed to use the calls to help him with creating a frame to bring into our relationship the organizing or psychotic transference.

In his own way Eddie can describe the theory of the organizing transference—he puts it in terms of his reaching out for contact with mother and encountering some type of violent intrusion that breaks the contact, and then the pulling back of the reaching tendril with the resolution to never go there again. Basically, Eddie now understands the sense of violent intrusion he often feels when he is with me as being replicated from much earlier in his life. He now understands experienced intrusions as sometimes very real and at other times as transferred representations of his life's earliest intrusions. Usually the

associations start with something present and take us back in time.

Eddie has come to believe that the violent intrusions started for him before he was born, when his mother's not wanting to be pregnant affected him. She was schizophrenic. He believes that her body was biologically pulling away from his even while he was a fetus.

Larry: Why did you decide now to increase the contact time?

Sean: Because Eddie and I had not been able to get together enough the previous month in our usual twice-a-week way. I thought it was because he was having troubles at the homeless shelter that he now manages. He has a separate apartment from the homeless psychotic people now instead of being housed with them, which is his way of differentiating himself from them concretely. His car was breaking down. There was rain that flooded the streets. He's been having some problems with his teeth so he was going through a

period of a lot of pain. We just weren't able to meet as often as usual. So we had to spend more time on the phone. Phone time is different than being with him. After missing him for so long I found myself saying, "You know we haven't seen each other much lately, Eddie. Your car is working now. Who knows what's going to happen next week? We really need more time together. Let's get it on, come on in." I gently pushed and he was up for it. So we decided on three times weekly for a while. We've done that occasionally, even if things were going fairly well.

Sean (reading from session notes): The first Monday on our new time schedule Eddie comes in feeling very good, with his dentures in.

Mary: That's a sign he's feeling good?

Sean: That's a sign, because his dentures often hurt him and he can't or doesn't wear them. He's looking great! He's very color coordinated. He's well dressed, which is a sign. There's a connection to

social consensus for him by how well things are put together. And he's laughing. He's feeling good. The first thing he notices in that session is Mullon handing me my coffee. (*Note: Sean is in a wheelchair; Mullon is his assistant who helps him start the day.*) Eddie had come in early, and I'm still setting things up. I just let him come in. He doesn't usually talk to Mullon. Mullon's bringing my coffee over to my desk. Eddie's engaging Mullon saying, "Why don't you let me do that?

Larry: If we're going to watch an interesting week develop now, it's important that the kickoff is with Sean noticing that they're relating to the third (i.e. social consensus). And that Eddie's wanting to relate in the triangle. It's a seemingly small piece of business but as a kickoff to a week in which both participants have made a renewal of commitment it may be critical in understanding the events of the rest of the week. The other thing present at this time is budding narcissism, in terms of his dress and

prideful demeanor. Recall how bad his hygiene and dress had been in the past.

Sean: Yes. As a matter of fact he was color coordinated and feeling pretty dapper—quite a feat for someone who has been so socially inept for so many years. When we started, anyone would have seen him as a "burnt-out schizophrenic," a total emotional and social wreck.

Larry: Did he elicit a comment from you?

Sean: (Smiling) Yes. He came in smiling with his glasses on. He knows he looks good. I say, "Eddie you look wonderful today! This is the best I've ever seen you look." I was sincere and I really was thinking that I wouldn't mind having a shirt like that! He was able to take my compliment in and laugh, to tell me "thank you," and to feel good about it. Mullon was still present and was allowed to be a part of the jovial interaction.

Larry: So we have two higher levels of development being activated at the beginning of this week, which you tell us is significant. We have a touch of body narcissism and enjoyment with the selfobject function of feeling good about being admired. And we have an emotional triangulation presumably in response to your invitation to have more committed time together into a psychotic part of him hearing voices.

Sean: The spontaneity and repartee were fun for both of us. By the way, no voices at all this day. He often still hears murmuring of some sort or another. But no murmuring today. He's able to engage me playfully today. I can be angry with him and say, "You can't do that." And Eddie is able to respond, "I can very well do what I want." It feels like this exchange is consolidating for him. Part of his growing sense of consolidation is that he's realizing he's able to take me on a bit—to stay with the conflict and no demon comes in and says, "You're a piece of shit," which used

to happen to him quite frequently. He's getting built up in this moment. So this is the essence of Monday.

Larry: You're characterizing the interaction as a 2-year-old separation movement—that phase mothers call "the terrible twos". We feel aggression, playful opposition in the service of individuation.

Sean: Yes. We are definitely in a separation-type process.

Larry: That's what the fighting is about.

Sean: Yes.

Larry: "I have my own mind."

Sean: Absolutely. That's why I characterized him in the 18- to 24-month-old phase, because in his own way he's separating and individuating.

Larry: So you've got three higher-level functions all operating in this hour—a touch of the oedipal triangulating ambivalence, a touch of the narcissistic search for selfobject recognition, and some separation-individuation material.

Sean: With a previous month of his just being very absent—physically withdrawn, and with everything breaking down in his life. This one worker at the day treatment was saying horrible things about him to his clients, who would come back and tell him. Then he would go tell his boss. It was quite disturbing and he had a hard time separating reality from paranoid delusions.

Cindy: Did he confront that person?

Sean: He's confronted that person. Although this person, I have a feeling is also pretty disturbed. So his engaging the other person is not solving anything. But I did encourage him to confront his boss more. I'm saying, "Eddie, your boss knows you. You've been managing this place for three years. She just got you your own place to live. The owner loves you. If you're going to confront anybody, go confront *them* with the issue....

That's Monday basically. We talked briefly on the phone that night. We

talked briefly again on Tuesday.

Wednesday's session was similar. He's well-dressed, doing good. But I'm noticing that it's not quite as good. Where Monday was a 10, Wednesday was a 7. We're doing the same thing, but I'm also noticing it's in me as well, in the countertransference. I'm not feeling as good about him, about us. We talked again Wednesday night. We had made solid interpersonal contact Monday. And predictably, by Thursday he's breaking down. He's not feeling good, he has headaches. The voices are beginning to speak to him—the murmuring started late Wednesday night. Murmuring meaning audible hallucinations that he can't quite make out. But by Thursday he's hearing the voices again, and he's feeling strange things. There are a couple of problems at the shelter with clients. Things aren't going right in his life. There are many little details that are going sour on him. He's deteriorating in the wake of the great Monday session and a good

Wednesday session—both of which were containing and solid interactions with real personal contact occurring between us.

Larry: So watch out now! Connection has been made and felt.

Sean: Eddie wakes up Friday morning. This is going to be our third session this week. He's noticing early in the morning that there's a police officer patrolling the area where he lives. He had a bad encounter in the early seventies where he had a problem with a cop. It was so bad he actually got a settlement from the city. Eddie is Hispanic so there was not only violence but racial overtones. By Friday morning he's really in a psychotic place. So in his mind the police officer is not merely patrolling the neighborhood (which so far as I can tell he's doing). But the cop is experienced as actually watching Eddie, spying on him, and out to get him. The cop is waiting for an opportunity to attack him—just as he was attacked in the early seventies, and beaten up badly.

By Friday morning his body is in all kinds of hypochondriacal pain. He's hearing the voices saying, "You're a piece of shit, the Man's gonna get you." He's having all kinds of physical problems. He can't put his dentures in because he hurts so much. So he comes in with bare gums. I think that's important because that's a 4-month-old infant quality. And his teeth—his aggressive potential—are removed.

He gets to my office safely. He was all right driving. But he felt that the policeman was following him. He felt that the policeman was talking to other cops, that they were monitoring him with their radios. He's looking in his rear-view mirror feeling very scared. The terror is intensifying the closer he gets to my office ... it's a strange thing as he expresses it. On one level he feels like he's fleeing the cop and at another level he feels like he's coming to some type of even worse terror as he gets near my office and our time together.

He walks in and I'm not doing my best that day either. So the countertransference is exquisitely responsive to the transference psychosis! He's not dressed nearly as spiffy as he has been lately. His hygiene isn't as good. He hasn't showered. He doesn't have his teeth in. He's got his sunglasses on again. On Wednesday he came in and took his sunglasses off, set them on the table, and we laughed together as we reflected back to the days his sunglasses were used to shield him from contact with me. This is always in our minds now. When we think about the old days of his always hiding behind his sunglasses we laugh because it was wonderful working through that. So Friday when he comes in he doesn't take his glasses off, he's feeling paranoid and angry. A bystander might again say, "You have a paranoid schizophrenic in your office right now. He's very unstable and he's probably dangerous." He was so visibly agitated that I was feeling scared. This was only the second time I have ever felt scared with Eddie. As I

talked to him he was breathing heavily and irregularly.

Jeanne: His breathing is important here.

Sean: When your diaphragm is paralyzed it's even more important. I didn't really have to ask him much. I said, "Tell me what's happened." Right away he knows why he's there. He knows he's there to tell me what's happened. So he sits down and he begins to just go off into a tirade about how this police officer, this motherfucker cop, is patrolling him, out to get him, and "God damn it, if he comes near me, God damn it, he's gonna have to draw his gun, 'cause I'm gonna get him." He's saying this with intensity, sunglasses on. He's furious. He starts off talking about the cop, about the situation, but he is talking wildly at me. He's raging at me telling me all this. It's so intense and his controls seem so tenuous that I'm feeling scared.

But Eddie and I have worked long and hard to get to this moment. So I allow

myself to feel scared. It's a way of seeing where he's at. But while I'm feeling frightened by this madman in front of me I also feel strangely very safe. I think, "We've spent a lot of years structuring a safe frame for this to occur in. There are people in the office, secretaries and others whom I can call on in a moment's notice. I've got my phone at hand with 911 buttons I can hit. So right now I'm safe, just like he knows he's safe here. And what I'm doing is I'm allowing him to go into it. I say, "I want you to be able to feel my presence." And I just let him go. He heard me. He's gummy like an infant because of his teeth. The voices in his head are very loud for him. He is convinced at this moment that these are demons and that they're outside of him, screaming at him. He's talking about this cop, his face is grimacing—almost as if to say, "Let yourself experience me." It almost looks like his face moves closer to me. All of a sudden the full-blown rage is directed right at me. Like I'm the motherfucker cop. He's calling

the cop a motherfucker, but he's shouting and glaring at me. It's as though he's shouting at another invisible person by talking to me. I feel the emotional force of it directed fully at me. I'm feeling as scared as I've ever felt. This is intense. I'm letting myself feel scared. Deep terror is a strange thing—it vibrates through your entire body. But another part of me is saying, "I don't care what anybody says, I know I'm safe. I know this man is not going to get up and hit me, or do any damage to my furniture, and he knows it too." He's allowing himself to be in a very scared place—a feeling that he reported later on when we processed this session.

During his tirade it slipped out that he had forgotten to take his antipsychotic medication today. This is important because forgetting for Eddie now functions very differently than it did for him in his first year. Now there is "purpose" in his forgetting. He doesn't simply "forget" or lose track of things any more. I realize he is unconsciously

saying, “We’ve made a frame where we can experience my psychosis together. I can hang onto Sean while I’m feeling quite crazy. The medication is going to get in the way of my having the experience I need to have so I’m not going to take it.” I think unconsciously that’s how he thought about it. Maybe even consciously. I also thought, “We need to just experience this now. Later on I’ll give interpretations.”

Cindy: I’m really impressed. This is very helpful to me to see how present you are with yourself, and how present you are with him as this fear surfaces. I know you’ve worked hard to get to this place.

Sean: That’s a welcome comment because I know you’ve followed this work with Eddie for a long time. I’ve struggled for years trying to stay present during our sessions, not to be bored or irritated, not to daydream. I’ve struggled to get him to be present, not to wander off in his delusions or little green men. It’s a function of our work together to be able to stay present with each other. We

don't daydream any more. And I'm certainly not daydreaming in this session!

(Group laughter)

Sean: I feel good that I've developed the ability to stay present and to focus this psychotic transference onto me, in what I believe is a contained way. When I heard he had "forgotten" to take his medication,' which he never does, I knew for sure we were where we needed to be. But I will admit, even though I feel I'm safe, I'm using my countertransference to assess his fear. It seems you can't deal with this level of transference terror without really feeling on the edge of danger. Terror is an experience you can only know, not intellectualize about.

Larry: I'm hearing you say there are two things going on in the room simultaneously. On the one hand, you know and it also seems like Eddie knows that there's a frame or a "setup" that you've both spent a long time working on so that a

certain quality of interpersonal experience can occur. You both feel the setup is essentially safe. But the experience that needs to occur within that frame is of a frightening, terrifying, or dangerous nature. So both of you are allowing it. He didn't take his medication. And as you're feeling closer and more scared, he's allowing himself to move toward being more out of control. You're feeling the fear he's lived with since infancy with his raging psychotic mother. But neither of you goes into a panic. You both know this situation must be lived out. You've both certainly rehearsed it many times together in miniature forms before you now actually try to live it out together so vividly.

Sean: Yes. And as he gets out-of-control…his out-of-control is being *carefully focused* on me. So there is a control in his "out-of-control" and both are directed at me. That's the *interesting* paradox here; he's in charge of this out-of-control experience. He *wants* and intends to get

me to be with him, to know, to share in his lifelong terrifying experiences. He needs to know that I know, to see that I see him and that I know him!

Larry: Right. It takes a long time to reach such a mutual understanding, a consensus, such a delicate balance in the working alliance.

Sean: It's not merely directed out to the universe. Most psychotic episodes are diffuse, chaotic, fragmented, and basically undirected or uncontrolled. This is an intense and interactional communication and both of us are feeling our parts.

Larry: Exactly. This is so very important to understand in order to be able to assess your and his safety.

Sean: We were living in a controlled "out-of-control."

Larry: There's no question he's in the room with you, that he intends for you to share his experience, to feel his demons talking to you. He knows he's scaring

you and that you must *feel* this to understand him, and for him to come to understand this part of himself.

Sean: That's what I've gotten so much of from being this group. An understanding of how we can follow these primitive states.

Gary: So Eddie's now able to bring all the paranoia into the session.

Larry: You've finally got the psychotic transference active in the here and now and you judge that its expression is safe. At the level of the intended communication the reality testing is functioning. But at the level of the interpersonal contact he has lost the reality testing function.

Sean: The paranoia isn't about the little green men he used to literally see on the wall. Now the little green man is coming out of my mouth and my eyes. It starts off in a diffuse way with his talking about the cop, but as we hone in on it we focus on

me and I'm allowing it. Feeling the fear, assessing the safety…

Larry: It's *"You're* a motherfucker, and *you're* out to get me."

Sean: Right. There's something to say about feeling on the edge here. Because if he ever did haul off and hit me I'm sure he would be surprised. I know I would be.

Larry: There's always a sense when exploring psychotic anxiety that you're on the edge. This is why Kohut [1984], when talking about this, basically said he didn't know why anybody would want to revive this primitive and chaotic pre-self experience for analysis. He believed that in principle this work could be done. But he knew he couldn't personally do it —the tools were not available then. But he knew the strain it would have to be on both patient and therapist and he wondered why anyone would be willing to put themselves through it. Eddie is, of course, the reason.

Sean: My sense is that during this session my ego is split in two. One part knows I'm safe and with the other part I'm letting myself feel the fear of this man. The split allows me to assess and to hypothesize about the nature of the psychotic transference arising from an early developmental experience. The experience to be remembered cannot be recalled directly but has to be enacted by allowing this type of emotional reliving.

Because of the strength of our relationship, if this man were really on the edge and we were to fall off the edge because I've misjudged, I believe he would protect me and hit the lamp and not me. That's him protecting me. I would also be more afraid if there was a history of violence.

Larry: This therapeutic relationship has taken eight years to develop. Sean has been saying in many ways "Let me be your psychotic mother, let's have an experience here between you and me. I know you're afraid of it. And perhaps I

will be afraid too. But let's see how much of the early experience that has damaged you so much can be remembered by our living it out together." Eddie has done everything possible not to be present during a month when his psychotic core has been realistically activated. But finally Sean says to him "Get yourself in here, we're going to really look at this now." And so we start off with a high-level triangle. We see the narcissistic urge for respect. We see the terrible two's—the growing independence of separation-individuation. And it's all directed at his therapist. It's all carefully structured. The dare is on, the ego nets are in place. So now we're going to drop into the psychotic place. And, as we see, it's structured too. Winnicott understood the structured qualities of the psychotic transference when he made his patients "line up" and take turns to experience therapeutic regressions with him. He knew they could wait and he knew the regression they needed to experience could begin on cue! He also knew that

he could only handle working through one psychotic transference at a time!

Larry: We have to trust the structuring effect of having worked for many years on the organizing transference so that Eddie can finally and safely direct his primitive rage at Sean in full force. And he's doing it right after this very nice set of connections for the week has been made. Which is exactly what we would predict—a terrified response to real interpersonal contact. Then, on cue, "You're trying to damage me, you're out to get me." And, "If you get near me you're going to have to use your gun." So *within the context of the transference development,* it's, a highly structured response.

Larry: But, the ongoing and careful assessment of safety is critical. I have often enough seen therapists in denial who foolishly believed that "this person would never hurt me." We have numerous records of therapists who were not careful and who have been badly hurt and even killed. But Sean does not seem to be in

denial here. They are both afraid but they are both engaged in working to know and understand the fear. Our anxiety for their safety is appropriate. But we have to trust these two and their process together.

Sean: There's been a lot of thought in preparation for having a moment like this. This is not our first month or year together "Well, let's give it a try," you know. When we finally drop into the organizing level it does start off slowly as we both get ready.

We become attuned to each other over time as Eddie waits for me to get ready for this. As I become more prepared, he begins to focus in on me. And now suddenly—but not really so suddenly at all—I'm being called a motherfucker. I'm being called a bastard. I haven't asked him to take off his sunglasses because I'm too scared. I'm feeling very frightened. I'm backing up in my wheelchair. He's leaning forward. He's in a very tense stance. All kinds of things are happening—go down the list

of what a paranoid schizophrenic is for a diagnostic litany, and they're all there.

Now the real question is, how long am I going to be able to tolerate this. (*Group laughter*) I'm giving him ego support that says, "You need to experience this … this has to be focused on me. We need to keep this going and contained. You have to be experiencing and assessing—we'll be processing this later. Part of you must also be noticing how you're experiencing me." So now Eddie's ready and he's really giving it to me. But it's rough on me and the question is how long I can take it. Now my own primitive psychotic part is being provoked internally, which I won't go into now because that's for my own therapy. (*Group laughs*) But in a moment like this I have to deal with my own internal psychotic mother abandoning and raging at me. I become frightened, in some sense immobilized by terror, and I want to back off or flee.

Larry: Because at this moment you're afraid you can't reach him like you once

couldn't reach her?

Sean: Right. And everything else that connects or fails to connect gets replicated. I let him run on intensely for at least a half hour with the thought, "It's just Eddie, you're safe." I'm wanting to get more information out of our experience. It's getting more intense. As he's sitting forward in the chair it's escalating. I have to back up. At that point it's more than that the voices are louder. Demons are now everywhere around us. And the demons are coming from me. I'm becoming a demon for him and he's raging at me. Finally, I'm too scared, too overwhelmed.

And here's where I know that I'm safe. I finally say, "Eddie, you've got to calm down. You've got to stop now." And he instantly went from looking like this to looking like this (*demonstrates threatening to contrite*).

Gary: You touched him?

Sean: No. I didn't touch him. I simply told him, "Eddie, I'm too scared now. I've had enough of your psychotic mother. We have to stop now." And when I told him to do that he instantly shut it off. But there was an immediate sense of depletion. It's like he has some kind of container for his psychotic mother in his body. He released her to fill his body, to fill the room, and to be directed at me. Then when I asked him to stop he pulled it all back in—let it all go back into that depressed and depleted container. Then he's exhausted, spent, and empty. And so am I.

I notice myself thinking, "Whew! I really am in control here, thank you God!" (*Group expressions of relief*) That's evidence that I am. And now I'm asking Eddie to relax. I'm asking myself to relax. "Why don't we just be quiet for a moment and just be together. This has been intense for both of us." This is toward the end of the session. I give him very little in this depleted place ... I'm saying it more for myself. I say, "Eddie

we've had some really meaningful personal contact this week that provoked something very intense in you. This is what happens when we get this close and we have this much good time together. We're going to spend some time looking at this. How should we end?" He wants to pray. And that's something we've done before. He just reaches out and holds my hand. This is interpretive touch, in that this is concrete touch that fills him back up, that he has learned allows him to stay present for a while longer. He regains vitality through my containment, our touch, and our silent prayer together. I'm feeling relieved. We can touch and we can have a true connection that he isn't terrified of. The silent interpretation is that we can weather this and be together. Now he's able to pray to Jesus and not be pulled into a psychotic dimension. The session ends not quite as nonpsychotic as I'd like it to be, but enough for now. I say, "We're going to have to be talking on the phone this weekend. I want you to go home

and take a Trilafon. I want you to go home and listen to your music. I want you to take care of business and do only what feels good." Then we say goodbye and he leaves. So this was our week.

Larry: We only have a few minutes remaining. Do you have a summary or a follow-up?

Sean: We had set up an experience of the psychotic transference that we were able to analyze in the following two meetings in a phenomenal way. That's about all I can say right now. I would love to say how the analysis of that transference has brought him into better ego function, created more ego space, and brought us closer together via more connection with others in his life. Everything about Eddie is vastly more functional than when we began. His teeth are back in now, he's feeling better than ever, and he's physiologically much better. It's clear we reached a core experience.

Jeanne: Can I ask you a question? Did he come back and apologize for what he said to

you or for screaming at you?

Sean: What's there to apologize for? No, he didn't apologize, because I had invited the expression and he gave it to me.

Larry: We both knew that this was what we've been trying to do. So there's no reason to apologize. They both knew the experience was transference expression and not real.

Jeanne: Does he acknowledge that "I did it," or "We did it?"

Sean: Yes.

Larry: It's not that he did anything to Sean. It's that "We did something together."

Jeanne: That's acknowledged by him?

Sean: Right. I'm being used. He's using me for transference experiencing.

Larry: Your experience is very moving to hear about, Sean.

Sean: I'm very excited. As I think about the next two sessions that followed and how

we analyzed the transference, Eddie said many important things to me about his past, his mother, and the demons. He was alert, thinking, and intact. He could have been here with us today dressed normally, feeling like us, and being able to read in the book about how he appeared on his first session eight years ago. This is not to say that if something were to hit him broadside tomorrow he wouldn't regress. Nor is it to say that our transference experiencing is over. I don't know about these. But I do know we finally got to a place in his infancy where he experienced monstrous terror and rage. Some of what he expressed was an infant raging at his mother for coming too close, for traumatically intruding. Some of it seemed to be identification with the aggressor—his raging at me and frightening me the way his psychotic mother did him. He needed to relate his infant needs to her, but she found them intolerable and tried to frighten him away by raging intrusiveness. He knows that I have a

personal need to relate to him and he must attempt to frighten me away. I feel good about our work.

Group: Good! You should! Congratulations! Great work! Thank you for sharing this. It's been very insightful.

Hedges' Comments

I want at this point, to take the opportunity to comment on an essential aspect of psychoanalytically oriented psychotherapy—the "as if' quality, or the mutually agreed upon game that speaker and listener engage in for a therapeutic or analytic purpose. This aspect of therapeutic processing is distinctly different from any realistic "holding," "containing," and/or "re-parenting" aspects of the therapeutic relationship.

I and many others have attempted to distinguish re-parenting, ego-building, and *constructive* "educational" relationship-building processes that sometimes go on in psychotherapy, from the more crucial dismantling, taking apart, destructive, "analytic" processes that have always essentially characterized psychoanalysis but are sometimes difficult to conceptualize apart from the ego enhancement or psychological growth aspects of therapy.

The "as if" or game quality of the psychoanalytic encounter necessarily persists in the analysis of structures built at all levels, although the encounter seems more "realistic" when working on developmentally earlier levels where the issues are farther removed from

symbolization. That is, at all developmental levels of psychic structure brought for analysis, two people engage in a real relationship for a purpose—the purpose of bringing into the relationship for both to see and to know about, long-standing emotional relatedness habits and patterns so that they can be known, talked about, and lived with together. And in the process of living and talking, they are giving a new symbolic place and perspective in both peoples' lives—the very meaning of "consciousness."

While this process of bringing forth from the "unthought known" (Bollas 1987) or putting words and symbols on heretofore unrepresented, unreflected, and unsymbolized psychological habits may require different kinds of techniques for

different developmental levels in differently structured people, the aims of the psychoanalytic process remains the same. The subject of *Strategic Emotional Involvement* (Hedges 1996) is the contrast of different developmental structures and their differential accessibility through various kinds of emotional strategies that serve to bring transference and countertransference material into the known of the here-and-now therapeutic setting and relationship. Through representation and symbolization of heretofore unavailable, unknown, and unconscious psychological habits or psychic structures in the therapeutic relationship, both participants develop more *flexibility* in

their ways of knowing about, processing, and participating in relationships.

In Sean's intense encounter with Eddie, we can see how long it took to build safety in the relationship and how many years it took for the two to develop a language and a style of experiencing and talking about the deepest transference aspects of their relationship. At the moment of the encounter Sean tells us that he is clearly experiencing an ego split, that there is a part of him committed to experiencing the fear that Eddie has come today to show him. And there is a part of him that is observing, reviewing the safety nets, remembering their purposes, chuckling to himself when he finds that Eddie has "forgotten" to take his meds today, and conversing with his

supervision group in his head, being sure that everything is in order and reassuring himself that this is a "focused, intentional, and controlled out-of-control" experience. For Eddie's part, he checks out the relationship on Monday and Wednesday to be sure everything is in place between himself and Sean. Then Wednesday night and Thursday he allows the regression to develop and cues Sean in over the telephone, so that by Friday morning Eddie is flying on the wings of his lifelong persecutory madness. The two meet in an emotionally intense encounter, Eddie using his sunglasses as a device to alert them both to the break in realistic contact that this episode entails. He even slips Sean the information that he is winging it today

without his anti-psychotic meds. The in-your-face rage that has tormented Eddie a lifetime and from which he has been forced by the world to retreat is now to be given full reign and they both know it and live it fully for thirty minutes. Finally Sean says he can't take it anymore, asks Eddie to stop, and Eddie collapses, totally depleted, the message from the depths of his soul at last fully expressed, fully heard and responded to.

There are many ways to understand such an intense interaction, but I am at this moment most fascinated by the "as if" quality, the analytic game of discovery and how these two play it. We see in the follow-up the memories that emerge and the new representations that develop between Sean

and Eddie with the later expectable relief on both sides, and notably better functioning for Eddie—and for Sean as well. We cannot fail to be transformed by such deeply involving experiences.

The important point Sean's work and these vignettes bring out, is that at the earliest level of making contact with the mothering person, many babies have had to learn to read a complex and traumatizing emotional situation and to warp their physical and mental responsiveness in an attempt to hold on to their perceived sources of survival. Thus, early organizing experiences often take on a quality of coerciveness, manipulativeness, and inauthenticity. How such early warped learning sets up vicious cycles with

caregivers that persist into later relationships to alienate others is the subject of much current psychoanalytic study.

It seems that several important lessons are to be gained from these observations: (1) therapists need to be exquisitely tuned in to countertransference feelings as vital sources of information (Hedges 1992, 1994c, 1996); (2) when working organizing experiences, the connecting/disconnecting dimension must at all times be in the forefront of the analyst's mind so that every detail of relatedness can be scrutinized with this lens; (3) various aversive reactions that analysts often have to organizing states must not be carelessly overlooked, either for their connecting/disconnecting potential or

for their manipulative, coercive/inauthenticity qualities. The wisdom that every baby is born with is how to track, adapt to, and connect with the available essential sources of nurturance, comfort, and survival. When, for whatever reason, there is a deficient or faulty baby-environment meeting, the infant must do whatever she/he can to ensure survival. Being forced to react, to search, to think, to respond before she or he is ready is inevitably traumatic—whether visible at the time or not—and leaves deep organizing scars. It is these scars, like the ones Eddie's schizophrenic mother left him with, that must be brought to light in analysis. Working with these early scars is always a significant strain on the analyst.

Terror in the Dark Pit by Jolyn Davidson[26]

Introduction

Rarely do we have an opportunity to see and feel what lies beneath the archetypal reconstructions of satanic ritual abuse experiences. Davidson skillfully moves us past the memories, the dissociations, and the multiple self-states that serve as resistances to experiencing the here-and-now terrors of emotionally connecting in a personal relationship. Through a careful study of the nonverbal resistances and transferences, what emerges is a clear picture of a variety of kinds of infantile trauma that had found their initial expression in “memories” of cult abuse and incest.

Case Study

Transference and countertransference issues are a central part of therapeutic work, but dealing with the terrifying transference adds another dimension. This dimension taps into the central core fears of both the client and the therapist. As such, the terror that gets evoked in the client can tap into the therapist's issues as well. This case presents a piece of the therapeutic journey through "the valley of the shadow of death" where these fears are encountered and relived, both by the client, Rachel, and myself, as therapist.

Rachel was born into a large family that was quite poor. Her father died when she was an infant, and her mother remarried. Her mother left all the children except Rachel with foster families and moved with

Rachel and the stepfather to a different state. She appears to have been a passive schizoid person who didn't know how to manage relationships or her life. The stepfather was schizophrenic and had been hospitalized in a state hospital several times. Rachel reported an extensive history of psychological and sexual abuse and neglect by her parents and others.

When Rachel began treatment, she presented with symptoms of depression, panic attacks, and suicidal behavior. She made frantic efforts to avoid what she called abandonment. She was compulsive in several areas, including bulimic behaviors, which had been a pattern for twenty years. Rachel had difficulty managing interpersonal relationships both at home

and at work. She frequently developed enmeshed relationships with people who would ultimately overwhelm her with their intrusiveness or abusiveness. She attended multiple self-help groups and would conscientiously try to act according to everything she heard. She avidly read self-help books.

What she referred to as fears of abandonment seemed more like fears of the loss of attachment to others that she needed in order to keep herself intact but could not make consistent use of. The bingeing appeared to be a frantic effort to take the object in, but then an inability to hold onto the object, and hence the vomiting.

What was it like for Rachel to live in this psychological state created by a schizoid mother and schizophrenic father? Rachael remembers:

> I see faces of witches with hoods over their heads. They look down at me one at a time, then disappear. I am in a deep pit waiting, waiting. It's cold down here and my body is cramped. There isn't room to straighten my legs. I hear them all leave. They are leaving me here in this hole. I'm alone. It's dark and damp and cold. No one knows where I am. They aren't coming back. I can't get out. Please come and get me. I'll be good. Don't leave me here. Where is my mommy? Am I going to die? Get me out of here. Please, please don t leave without me. I'll do whatever you tell me.
>
> I see a fire that's used for light. There is a naked body of a woman stretched out and tied to a log next to the fire. I am taken in front of the group of women

who are circled around the fire. The women are chanting in unison. The leader takes me to the body. With my hands in hers, she picks up a long sharp knife. Together, we lift the knife into the air and thrust it into the neck of the woman. I feel the knife plunge through the flesh. The blood spurts out like a fountain and splatters all over my face and hair. The head falls to the ground. Back into being his little girl. I play with my friends. I go to school. I am good. None of the terror exists, or does it?

At one point, I lost all ability to fight. The life, the energy, the will to survive left me. My self was shattered into tiny fragments that seem to be irretrievable. Another part of me sank into a deep, dark hole from which I can't seem to get out. I think part of me died.

I now believe this to be true: if I try to reach out to connect with others and to get nurturing, I will be violated, damaged, and die. It's not *just* that others will kill me, but that *I* will be

> forced to participate in that destruction. Yet a very real part of me is still alive crying out, 'Hang on to me —don't let me go.' I'll hang on for dear life, too.

At other times, Rachel would describe family dramas of fighting, chaos, and psychological abuse at home that reflected the mode Fraiberg (1982) described as "fight." Rachel would rage at others or endure their rage at her. There were multiple episodes of all the family members arguing and screaming at each other. There were even times when Rachel would angrily chase her teenage daughter, or the daughter, in turn, would attempt to terrorize Rachel. She seemed to be involved in the process *of participating* in "killing" them while at the same time being damaged herself. Her

husband participated in the pattern also, by being verbally abusive to her. When he attacked and criticized her, Rachel would curl up, literally, in a ball of fright in the corner (Fraiberg's freeze response).

It seemed inevitable that Rachel must experience this transference rage with me in therapy, as well. About the fifth month of therapy, she began sending letters to me between sessions expressing her rage at me. In one of these letters, she wrote,

> Today I felt very distant from you. You sat there with your arms folded, crossed, and closed to me. You listened, but you yawned. I can't hang on to you like before. You're really not there. I can't touch you. There might as well be a window of glass between us. I need you at least right now. But when I reach for you, you move away. I can't hang on to your skirt. It's not there anymore.

> You don't feel warm, cuddly, and concerned. You feel cold, indifferent, and analytical. I feel detached from you. The bond is broken. You seemed rather indifferent.

Through the rage directed at me, I began to understand how Rachel lived her entire life behind a metaphoric glass barrier. "I see you, but you're not available to me." The living part of her could not be seen, touched, or found, so that, in the transference, I became the cold, aloof, uncaring, and damaging parent.

During the sixth month of therapy, following one of these incidences of rage at both her family and me, Rachel overdosed on medications and had to be hospitalized. The hospitalization seemed to serve several possible functions. The hospital may have

served as a retreat from the new sense of life she was cultivating in her direct experiences with me in therapy. It was as if she were experiencing a significant connection with me and her family, and it was too much presence for her to manage at home. Or Rachel may have needed to experience her rage and fears in a safe place. Also, it may have been that she found that piece of me that gave her the freedom to realize she was in an abusive home environment and to escape from the family pattern.

Rachel came up with a plan for us to exchange scarves in order for her to have some tangible way to hang onto me between sessions. If she could hold onto a scarf of mine, she could remember me. If I were holding onto a scarf of hers, I would

remember her. It was as though, in the "pit," not only did she have difficulty maintaining a sense of others, but she was afraid people didn't know where *she* was—they didn't remember *her*. She talked of her ambivalence about connections. She experienced a need to merge into a caring relationship but was terrified of engulfment. A sense of detachment accompanied these conflicting needs. During this time, Rachel began to talk more of her history of molestation experiences by her siblings and stepfather. She expressed her feeling and belief that they had "damaged the fabric of my person." Rachel would follow these rage episodes *in* sessions with letters sent between sessions stating she wouldn't continue in therapy. She would write,

> I'm not coming back. You're cold and indifferent. You don't really care. It's just a job to you. I feel so afraid that if I let down, if I cry, if I fall apart, you'll just sit there like a bump on a log, analyzing me, figuring me out, but having no feelings, having no emotions. You're just like everyone else. I'm weird. I'm tainted. I can't figure out how to climb out of my hole.

She was re-experiencing with me the feeling of being left in the pit or in the hands of the abusers. She was experiencing me, in the transference, as the detached, observing mother of the molest memories or the cult leader of the witch memories. She believed that I could provide more for her than I was giving during our interactions. She felt helpless to get what she needed from me. She believed I was withholding from her. She stated,

- I'm trying hard to find a connection to someone who understands and who can help me walk through these feelings and experiences that I detach from.
- You *could* be there for me, but you're not. I have my guard up, though. I'm pulling away from intimacy from everyone.
- I spend lots of time sitting on the floor curled up between my bed and dresser, hugging a big stuffed bear. I turn inward and isolate myself as often as possible.
- My guard is up. I'm afraid to feel. I'm afraid to feel an empathetic response from you.

Naturally, I was concerned and perturbed that Rachel continued to read into my behavior a set of responses that I didn't believe I was giving to her or, at least I hoped I wasn't. I wondered if the function of Rachel's experiencing me withholding

and withdrawing was to actually push me away, to actually *create* a sense of ruptured contact or unavailability.

By this time, clearly, some rudimentary forms of connection between Rachel and me had begun. Rachel cried for the first time in therapy. Her voice tone and body language began to become more age-consistent more frequently. We were able to be together and deal with here-and-now issues of her relationships with her family and me more frequently.

It was at this point in treatment, as we were beginning to experience real moments of connection, that the trauma memories started emerging. Her letters written between sessions contained much of the

bizarre abuse content described earlier in the chapter. Her handwriting in the letters was different in each paragraph, suggesting the potential for multiple self-states. Not so surprisingly, as the “memories” would emerge, she began having more frequent episodes of bingeing and purging. She also had more frequent dreams of impending disaster. During this time, when Rachel would experience overwhelming episodes of intrusive “memories” of the satanic ritual abuse, she would panic. She would call me with an “emergency," usually very late at night on a weekend, to tell me the “memory” in graphic detail and for me to calm her.

As much as I was empathic and served to contain her during this period, I found myself feeling pressed-in on with her anger,

demands, and mood swings. During the calls, in some ways, I felt like I was being intruded upon. I experienced the intrusive abuse *myself* by just having to listen to the awful "memories." I didn't want to listen to the horror she recounted. I felt like pushing her away. On one level, part of me was engaged in keeping a connection, but, on another, part of me would detach in order not to be overwhelmed myself so that I could preserve myself and still respond to her.

How tempting it might have been to try to figure out the "meaning" of the abuse memories. But to do so would have been to miss what was happening. As long as Rachel was entrenched in archetypal symbols, she avoided dealing with me. I

understood the resurgence of memories and the dissociative qualities as representations of fears emerging as a result of our growing relatedness. Therefore, I chose to be empathic to the memories and to the dissociated sense of self, but to keep our focus in therapy on relationship issues with her family and with me. In other words, *I understood the emergence of the memories and symptoms as a psychological resistance to Rachel's experiencing her transference terrors more directly with me.* Every time she tried to draw me into a memory story, it was an attempt to flee from a connection with me. Hedges (1994c) describes the character of the resistance at the organizing level: "At the organizing level, the resistance is to dealing with the

psychotic mother transference structure, to dealing with the breaking of contact and the rupture in relating. The breaking of contact guards the door to keeping the person from re-experiencing primitive overwhelming trauma and breakdowns that once occurred when contact was sought and had to be painfully withdrawn from" (p. 192).

About this time, Rachel's images of her connection to me had begun to shift. The images were no longer ones of just hanging on to the hem of my skirt. Now, she fantasized sitting in my lap, and hanging on tight to my arms. She still reported little sense of me responding by holding on to her, however. We scheduled one regular five-minute call between sessions to help her contain her anxiety, which emerged

when she wasn't able to maintain an internal sense of connection to me.

She demanded I make her a cassette tape describing her progress, so she could hear my voice between sessions. And, I hoped, so she could experience my reaching out to her through the tape. She took a picture of me so that she could have it at home to remember me when she couldn't bring up my image mentally. Again, she requested that *I* give her a scarf of my own that she could hold onto as a concrete way to hold on to me, though she reported losing the scarf at times and then feeling depressed.

I felt somewhat uncomfortable with Rachel's requests for "Twelve-Step hugs" and her continued presentation of the little

gifts that she insisted on bringing despite my protests, interpretations, and attempts to stop them. Obviously, her need to relate to me in these forms was very important to her. I was afraid that if I protested too strongly or tried to deflect these actions more actively, it would have disrupted seriously the sense of continuity we had worked so hard to attain. But her insistence and my discomfort also seemed to represent a certain kind of breach in connecting. In the intensification of requests and attempts to draw me closer, she had in fact succeeded in disrupting the connection *in me* by getting me to feel uncomfortable and so backing away slightly. That is, her insistences functioned to disrupt our

emotional contact by unsettling *me* rather than by *her* holding back.

To help me gain more of a sense of how the traumatizing psychotic mother was internalized for Rachel, I tried to imagine what our interactions would look like in the early child interaction between Rachel and her mother. I could picture Rachel's mother as a person who was passive and withdrawn, and who didn't know how to respond to her baby's needs. The mother was either very detached or intrusive. The mother had a "mimical self," *acting* like what she thought mothers were *supposed* to be like. She would go through the motions of mothering. It was as if she were saying, "I don't have anything inside to connect to you with." Other times, she would move intrusively

into the baby's space, demanding that the *baby* respond to the *mother's* needs or to act in a prescribed way. The message to Rachel was, "when I'm in a certain mode, *you're* supposed to give to me." The mother was not in tune with the interpersonal reality of infant and mother. Instead, she was clinging to the baby. Her clinging to the baby was, in a sense, abusive, in that it was not a mutual connection. Rachel persisted in clinging to me for fear she will die.

Hedges (1994c) describes the nature of this fear in detail.

> This means that listening to organizing experiences, there will always be in the background the fear of the loss of the needed other upon whose presence life itself depends. ...What is feared is the threat of death (in a myriad of forms) and experiencing the agonies

> associated with fearing death that lie beyond failed dependence. The fear of breakdown, death, and emptiness resulting from the breakdown of somatopsychic channels to survival sources is an ever-present (and often deeply repressed) memory of any person reliving an organizing state. In early experiences that blocked the path to further organization, the infant experienced an environment devoid of responsiveness. The formation that remains in psychic structure is emptiness, fear of breakdown, and/or the threat of death. [Winnicott 1974, cited in Hedges 1994c, pp. 112-113]

With this picture in my mind, I had no trouble understanding how Rachel could represent this nightmare of infancy through the archetype of satanic ritual abuse and of organized sexual abuse. Also, I then *could empathize more with her symptoms* of vomiting, dissociative states, anxiety, panic,

depression, rage, and with her physical sensations of trembling, difficulty breathing, chest pains, and falling into a dark hole.

Despite my increased understanding and sensitivity to Rachel's internal experience and needs, I was still in a very real dilemma. I wanted to transition Rachel from physical to mental and emotional forms of connecting. I was feeling a need to set some firm boundaries about the hugs and gifts. But *I* knew she would experience this action on my part as rejection and damage, no matter how hard I might try to reassure her that I was not rejecting her, and no matter how hard I might try to frame the boundary in some type of interpretation. In the countertransference, I felt that I was under the threat "to be a good little girl, minding

my p's and q's." If I were to be more "me," I feared she would be angry and leave me, just as her mother had done repeatedly with her.

When I spoke with her about the boundaries, Rachel, in fact, did become tearful, hurt, angry, and depressed as I had anticipated. She wanted to run away. We talked about how she experienced me, at that point, as giving her a message that said she was bad. We discussed how she *believed* she was bad because in her life, she was blamed for having needs. Through interpretation, I tried to clarify the issues. My words were like dust in the wind. The key to the therapeutic intervention at that point was that I had to be very active in

reaching out to Rachel and in trying to maintain a connection.

One day, I talked to her fervently about the fact that both of us needed to hang on at that moment: she must hang on, and I must hang on. We *both* needed to find ways to stay connected. I felt that at some level, she heard me.

Rachel was re-experiencing and re-enacting with me the essence of the early trauma she had experienced with her mother. As painful as this place was, however, Rachel had to re-experience and work through the early trauma of infancy in a *here-and-now* relationship in order for her to develop different modes of relatedness and to move on in her

psychological and emotional development . We had to work continually on finding ways to stay connected during this fragile and vulnerable time.

During the working-through phase, Rachel alternated between feeling a connection to me and feeling rage at me for her being in that 'terrible, traumatic emotional place. As Rachel was going through this distress, she needed to be assisted by the use of antidepressants and antianxiety agents as well. Rachel demonstrated how she experienced the terror on a body level. On one occasion, Rachel had an incident of heart palpitations that caused her to be admitted to the hospital because of her fears of dying from a heart attack. The doctors determined that

she had had a panic attack. We understood the panic as a means to move her away from feeling in her relationship with me and dealing with her anger.

Also, Rachel reported frequent bingeing and purging episodes and focused more on her "eating disorder." A pattern to the episodes emerged: she would experience an emotion, either positive or negative; then she would deny or discount her own feelings or experience others as discounting her; she was then left feeling angry at herself and others; and finally, from the place of anger, she would binge and vomit. It was as though she would take in resources desperately, but not be able to retain them.

At times Rachel expressed her rage at me more directly as well as indirectly. She reported that she was still angry that I had set a limit on the Twelve-Step hugs because they made me feel unsafe, she talked of having an increase in suicidal fantasies. "I have thoughts of putting a hair dryer in the bathtub and calling you over to my house so that you can see my body turn rigid." She wanted me to feel the same guilt, fear, and helplessness that she experienced. We continued to work directly on the anger issues. Concurrently she began clinging to the scarf again.

As time went on, Rachel continued to develop an increased ability to internally maintain a connection with me. She gave back the scarf I had given her, though she

asked me to save it, as she might need it again. She reported not needing the five-minute calls between sessions any longer. Her vomiting behaviors subsided. She lost significant weight. If she had a panic attack and was unable to reach me, she became able to calm herself or to use other resources such as friends to help her. She said she was trying to get out of co-dependent relationships and "always looking for a mother to care for me." She was trying to do more herself. She experienced some anxiety and struggled with this but was able to manage the distress more effectively. Rachel showed an increased ability to problem-solve on her own. She catastrophized less frequently. She began to see her pattern of trying to rescue

as a way of trying to connect. She expressed more experiences of positive connected feelings, strength, energy, and comfort with setting boundaries for herself, and reported feeling much more stable, though she still felt fragile and vulnerable.

We worked on Rachel's allowing herself to feel good and settle into good feelings and relationships without reverting to creating chaos. While preparing this chapter, Rachel and I talked about her terrifying journey out of the "pit," and of all the work she has had to do— the "witches" and "molesters" she has had to face and stand against past and present. At one point she said, "I was thinking about the past several years of going through this. I remember how terrible it has been. But then, I realized you went

through it with me. It must have done something to you, too."

Yes, Rachel, our journey together *has* "done something to me" In order to be with you, to stay with you, and to "hold" you, I have had to face my own fears. In a sense, I had to find my own way of going into the "pit" and into "the bed of abuse" with you in order to try to understand better how terrifying the world has been for you and the rage that you have felt about the trauma you experienced. In doing so, I have had to face my own fears of anger, of engulfment, of abandonment and of being damaged on a deeper level. In learning how to be a safe and reliable container for your overwhelming fears and anger, I have learned more about managing and

dispelling my own. Faith has been described as “the substance of things hoped for, the evidence of things not [yet] seen” (Hebrews 11:1). It is very dark in the “pit.” It is very difficult to “see” through the darkness, to maintain hope, and to believe that there is a way to bring healing to the traumatized parts of our infant selves Our journey together has confirmed and fortified my faith and my belief that there is a way out of the “pit of terror.”

Hedges' Comments

What better example could we ask for of how *not* to become carelessly involved in organizing level content! By not colluding with the content-resistant ploys, Jolyn safely moves her client toward fulfilling relationships.

A Countertransference Collapse by Lawrence Hedges[27]

A year into therapy and following a lively discussion about Paul's parents and some difficult relationships he was having at work, Paul and I began to formulate some important aspects of his Organizing transference.

Paul: As people encounter me, I subtly behave in ways so as to discourage or at least not to encourage the connection. I feel this scary, paranoid distortion and I am unable to bridge it by showing kindness, warmth, or generosity or by being at ease with the other person. In this distortion I feel that they don't like me, or that they want to use me, to abuse me, or to cheat me. I then subtly withdraw. This so clearly comes from my relationship with my mother, Louise.

Larry: I hear you saying that when a person, perhaps even a neutral person, who neither loves nor hates you moves into your life and is giving neutral or perhaps even lukewarm "getting acquainted" responses, your paranoid delusions take over and you feel that they hate you or want you dead—like with Louise.

Paul: And then I am stuck. I can't go across any bridges. My distortion makes me afraid, and so we play a standoff game. I'm scared of them and they of me. Unless that person clearly and affirmatively reaches out we are not sure if we can trust each other. I can't initiate warmth and generosity, no way. The best people can see of me is that I'm withdrawn and scared—even if they see I have an honest intent.

Larry: It's not just that you're shy and afraid?

Paul: No. I'm clearly forbidden to reach out. *It's as though there is a force field from outer space that paralyzes my brain. Injecting terrified anxiety feelings into*

me. An outside force setting up an overriding terror which totally prevents me from sharing intimately, warmly, generously, affectionately, or presenting myself in a positive light. I have to be passive, awaiting their judgments and pronouncements on me, which are bound to be bad. Even if their estimations of me aren't negative at first, I make them bad. I actively make people see me in a bad light. That's the important part—I force people to see me as bad.

Larry: I have the image of two people with neutral or lukewarm feelings toward one another, wanting to get to know each other, and slowly approaching each other as though they are getting ready to do a relationship dance. It's as if there are invisible tendrils of relatedness silently reaching out...

Paul: (*Interrupting*) And I have scissors that snip them off!

Larry: But how is this accomplished?

Paul: I interrupt. I don't let people finish their sentences. I give people the cold shoulder. I make them see me as a miserable wreck. I make them hate me.

Larry: You are telling me that you actually cut off what might become a warm flow between you and someone else of ideas and feelings. You cut off the tendrils of relationship, because of the Louise living inside. You snip off the connections. The Louise you identified with in infancy, who is still living inside of you, has snipped those connections, has forced the relatedness flow to stop. You are saying that you comply with the inner Louise's instructions to destroy the interpersonal links, the potential tendrils of real connection which might allow for friendship and love. Alternatively, you make people somehow feel cut off from you, confused, or lost track of.[28]

Paul has many ways of devaluing himself in personal interactions with his recurring belief that others see him as an ineffective, weak, confused, miserable wreck. The images, the people involved, and the negative qualities vary considerably, but the downward spiral of Paul's line of self-criticism during many sessions invariably drones on in a similar vein ending with the surprise line directed at me—"and you think so too!" The accusation effectively ruptures any sense of connection we have at the time because I feel regularly obligated to address it.

By the time we had spent three years together I had gone through various phases of responding to this challenge regularly thrown at me. In the early phases I would

protest that I had no such view, that in fact I liked him very much, saw him as quite competent, and respected him in every way, and so forth—depending on whatever barrage of self-criticism he had just unleashed and whatever I could honestly state at the moment. But Paul always "had" me in some way or another because he could quickly quote something potentially critical that I had indeed said earlier in the session or on some previous occasion. He would give the line a deadly negative twist to prove that I indeed did think ill of him. That he was right, that it was true that I saw him as a sloppy miserable wretch or/as a ne'er do well too.

At first I would go into momentary confusion at Paul’s seemingly deliberate

misinterpretation of what I had said. Then I learned to confront him and to dispute what he was imputing to me—and then to reaffirm him. But these downward spirals of self-criticism followed by a gauntlet thrown to me continued. At times, I tried to go with whatever negativity might have been implicit in my former comments. Then I would attempt to show Paul that my meaning was essentially positive—but he would remain unconvinced, nonplussed, or skeptical. After a while I got frustrated and tried to point out the double bind Paul put me in on these occasions. At other times I would get angry with Paul insisting that he was deliberately distorting what I had said or done—just to irritate me! Then I would try to show what his motivation might be for

needing to see me as a harsh critic of his at this particular point in time. I tried various ways of exploring meanings, of looking for contextual cues and of attempting to align Paul on the side of studying the interaction —all to little avail. Something critical was not yet understood. Whenever I was indeed impatient or irritated I did my best to cop to it, but mere acknowledgement of my ill feelings toward Paul struck him as superficial and forced. I saw him as a needy wretched creature, hated him, and wanted him dead—that was that.

Eventually I could feel myself squarely in Paul's trap every time he laid it. I simply lapsed into looking at him inquisitively in response, trying to get him to elaborate what had just transpired between us and

why. Paul wasn't uncooperative in these searches for meaning, but he always somehow got back to the refrain that I indeed hated him and that I had said it clearly in so many words, no matter how much I tried to deny it. Of course we tried in vain various transpositions of Louise and of his father, Leonard transference, all of which led up to the following events.

After a particularly social, but frustrating, weekend Paul had the following dream:

> I was going somewhere with Jerry (whose passivity all weekend had messed up a series of plans). Like we were in some European city, maybe Paris, and were supposed to be going to eat at this rather elegant cafe or restaurant. When we arrived we were shown the sideboard where two live

> horses were laid out, sedated with their eyes covered so they couldn't see what was happening. We were handed these knives or meat cleavers and a plate in a nonchalant way. Like what you were supposed to do for your dining pleasure in this elegant bistro was to chop off chunks of meat—live flesh to eat. Like it was supposed to be some sort of delicacy and we were expected to simply go along with it. I recognized the scene as bizarre, as something I simply didn't want to do. I was immediately nervous and began looking around, like maybe there was some vegetarian dish instead! I woke up very upset and began thinking about my relationship with Leonard.

In Paul's associations to the dream he emphasized the element of passivity, that he was simply expected to go along with this horse's ass kind of banquet. He and Leonard are always taking chunks out of each other's

flesh and it's supposed to be okay, the proper and pleasurable way to relate. In the dream the two horses are laid out, sedated, and blindfolded so they won't actually see or feel what is being done to them (the passive position). Paul could see that the underpinning was, of course, the scenarios with Louise in which each had to be the destruction of the other—but both pretended that everything was as it should be. Paul said that he has always felt forced to passively comply with this bizarre and monstrous feasting on flesh that was in vogue in his family.

My interpretations focused in a congratulatory way on Paul's actively deciding to turn away from his life-long pattern of feasting on flesh—this scenario of

mutual cannibalism—to something different, namely to nourishing and healthy vegetables. We processed this dream in a variety of ways for several sessions.

A week later Paul started into another one of his downward spirals of self-criticism. By now well-accustomed to the horror of watching Paul rip himself limb from limb in these tirades, I watched with the fresh image of a flesh-eating banquet in the back of my mind. This time, I saw the gauntlet coming a good three minutes before it landed squarely in front of me. I was lying in wait, in almost open-mouthed amazement, watching Paul's downward spiral of self-effacement with horror, knowing he would soon launch his surprise attack on me. I wish I could remember the

exact content, but I was swimming in the increasing intensity of the moment. Paul suddenly looked up directly at me and said his usual, "and you think so too." But I was ready. I went with it this time. I continued his vicious, destructive banter along the same content he had just provided me with. I told him with full intention and affect that it was true that I hated him, that he was indeed worthless, psychotic, delusional, despicable, a miserable wretch, and so forth. Paul was stunned. But grasping my ploy, he quickly added, "you take your pleasure and amusement from watching me tear myself down and slowly self-destruct."

I immediately fell into a dark pit. In this quick and brief exchange we had deepened the emotional material to a horrifyingly new

low. At some level I knew instantly that his accusation was true, whether I was consciously aware of it or not. Then Paul added, "and you do it so you can feel secure in your superiority." I was truly stunned. I remember thinking, "I have to go here. This is about me. I have to let myself feel all of this." And I did. As the two of us sat in momentary silence I let my body and my mind drop into the experience of taking my pleasure and amusement from watching Paul self-efface and self-destruct in front of my very eyes. I had to actively let myself enjoy his misery and pain so that I could feel secure in my superiority. Sinking rapidly, I got there—and I enjoyed it. I actually allowed a full sense of cannibalistic glee and destructiveness to overcome me. Paul tried

to talk—but I waved him off to shut him up. My mind swam in timeless delight and horror—images of Caesars languishing in decadent delight in the Roman Circus swirled. I saw slaves being slaughtered and eaten alive by lions. I thought of Nero, of Rome Burning, of Hitler, of lines of Jews, the ovens, of Sade, of naked savages chewing on human bones, of children being mercilessly beaten, of psychotics being tortured by mindless gambits of sadistic therapists. Tears welled up in my eyes. My stomach churned in violent upheaval. I stammered trying to speak what I was experiencing—voice quaking, facing the wide-eyed Paul.

I slowly came to myself; "I can't do it! I won't do it! I refuse this God-forsaken

banquet of flesh—show me the vegetables!" We laughed but were both taken aback—shaken by the truth and violence of the moment and by our mutual willingness to go there. Vegetables were a welcome comic relief.

> "As a child, Paul, you had no choice. You were led to this flesh-eating banquet by the parents that you loved and trusted and then you were expected to partake. It was all that was offered. You had no way of knowing that there was a better way. You were drugged and blinded and told to eat. But I'm not a child. Nor am I passive. This flesh-eating banquet you lead me to is a bizarre horror and I will have nothing to do with it. I will not eat!"

I had to repeat the lines forcefully several times to rescue myself from the dizziness and emotional pull of the

sadomasochistic pit, the swirling horrors, the timeless spinning, and the disgusting nausea of destruction. "I saw it. I felt it. It was terrifyingly real and horrible. I won't go there with you. I absolutely will not!" But, of course, I had in fact already gone there with him.

When Paul was wakened from the dream by his refusal to be passively led into cannibalizing on chunks of flesh, I understood his anxiety as his fear of turning away from the table that has always been laid for him. When Paul tried once again to take me to that bizarre flesh-eating banquet table, I finally grasped at an experiential body level what has been perhaps Paul's deepest truth. Terrified, horrified, I yelled, "horse's ass, I won't go there with you!" Paul

and I were together at last. We both were refusing in our relationship to be passively traumatized by our internalized sadomasochistic parents.

Paul has for a lifetime feared relationships based on the template of a drugged and blinded cannibalistic scenario. He has experienced his emotional relationship with me according to the same pattern of abusive horrors. But until now Paul has been compelled to return repeatedly to being the self-destructing sacrifice for his internal parents' amusement, pleasure, and self-aggrandizement. It was the only way of emotionally relating that Paul had ever learned, the only way of connecting to me that he knew. To connect meant to

experience humiliating, self-abusive, masochistic surrender. For a lifetime intimate emotional relationships had been systematically avoided. To disconnect from all human contact is paramount to withering and dying. I had to experience with Paul the horror of my own deep psychological images and the ways in which I too sadistically cannibalized him—made my livelihood, took my self-satisfaction and security, off of his mutilated living flesh and blood.

We were both sobered by the experience we had created together; the experience that told a truth we had neither before dared to articulate. Paul's deep pattern was yielding at last—and mine as well.

Conclusions

- Trauma studies over the last three decades have made clear that terrifying experiences in early life are universal.

- The degree to which they have disturbed the developing sense of I (the Ego) dictates the extent to which traumatic features become formative in higher personality development.

- In the organizing period of relational development (+ and -4 months from birth) the trauma that transfers into later relationships has to do with the desire to connect versus the terror of connecting.

- The traumatic experiences that occur during the symbiotic period (4 to 18 months) determine the ways in which in later life the person transfers their need

to coerce and manipulate others into satisfying their needs.

- In psychotherapy the relationship dimension invites the reexperiencing of organizing and symbiotic level traumas to be re-experienced in the here and now relationship.

- The extent to which these early developmental and relational traumas can be re-experienced in the therapeutic setting is a function of the ability and willingness of both client and therapist to live through these traumatic moments together. This may include increasing sessions and even setting up five minute contact phone calls every day. The fragmenting aspects of this kind of therapeutic progression may also call for various kinds of psychotropic medication and/or some form of hospitalization—though I recommend against measures other

than increased contact and consultation because of the disruption they cause.

- When experiencing such traumas with a client, it is difficult for any therapist to maintain good boundaries while at the same time extending oneself empathically.

- During these overwhelming times for the therapist it is critical that the therapist secure consultation in order to maintain a steady course through the reexperiencing of the often very disorganizing infantile traumas.

Appendix

Here is an elaboration of the four Listening Perspectives (Hedges 1983, 2005) and the seven associated relational fears (Hedges 2012, 2013). In this book we are primarily interested in the Organizing and Symbiotic experiences.

I. THE ORGANIZING EXPERIENCE:

Infants require certain forms of connection and inter-connection in order to remain psychologically alert and enlivened to themselves and to others. In their early relatedness they are busy "Organizing" physical and mental channels of connection —first to mother's body, later to her mind and to the minds of others—for nurturance,

stimulation, soothing, and evacuation. Framing Organizing patterns for analysis entails studying how two people approach to make connections and then turn away, veer off, rupture, or dissipate the intensity of the connections

1. The Fear of Being Alone: We dread reaching out and finding nobody there to respond to our needs. We fear being ignored, being left alone, and being seen as unimportant. We feel the world does not respond to our needs. So what's the use of trying?

2. The Fear of Interpersonally Connecting: Because of frightening and painful experiences in the past, connecting emotionally and intimately with others feels dangerous. Our life experiences have left us feeling that the world is not a safe place. We fear injury so we avoid and withdraw from connections.

II. THE SYMBIOTIC EXPERIENCE:

Toddlers are busy learning how to make emotional relationships (both good and bad) work for them. They experience a sense of merger and reciprocity with their primary caregivers, thus establishing many knee-jerk, automatic, characterological, and role-reversible patterns or scenarios of relatedness. Framing the symbiotic relatedness patterns for analysis entails noting how each person characteristically engages the other and how interactive scenarios evolve from two subjectively-formed sets of internalized self-and-other interaction patterns.

3. The Fear of Being Abandoned: After having connected emotionally or bonded with someone, we fear being either abandoned with our own needs or

being swallowed up by the other person's needs. In either case, we feel the world is not a dependable place and that we live in danger of emotional abandonment. We may become clingy and dependent, or we may become super independent—or both.

4. The Fear of Self-Assertion: We have all experienced rejection, and perhaps even punishment for expressing ourselves in a way that others don't like. We thus may learn to fear asserting ourselves and letting our needs be known in relationships. We feel the world does not allow us to be truly ourselves. We may either cease putting ourselves out there altogether, or we may assert ourselves with demanding vengeance.

III. THE SELF-OTHER EXPERIENCE:

Two-and-three-year-olds are preoccupied with using the acceptance and approval of others for developing and

enhancing self definitions, self skills, and self-esteem. Their relatedness strivings use the mirroring, twinning, and idealizing responses of significant others to firm up their budding sense of self. Framing for analysis the self-other patterns used for affirming, confirming, and inspiring the self entails studying how the internalized mirroring, twinning, and idealizing patterns used in self development in the pasts of both participants play out to enhance and limit the possibilities for mutual self-to-self-other resonance in the emerging interpersonal engagement.

5. The Fear of Lack of Recognition: When we do not get the acceptance and confirmation we need in relationships, we are left with a feeling of not being seen or recognized for whom we really

are. Or, we may fear that others will only respect and love us if we are who they want us to be. We may work continuously to feel seen and recognized by others, or we may give up in rage, humiliation, or shame.

IV. THE INDEPENDENCE EXPERIENCE:

Four- to seven-year-olds are dealing with triangular love and hate relationships and are moving toward more complex social relationships. In their relatedness they experience others as separate centers of initiative and themselves as independent agents in a socially competitive environment. Framing the internalized patterns of independently-interacting selves in both cooperative and competitive triangulations with real and fantasized third parties entails studying the emerging

interaction patterns for evidence of repressive forces operating within each participant and between the analytic couple that work to limit or spoil the full interactive potential.

6. The Fear of Failure and Success: When we have loved and lost or tried and failed, we may fear painful competitive experiences. When we have succeeded or won—possibly at someone else's expense—we may experience guilt or fear retaliation. Thus, we learn to hold back in love and life, thereby not risking either failure or success. We may feel the world does not allow us to be fulfilled. Or we may feel guilty and afraid for feeling fulfilled.

7. The Fear of Being Fully Alive: Our expansiveness, creative energy, and joy in our aliveness inevitably come into conflict with family, work, religion, and society. We come to believe that we

must curtail our aliveness to conform to the expectations and demands of the world. We feel the world does not permit us to be fully, joyfully, and passionately alive. Rather than putting our whole selves out there with full energy, we may throw in the towel, succumb to mediocre conformity, or fall into living deadness.

Reading List

Altheide, D. L. (2017). *Terrorism and the Politics of Fear*. Lanham: Rowman and Littlefield.

Balint, A. (1943). Identification. *Int. J. Psycho-Anal.*, 24:97-107.

Beebe, B. and Lachmann, F. M. (2002). *Infant Research And Adult Treatment*: *A Dyadic Systems Approach*. Hillsdale, NJ: Analytic Press.

Beebe, B., & Lachmann, F. (2003). *Infant Research and Adult Treatment: Co-Constructing Interactions*. New York: Analytic Press.

Benjamin, J. (2013). The Bonds of Love: Looking Backward. *Studies in Gender and Sexuality*, 14(1):1-15.

Chenoweth, E., English, R., Gofas, A., and Kalyvas, S. (2019). *The Oxford Handbook of Terrorism*. Oxford: The Oxford University Press.

Crenshaw, M. (20011). *Explaining Terrorism: Causes, Processes And Consequences*. New York: Routledge.

Diamond, N. & Marrone, M. (2003). *Attachment and Intersubjectivity*. New York: John Wiley & Sons.

Fonagy, P. (2001). *Attachment Theory and Psychoanalysis*. New York: Other Press.

Fonagy, P., Gergely, G., Jurist, E. and Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly* 51:612-635.

Freud, S. (1938) Splitting of the ego in the process of defense. *Standard Edition of the Complete Works of Sigmund Freud*. 23:271-278.

Furedi, F. (2018). *How Fear Works: Culture Of Fear And The 21st Century*. London: Bloomsbury.

Gardner, D. (2009). *Sounds Of Fear: How A Culture Of Fear Manipulates Your Brain*. New York: Penguin Random House.

Glassner, B. (2010). *The Culture Of Fear: Why Americans Are Afraid Of The Wrong Things*. New York: Basic Books.

Hedges, L. (2012a). *Overcoming Relationship Fears*. International Psychotherapy Institute e-book, www.freepsychotherapybooks.org.

_____(2013a). *Overcoming Relationship Fears Workbook*. International Psychotherapy Institute e-book, www.freepsychotherapybooks.org.

_____(2015). *Facing Our Cumulative Developmental Trauma,* The International Psychotherapy Institute e-book, www.freepsychotherapybooks.org.

_____(2017). *Relational Listening A Handbook*: International Psychotherapy Institute e-Book, www.freepsychotherapybooks.org.

Hobfoll, S. E. (2018). *Tribalism The Evolutionary Origins of Fear Politics*. New York: Palgrave Macmillan.

Hoffman, B. (2017). *Inside Terrorism*. New York: Columbia University Press.

Kernberg O. F. (1975). *Borderline Personality Organization*. New York: Jason Aronson.

Law, R.D. (2016). *Terrorism A History*. Malden, MA: Polity Press.

LeDoux, J. (2015). *Anxious: Using the Brain to Treat Anxiety and Fear*. New York: Penguin Random House.

Lichtenberg, J. D. (1983). *Psychoanalysis And Infant Research*. Hillsdale, NJ: Analytic Press.

Martin, G. (2018). *Essentials of Terrorism Concepts and Controversies*. London: Sage Publications.

Mitchell, S. A. (1988). The Intrapsychic and the Interpersonal: Different Theories, Different Domains, or Historical Artifacts?. *Psychoanal. Inq*., 8(4):472-496.

Norcross, J. (2002). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford

Porges, S. W. (2004, April/May). Neuroception: A subconscious system for detecting threats and safety. *Zero To Three* 24(5), 19-24.

Sander, L. W. (1995). Identity and the experience of specificity in a process of recognition: commentary on Seligman and Shanok. *Psychoanal. Dial.*, 5(4):579-593.

Schore, A. N. (2003). *Affect Regulation and Disorders of the Self*. New York: W. W. Norton & Company.

_____ (2003). Early superego development: the emergence of shame and narcissistic affect regulation in the practicing period. In *Affect Regulation & the Repair of the Self*. New York: W.W. Norton & Company.

_____ (2003). The experience-dependent maturation of a regulatory system in the orbital-prefrontal cortex and the origin of developmental psychopathology. In *Affect*

Dysregulation & Disorders of the Self. NY: W.W. Norton & Company.

_____(2013). *The Science of the Art of Psychotherapy*. New York: W. W. Norton & Company.

Siegel, D. J., (1999). *The Developing Mind*: *Toward A Neurobiology Of Interpersonal Experience*. New York: Guilford Press.

Simon, J. (2016). *Lone Wolf Terrorism: Understanding the Growing Threat*. New York: Prometheus Books.

Stern, D. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

Stolorow, R., and Atwood, G. (1992). *Contexts of Being: The Intersubjective Foundations of Psychological Life*. Hillsdale, NJ: Analytic Press.

Stolorow, R., Atwood, G., and Brandchaft, B. (1994). *The Intersubjective Perspective*. Northvale, NJ: Jason Aronson.

The Alliance of Psychoanalytic Organizations. (2006). *Psychodynamic Diagnostic Manual: (PDM)*. New York: The Alliance of Psychoanalytic Organizations.

Trevarthen, C. B. 1979. Communication and cooperation in early infancy: A description of primary intersubjectivity. In M. Bullowa (ed.), *Before Speech*. Cambridge: Cambridge University Press.

Trevarthen, C. (1980). The Foundations of Intersubjectivity: The Development of Interpersonal and Cooperative Understanding in Infants. In *The Social Foundations of Language and Thought*, ed. D. R. Olson. New York: Norton.

Notes

[1] Norcross, J. (2002).

[2] Stolorow and Atwood, 1992, p. 3.

[3] *Ibid.*

[4] Benjamin 1988, 1995.

[5] Schore, A. N. 1999, 2003a,b, 2013.

[6] Siegal. A., 2002.

[7] Porges, S. 2004.

[8] *Anxious: Using the Brain to Understand and Treat Fear and Anxiety*, 2015.

[9] See Lichtenberg 1983; D. N. Stern 1985; Tronick 1998; Sander 1995; Beebe, et al. 2005; Fonagy 2001; and Beebe and Lachmann 2003.

[10] Beebe, B., & Lachmann, F. 2003; Fonagy, P., Gergely, G., Jurist, E., and Target, M. 2002; Stern, D. N. 1985, 2004; Trevarthen, C. 1980.

[11] See for example one of their early papers, Stern, et al., 1998.

[12] Diamond, N., & Marrone, M. 2003; Fonagy, P. 2001, 2002.

[13] Stern, D., 1985, 2004.

[14] Mitchell, S. 1988; Benjamin 2013.

[15] Hedges, L., 1983, 2018.

[16] These relational listening perspectives and relational fears are elaborated considerably in Hedges 2012 and 2013. A Summary is in the Appendix to this paper.

[17] Freud, S. (1938). The Splitting of the Ego in the Process of Defense.

[18] Balint, A. (1943). Identification.

[19] This is an unusual use of "self". In that historically later definitions point to self as the organizing center of personality (Hartmann) or as a later developmental achievement (Kernberg, Kohut). It is used here solely to illustrate Freud's incomplete formulations on the splitting of the ego.

[20] We think here immediately of "borderline" character formations but all character formations show the same push toward obligatory responsiveness demands.

[21] Interpretive work will be illustrated in later cases.

[22] First Presented at the New Zealand Psychological Association March 19 and 20, 2020

[23] Hedges 2015, Shubbs, 2020.

[24] The full version of this case study is published in Hedges, 2000.

[25] The full version of this case is published in Hedges, 2000.

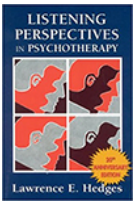
[26] The full version of this case study is published in Hedges, 2000.

[27] The full version of this case study is published in Hedges, 2000.

[28] In the extended version of this case report (Hedges, 2000) I am able to show Paul how he is in fact doing what he is talking about to me during the process of this hour and how my tendency has been to comply with his constant severing of connection between us.

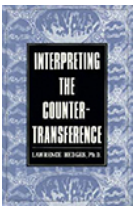
Other Books Authored and Edited by Lawrence Hedges

Listening Perspectives in Psychotherapy (1983, Revised Edition 2003)



In a fresh and innovative format Hedges organizes an exhaustive overview of contemporary psychoanalytic and object relations theory and clinical practice. “In studying the Listening Perspectives of therapists, the author has identified himself with the idea that one must sometimes change the Listening Perspective and also the interpreting, responding perspective.” –Rudolf Ekstein, Ph.D. Contributing therapists: Mary Cook, Susan Courtney, Charles Coverdale, Arlene Dorius, David Garland, Charles Margach, Jenna Riley, and Mary E. Walker. Now available in a Twentieth Anniversary edition, the book has become a classic in the field.

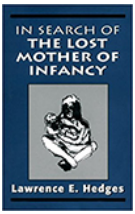
Interpreting the Countertransference (1992)



Hedges boldly studies countertransference as a critical tool for therapeutic understanding. “Hedges clearly and beautifully delineates the components and forms of countertransference and explicates the technique of carefully proffered countertransference informed

interventions…[He takes the view] that all countertransferences, no matter how much they belong to the analyst, are unconsciously evoked by the patient." — James Grotstein, M.D. Contributing therapists: Anthony Brailow, Karen K. Redding, and Howard Rogers. Selected as one of the notable contributions to psychoanalysis during its first century—Elisabeth Young-Bruehl and Christine Dunbar (2009).

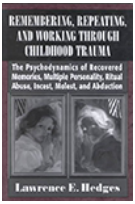
In Search of the Lost Mother of Infancy (1994)



"Organizing transferences" in psychotherapy constitute a living memory of a person's earliest relatedness experiences and failures. Infant research and psychotherapeutic studies from the past two decades makes it now possible to define for therapeutic analysis the manifestations of early contact traumas. A history and summary of the Listening Perspective approach to psychotherapy introduces the book. Contributing therapists: Bill Cone, Cecile Dillon, Francie Marais, Sandra Russell, Sabrina Salayz, Jacki Singer, Sean Stewart, Ruth Wimsatt, and Marina Young.

Remembering, Repeating, and Working Through Childhood Trauma: The Psychodynamics of Recovered Memories, Multiple Personality, Ritual Abuse, Incest, Molest, and Abduction (1994)

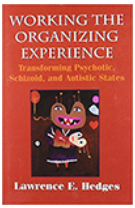
Infantile focal as well as strain trauma leave deep psychological scars that show up as symptoms and



memories later in life. In psychotherapy people seek to process early experiences that lack ordinary pictoral and narrational representations through a variety of forms of transference and dissociative remembering such as multiple personality, dual relating, archetypal adventures, and false accusations against therapists or other emotionally significant people. “Lawrence Hedges makes a powerful and compelling argument for why traumatic memories recovered during psychotherapy need to be taken seriously. He shows us how and why these memories must be dealt with in thoughtful and responsible ways and not simply uncritically believed and used as tools for destruction.”—Elizabeth F. Loftus, Ph.D. Nominated for Gradiva Best Book of the Year Award

---

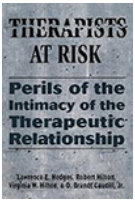
Working the Organizing Experience: Transforming Psychotic, Schizoid, and Autistic States (1994)



Hedges defines in a clear and impelling manner the most fundamental and treacherous transference phenomena, the emotional experiences retained from the first few months of life. Hedges describes the infant’s attempts to reach out and form organizing connections to the interpersonal environment and how those attempts may have been ignored, thwarted, and/or rejected. He demonstrates how people live out these primitive transferences in everyday significant relationships and in the psychotherapy relationship. A critical history of psychotherapy with primitive transferences is contributed

by James Grotstein and a case study is contributed by Frances Tustin.

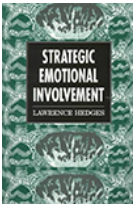
Therapists At Risk: Perils of the Intimacy of the Therapeutic Relationship (1997)



Lawrence E. Hedges, Robert Hilton, and Virginia Wink Hilton, long-time trainers of psychotherapists, join hands with attorney O. Brandt Caudill in this *tour de force* which explores the multitude of personal, ethical, and legal risks involved in achieving rewarding transformative connections in psychotherapy today. Relational intimacy is explored through such issues as touching, dualities in relationship, interfacing boundaries, sexuality, countertransference, recovered memories, primitive transferences, false accusations against therapists, and the critical importance of peer support and consultation. The authors clarify the many dynamic issues involved, suggest useful ways of managing the inherent dangers, and work to restore our confidence in and natural enjoyment of the psychotherapeutic process.

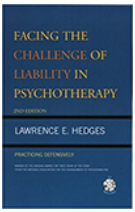
Strategic Emotional Involvement: Using the Countertransference in Psychotherapy (1996)

Following an overview of contemporary approaches to studying countertransference responsiveness, therapists tell moving stories of how their work came to involve them deeply, emotionally, and not always safely with clients. These comprehensive, intense, and honest reports are the



first of their kind ever to be collected and published. Contributing therapists: Anthony Brailow, Suzanne Buchanan, Charles Coverdale, Carolyn Crawford, Jolyn Davidson, Jacqueline Gillespie, Ronald Hirz, Virginia Hunter, Gayle Trenberth, and Sally Turner-Miller.

Facing the Challenge of Liability in Psychotherapy: Practicing Defensively (2000, Revised 2017)



In this litigious age, all psychotherapists must protect themselves against the possibility of legal action; malpractice insurance is insufficient and does not begin to address the complexity and the enormity of this critical problem. In this book, Lawrence E. Hedges urges clinicians to practice defensively and provides a course of action that equips them to do so. After working with over a hundred psycho-therapists and attorneys who have fought unwarranted legal and ethical complaints from clients, he has made the fruits of his work available to all therapists. In addition to identifying those patients prone to presenting legal problems, Dr. Hedges provides a series of consent forms (on the accompanying disk), a compelling rationale for using them, and a means of easily introducing them into clinical practice. This book is a wake-up call, a practical, clinically sound response to a frightening reality, and an absolute necessity for all therapists in practice today. Now available in a revised and updated edition. Gradiva Award best book of the year.

Terrifying Transferences: Aftershocks of Childhood Trauma (2000)

There is a level of stark terror known to one degree or another by all human beings. It silently haunts our lives and occasionally surfaces in therapy. It is this deep-seated fear–often manifest in dreams or fantasies of dismemberment, mutilation, torture, abuse, insanity, rape, or death–that grips us with the terror of being lost forever in time and space or controlled by hostile forces stronger than ourselves. Whether the terror is felt by the client or by the therapist, it has a disorienting, fragmenting, crippling power. How we can look directly into the face of such terror, hold steady, and safely work it through is the subject of *Terrifying Transferences*. Contributing therapists: Linda Barnhurst, John Carter, Shirley Cox, Jolyn Davidson, Virginia Hunter, Michael Reyes, Audrey Seaton-Bacon, Sean Stewart, Gayle Trenberth, and Cynthia Wygal. Gradiva Award Best Book of the Year.

Sex in Psychotherapy: Sexuality, Passion, Love, and Desire in the Therapeutic Encounter (2010)

This book takes a psychodynamic approach to understanding recent technological and theoretical shifts in the field of psychotherapy. Hedges provides an expert overview and analysis of a wide variety of new perspectives on sex, sexuality, gender, and identity; new theories about sex's role in therapy; and new discoveries about the human brain and how it works. Therapists will value Hedges' unique insights

into the role of sexuality in therapy, which are grounded in the author's studies of neurology, the history of sexuality, transference, resistance, and countertransference. Clinicians will also appreciate his provocative analyses of influential perspectives on sex, gender, and identity, and his lucid, concrete advice on the practice of therapeutic listening. This is an explosive work of tremendous imagination and scholarship. Hedges speaks the uncomfortable truth that psychotherapy today often reinforces the very paradigms that keep patients stuck in self-defeating, frustrating behavior. He sees sexuality as a vehicle for both therapists and patients to challenge what they think they know about the nature of self and intimacy. This book is a must-read for anyone interested in understanding 21st century human beings—or in better understanding themselves and their sexuality.

Overcoming Our Relationship Fears (2012)

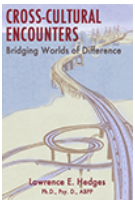
We are all aware that chronic tension saps our energy and contributes to such modern maladies as high blood pressure and tension headaches, but few of us realize that this is caused by muscle constrictions that started as relationship fears in early childhood and live on in our minds and bodies. Overcoming Our Relationship Fears is a user-friendly roadmap for healing our relationships by dealing with our childhood fear reflexes. It is replete with relationship stories to illustrate each fear and how we individually express them. Dr. Hedges shows how to use our own built-in "Aliveness Monitor" to gauge our body's reaction to daily interactions and how they trigger our fears. Exercises in the book will

help us release these life-threatening constrictions and reclaim our aliveness with ourselves and others.

Overcoming Our Relationship Fears: WORKBOOK (2013)

Developed to accompany Hedges' Overcoming Relationship Fears, this workbook contains a general introduction to the seven relationship fears that are a part of normal human development along with a series of exercises for individuals and couples who wish to learn to how to release their Body-Mind-Relationship fear reflexes. An Aliveness Journal is provided for charting the way these fears manifest in relationships and body maps to chart their location in each person's body.

Cross-Cultural Encounters: Bridging Worlds of Difference (2012)



This book is addressed to everyone who regularly encounters people from other cultural, ethnic, socioeconomic, linguistic, and ability groups. Its special focus, however, is aimed at counselors, therapists, and educators since their daily work so often involves highly personal cross-cultural interactive encounters. The running theme throughout the book is the importance of cultivating an attitude of tentative and curious humility and openness in the face of other cultural orientations. I owe a great debt to the many students, clients, and friends with diverse backgrounds who

over the years have taught me how embedded I am in my own cultural biases. And who have helped me find ways of momentarily transcending those biases in order to bridge to an inspiring and illuminating intimate personal connection.

The Relationship in Psychotherapy and Supervision (2013)

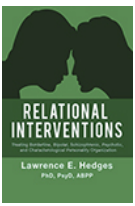
About the Book: The sea-change in our understanding of neurobiology, infant research, and interpersonal/relational psychology over the past two decades makes clear that we are first and foremost a relational species. This finding has massive implications for the relational processes involved in teaching and supervising psychotherapy. Clinical theory and technique can be taught didactically. But relationship can only be learned through careful attention to the supervisory encounter itself. This advanced text surveys the psychodynamic and relational processes involved in psychotherapy and supervision.

Making Love Last: Creating and Maintaining Intimacy in Long-term Relationships (2013)

We have long known that physical and emotional intimacy diminish during the course of long-term relationships. This book deals with the questions, “Why romance fades over time?” and “What can we do about it?” Relational psychologists, neuropsychologists, and anthropologists have devoted the last two decades to the study of these

questions with never before available research tools. It is now clear that we are genetically predisposed to search out intersubjective intimacy from birth but that cultural systems of child rearing seriously limit our possibilities for rewarding interpersonal relationships. Anthropological and neurological data suggests that over time we have been essentially a serially monogamous species with an extraordinary capacity for carving out new destinies for ourselves. How can we come to grips with our genetic and neurological heritage while simultaneously transcending our relational history in order to create and sustain exciting romance and nurturing love in long-term relationships? Making Love Last surveys research and theory suggesting that indeed we have the capacity and the means of achieving the lasting love we long for in our committed relationships.

Relational Interventions: Treating Borderline, Bipolar, Schizophrenic, Psychotic, and Characterological Personality Organization (2013)



Many clinicians dread working with individuals diagnosed as borderline, bipolar, schizophrenic, psychotic, and character disordered. Often labeled as “high risk” or “difficult”, these relational problems and their interpersonal manifestations often require long and intense transformative therapy. In this book Dr. Hedges explains how to address the nature of personality organization in order to flow with – and eventually to enjoy – working at early developmental levels. Dr. Hedges speaks to the client’s engagement/disengagement needs, using a relational process-oriented approach, so the therapist can gauge how

much and what kind of therapy can be achieved at any point and time.

Facing Our Cumulative Developmental Traumas (2015)

It has now become clear that Cumulative Developmental Trauma is universal. That is, there is no way to grow up and walk the planet without being repeatedly swallowed up by emotional and relational demands from other people. When we become confused, frightened, and overwhelmed our conscious and unconscious minds seek remedies to deal with the situation. Unfortunately many of the solutions developed in response to intrusive events turn into habitual fear reflexes that get in our way later in life, giving rise to post traumatic stress and relational inhibitions. This book is about freeing ourselves from the cumulative effects of our life's many relational traumas and the after-effects of those traumas that continue to constrict our capacities for creative, spontaneous, and passionate living.

Relational Listening: a Handbook

Freud's singular stroke of genius can be simply stated: *When we engage with someone in an emotionally intimate relationship, the deep unconscious emotional/relational habits of both participants become interpersonally engaged and enacted thereby making them potentially*

available for notice, discussion, transformation, and expansion.

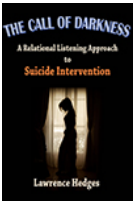
This *Handbook* is the 20th book in a series edited and/or authored by Dr. Lawrence Hedges and surveys a massive clinical research project extending over 45 years and participated in by more than 400 psychotherapists in case conferences, reading groups and seminars at the Listening Perspectives Study Center and the Newport Psychoanalytic Institute in the Southern California area.

The first book in the series, *Listening Perspectives in Psychotherapy* (1983), was widely praised for its comprehensive survey of 100 years of psychoanalytic studies and a 20th anniversary edition was published in 2003. But the important aspect of the book – that the studies were organized according to four different forms of relational listening according to different levels of developmental complexity – went largely unnoticed. Also generally unattended was the critical epistemological shift to perspectivalism which since that time has become better understood. The subsequent books participated in by numerous therapists expand and elaborate these Relational Listening perspectives for working clinicians.

This *Handbook* provides not only a survey of the findings of the 45 year clinical research project but, more importantly, an overview of the seven developmental levels of relational listening that have consistently been found to provide enhanced psychotherapeutic engagement.

The Call of Darkness (2018)

The White House has declared suicide to be a national and international epidemic and has mandated suicide prevention training for educational and health workers nationwide. *The Call of Darkness* was written in response



to that mandate and begins with the awareness that our ability to predict suicide is little better than chance and that at present there are no consistently reliable empirically validated treatment techniques to prevent suicide. However, in the past three decades much has been learned about the dynamics of suicide and promising treatment approaches have been advanced that are slowly yielding clinical as well as empirical results.

In this book, Dr. Hedges presents the groundbreaking work on suicidality of Freud, Jung, Menninger and Shneidman as well as the more recent work of Linehan, Kernberg, Joiner and the attachment theorists along with the features in common that these treatment approaches seem to share. He puts forth a Relational Listening approach regarding the origins of suicidality in a relational/developmental context and will consider their implications for treating, and managing suicidality. The tendencies towards blame and self-blame on the part of survivors raise issues of professional responsibility. Dr Hedges discusses accurate assessment, thorough documentation, appropriate standards of care, and liability management.

About the Author

LAWRENCE E. HEDGES, Ph.D., Psy.D., ABPP is a psychologist-psychoanalyst in private practice in Orange, California, specializing in the training of psychotherapists and psychoanalysts. He is director of the Listening Perspectives Study Center and the founding director of the Newport Psychoanalytic Institute in Tustin, California where he is a supervising and training psychoanalyst. He has been awarded honorary membership in the

American Psychoanalytic Association. Dr. Hedges is author of numerous papers and books including *Cross-cultural Encounters: Bridging Worlds of Difference* (2013), *Listening Perspectives in Psychotherapy* (1983 & 2003), *Interpreting the Countertransference* (1992), *Strategic Emotional Involvement* (1996), and *Facing the Challenge of Liability in Psychotherapy: Practicing Defensively* (2000 & 2007). To learn more about Dr. Hedges and his work, go to www.listeningperspectives.com