POST-TRAUMATIC STRESS AND THE LOSS OF ONTOLOGICAL SECURITY: OVERCOMING TRAUMA-INDUCED NEOPHOBIA IN ADULT CHILDREN OF ALCOHOLICS

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POST-TRAUMATIC STRESS AND THE LOSS OF ONTOLOGICAL SECURITY: 
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The purpose of this paper is to outline a theoretical model for understanding and treating post-traumatic stress when the disorder is a reaction to trauma experienced in the nuclear family. Until very recently, society denied the horrifying reality of pain and abuse endured by countless children living in severely dysfunctional families (Gelles and Straus, 1987). This evidence that for a large number of people the nuclear family did not offer shelter, nurturance and support but traumatized them instead (Booz-Allen Report, 1974) underscores the need for a comprehensive approach for treating family-based post-traumatic stress disorder (PTSD).

The central concept is that children who are subjected to repeated trauma in the family experience a profound loss of basic (ontological) security because they are unable to reliably predict and control the cause and effect relationships necessary for survival. In families where the habitual creation of violence is seen as normal, there is a pathological lack of respect for the child's need to be protected from harm. Because dependent children are situationally bound to the family, they are unable to escape from harm. To stay sane in such an atmosphere of threat, children are forced to deny their awareness of trauma and to inhibit the natural desire to overcome or avoid the source of pain. But choosing to dissociate from reality carries a huge price. The process of dissociation also makes it impossible for children to know when they have successfully acted on their own behalf. Children are thus cut off from receiving the information they need to make sound decisions on how to react in the presence of danger.

In the absence of sensory feedback, children cannot adequately perceive or respond to the demands of living in a punitive environment. They are unable to conceive and direct a plan of action which minimizes injury and pain and that successfully maintains a sense of ontological well-being. They exist in a state of fundamental ontological insecurity.
Definition of Terms

There is a great deal of confusion in the literature about the terms stress, trauma and shock. Stress is used to describe both the reaction to an aversive stimulus and to describe the stimulus itself (Selye, 1976) as in the case of stress induced analgesia. Stress is often substituted for trauma and is, therefore, imprecise in describing the magnitude of insult experienced by an animal or person. Similarly, trauma is used to describe both physical injury and conditioned emotional stimulation. The term shock is frequently employed for both stimulus and response. In this paper, the term trauma refers to optimal arousal of the sympathetic nervous system by pain or the threat of pain. Shock is the compensatory shutdown of hypervigilance and fight or flight activity when further responding could bring about permanent tissue damage or death. Stress (strain) is used to describe the systemic tension created by the denial of feelings surrounding the loss of ontological security. The term stressors refers to the stimuli which actually cause pain, both the unconditional pain response caused by physical irritation or injury and the conditioned emotional response brought about by pain-producing memories, thoughts or beliefs.

Rene Spitz (1946), in his classic study of anaclitic (dependency) depression, discovered that babies who were left alone and not held except during basic care developed a deep depression and rapidly lost the will to live. When the normal need for love and care is met with either abuse or neglect, children cannot survive except by denying their underlying feeling of hopeless despair. In the following section, I will explore the family conditions which can create this deep depression and investigate how a pattern of emergency reaction to trauma can develop into a life-long struggle to survive by continually dissociating from overwhelming feelings of panic and despair.

Ontological Insecurity and the Experience of Trauma

I would like to begin by summarizing R.D. Laing's idea of ontological insecurity and by examining the relationship of ontological insecurity to the physical phenomena of trauma and shock. Laing writes that people are "...always between being and non-being, but non-being is not necessarily experienced as personal disintegration." (Laing, 1971, p.51) In The Divided Self, he writes that a person with primary ontological security lives in the world feeling real, alive and complete and has a
sense of continuously existing in time and space. Differentiation from the rest of the world in ordinary circumstances is so clearly defined that personal identity and autonomy are never in question. Such a person is able to encounter the social, spiritual or biological threat of non-being (in the form of depersonalization, unconsciousness and death) with integrity and a belief that the self is valuable and worth protecting from harm.

Laing continues that for many people the experience of living is so painful that they are left in the opposite position of primary ontological insecurity. A person in this category may feel more unreal than real and be so tenuously separated from the rest of the world that personal autonomy and identity are always in doubt. Where an ontologically secure individual sees other people as a potential source of gratification, an ontologically insecure person sees only the possibility of being terrorized, engulfed or invaded and fears other people as a continuous threat to existence. (Laing, 1965, pp.39-47) The only escape from such existential despair is through the denial of reality and the anesthetization of feelings.

In the following passage from Self and Others, Laing moves from a psycho-philosophical discussion of ontological insecurity to an explanation using terms consistent with a psycho-physical description of trauma and shock:

Tillich (1952) speaks of the possibilities of non-being in the three directions of ultimate meaninglessness, ultimate condemnation, and ultimate annihilation in death. In those three directions man as a spiritual being, as a moral being, as a biological being, faces the possibility of his own annihilation, or non-being.

The ontological insecurity described in The Divided Self is a fourth possibility. Here, man, as a person, encounters non-being, in a preliminary form, as partial loss of the synthetic unity of the self, concurrently with partial loss of relatedness with the other, and in an ultimate form, in the hypothetical end-state of chaotic nonentity, total loss of relatedness with self and other. (Laing, 1971, P.51)

In an inspired leap downward from the mind into the body, Laing moves from a primarily cognitive concept of ontological security concerned with thinking about the meaning of existence, questions
of good and evil, and the planning of strategies for survival to describing an active personal struggle to maintain conscious control of behavior during trauma. The loss of conscious awareness of a symbolic self parallels the decreasing levels of consciousness found in neurogenic shock: "...confusion, lethargy, agitation, (agitated depression, parentheses added) stupor, and coma." (Kreis and Baue, 1984, p.164)

For a small child living in a violent home, the synthetic unity of a name, an ego and a self-image rapidly disappears when the corporeal self is constantly threatened with injury or damage. During periods of intense abuse by a parent or caregiver, a child can easily reach the "hypothetical end-state of chaotic non-entity" just prior to going unconscious, at the point when there is no sense of being connected to the self or to anyone else. Traumatized children come to regard the self as an unfeeling object to be moved toward or away from other people, directed by the force of habit rather than conscious choice.

A frightened or terrorized child is no longer psychologically present and is unable to adequately register or effectively respond to the demands of those in authority. The chaos and disorientation caused by the struggle to maintain conscious awareness and not succumb to the analgesia and forced sedation of shock disorganizes the perceptual capacities of the brain to such an extent that the idea of a subjective relationship with the self and other people ceases to have any meaning.

The seeds of primary ontological insecurity are sown during the times when the child is out of control and on the verge of literally going unconscious, when the greatest need for potency in directing survival behavior coincides with the greatest degree of powerlessness. The loss of ontological security occurs when a person recognizes that the psycho-social environment is so punitive no combination of perception, belief and motor behavior can guarantee physical safety or prevent an automatic, self-protective slide into dissociation, unconsciousness or death. The essence of being ontologically insecure is to be precariously balanced midway between full awareness and unconsciousness, a balance that preserves the possibility of becoming completely awake while partially shielding the person from the crushing realities of a harsh existence.

An examination of the events that occur during and after the experience of inescapable trauma is necessary for understanding the post-traumatic tension found in people following the loss of ontological security and for understanding how a person could become addicted or habituated to a cycle of trauma and shock.
Children who live in a violent home are trapped in what Bateson, et al. (1956) calls a double-bind, a situation where any move or failure to move could potentially cause injury, pain or death. The necessary elements for a double-bind are two opposing injunctions, one which is stated and one which is implied, that cannot be followed without violating one or the other injunction (Laing, 1971, pp.125-150). The double-bind found in a violent home is inherent as society instructs its children not to question the sanctity of the home or nuclear family, and violent parents or care-givers convey a strong non-verbal message to dependent children not to reveal any evidence of abuse to anyone outside the family. Children are unable to seek help outside the home and the prospect of interacting with abusive family members is a continual source of fear.

Abused children are caught in an agonizing approach-avoidance conflict because they are unable to reliably discriminate between when to approach and when to avoid the people on whom they depend for survival as these are the same people who are also causing them harm. Because of the continually recurring cycle of physical needs — the need for correctly modulated stimulation, undisturbed rest, and gentle homeostatic regulation — abused children must daily resolve the conflicting imperatives of need and fear. A small child, for instance, with a severe bladder infection may have no recourse but to approach a sexually abusive parent seeking soothing and care, knowing that the source of potential relief from internal pain may become the source of external injury stemming from a sexual attack by the parent. The ability to discriminate between when to approach and when to avoid their primary care-givers assumes critical importance when children recognize the futility of retreating into isolation. The inability of small children to adequately care for themselves continually forces them back into the social arena of the family where the only constants are confusion, disruption and the presence of pain.

Children living in homes where a high level of violence is the norm encounter pain on a regular basis. The immediate desire of children who are in pain is to separate the thing that is doing the hurting (the painful stimulus) from the thing that hurts (the somatic self). This is what Russell (1975) calls “separating the stimulus of pain from the response of suffering”. Successful separation depends on recognizing the stimulus, locating its point of somatic contact (where it hurts) and doing something to end the experience of pain.

In homes where there is respect for the need to be safe and secure, children are taught to recognize and avoid dangerous
encounters. Their suffering is acknowledged when they are hurt, and they are actively supported in their efforts to minimize injury and nullify pain. Children from loving homes see concern for their well-being and trust their care-givers to guide and protect them. The experience of consistent care gives children a sense of worth and confidence in their own ability to successfully care for themselves.

In homes where there is consistent disregard for the basic requirements of safety and security, and the effects of trauma are not acknowledged or discussed, children are left to deal with the real results of injury in a surreal atmosphere of distortion and denial.

The immediate effect of significant pain in a person is to bring about a state of extreme arousal by way of the sympathetic nervous system, the “fight or flight” emergency response first postulated by Cannon (1915). The response has been well documented and consists of a number of physiological changes, the purpose of which is to mobilize the body's available energy and allow the brain, heart, lungs and large muscle groups to function at peak capacity in the hope of rapidly and successfully resolving the emergency situation. In the case of a successful resolution, the parasympathetic branch of the autonomic nervous system begins to dominate the modulation of arousal and returns the body to a pre-emergency state of quiescence which allows time for rest and recuperation.

When children are consistently brought to a level of maximum sympathetic arousal (trauma) and are unable to escape or avoid pain, a self-destructive pattern of dysfunction begins to emerge. Seligman (1975) in his early explanation of “learned helplessness” was quite specific in stating that the cause of maladaptive responding following trauma is not trauma per se, but not having control over trauma. He continues that learning trauma is uncontrollable results in a marked decrease in expectation that responding will bring relief and in the creation of a rigid cognitive set wherein response and escape are not causally related. Only incidentally does he acknowledge the directly debilitating effects of trauma: conditioned fear, ulcers, weight loss, incontinence and pain.

Seligman's reliance on a purely cognitive explanation for post-traumatic dysfunction reveals a fundamental problem in treating chronic PTSD. There is an implicit assumption in cognitive behavior modification and psychotherapy in general that cognitive capacity remains the same throughout all motivational states. However, a brutalized child will not be able to respond
to cognitive intervention with the same degree of freedom and openness as a child who has never been severely injured or damaged. Diminished expectations and rigid perceptual gestalts are the result of trauma not the cause. They are aspects of a general contraction of the self (Reich, 1949), a closing down of "openness to experience" (Rogers, 1961) which is both mental and physical and only partially controlled by conscious choice. An animal or person does not simply choose to inhibit all movement and thought in the face of repeated physical insult. Rigid cognition and behavioral paralysis are the consequences of both conscious inhibition and unconscious reaction, designed to protect and maintain the corporeal self and to preserve the high level thought processes found in the neocortex.

**Neocortical Function**

The capacity of the neocortex to conceive and initiate behavior other than rote, reflexive reactions to stimuli is what separates humans from other animals. The vast enfolded of sensory, motor and associational brain mass in a small space is what allows human beings to receive and integrate sense information, compare that information with remembered experience, and bring about behavior that is optimally adapted to survival (Melzak and Wall, 1983).

The neocortex is the experimental portion of the brain which can image or imagine new behavior outside the range of instinctual responses. The value of being able to hypothesize and experiment with new behavior is obvious; freedom from instinctual domination, especially during a crisis, greatly expands the possibility of survival by introducing new ways of seeing and responding to threats.

In a normal emergency situation, a person "buys time" for the cortex to carry out its valuable rational function (Holden, 1973) -- to appraise the situation, to decide what needs to occur, and to implement the behavior needed to complete the chosen course of action. Time is bought for the necessary cortical activity by temporarily inhibiting the disruptive effect of pain. This defense against pain is accomplished by the psychological mechanism of displaced attention (the defense of soldiers in combat who give their undivided attention just to what is going on in front of them) and by intrinsic pain inhibition mechanisms (endogenous opioids and non-opioids) that chemically block the perception of pain (Terman, et al., 1984; Lewis, et al. 1983, (b); van der Kolk, et al., 1985).
This "buying of time" is ultimately a cannibalistic arrangement because the rest of the body is robbed of oxygen and glucose in order to maintain the higher brain function and the movement of the skeletal muscle system during an emergency. At a certain point in time, proprioceptive information will lead the "older brain" to overrule the experimental "new" brain (cerebral cortex) and revert to primitive instinctual responses in seeking to overcome adversity, (Schur, 1960; Simeons, 1960). If the instinctual phylogenetic reactions of "fight or flight" fail to resolve the situation, the medulla in the brain stem has no other option but "pulling the plug" on most higher brain activity and rendering a person unconscious. This allows the brain stem to function unimpeded in an attempt to stabilize heartbeat and circulation and regulate normal breathing activity without the intrusive effect of pain or misguided conscious responding.

A more detailed understanding of both optimal arousal and of the behavioral breakdown which occurs when trauma continues past an "optimal time frame for response" (Lewis, et al., 1983a,) may help make clear how the system is exhausted and the child becomes habituated to a cycle of trauma and shock. According to Hollingsworth (1973, p.13), the following changes take place when a person is threatened with danger: the hypothalamus sends out somatic and sympathetic nerve impulses to alert the body to the presence of danger and adrenaline is immediately released into the bloodstream. The depth of breathing increases expanding the lungs and improving flow of air. Digestion ceases and abdominal and peripheral blood vessels constrict while those and of the heart and large skeletal muscles expand. The rate and force of the heartbeat is increased. The blood pressure rises which sends blood rushing into the brain, heart, lungs and skeletal muscles. Muscle fatigue is relieved and strength and stamina increased by the adrenaline in the bloodstream. Accelerated circulation and an increased exchange of air in the lungs together with the release of red blood cells from the spleen greatly enhance the distribution of oxygen and the removal of waste materials throughout the body. The liver and muscles also deliver stored sugar to the circulation in order to provide immediate fuel for fight or flight.

A destructive pattern emerges when children are repeatedly brought to the peak of emergency preparation and are unable to escape or adequately control the traumatizing situation. In an emergency, diversion of oxygen and nutrients is accomplished by constricting the peripheral blood vessels and shunting the blood away from temporarily non-essential tasks, such as digestion and maintenance of peripheral organs. But there is a limit to how
long peripheral functions can be safely ignored without incurring permanent damage. The buildup of toxic waste and oxygen debt throughout the body begins to threaten well-being and becomes a source of trauma itself. Janssen (1985) describes the dilemma in the following way:

It appears that in shock (trauma, parenthesis added), the CNS (central nervous system) is unable or unwilling to assist in maintaining flow to peripheral organs. In fact, potential damage to peripheral tissue that is caused by the brain's attempt to maintain itself places the CNS in the role of a parasite. (p.192)

A breakdown in organized responding occurs when this parasitic relationship goes on for too long, when children are pushed beyond their endurance and are unable to channel the energy of high arousal into successful acts of escape or avoidance. A drunk and abusive parent may, for example, harangue a child for hours until the child is reduced to a state of terrified incomprehension. The acute effects of pain when children struggle to remain hypervigilant in a dangerous situation overwhelm the protective mechanisms of nonattention and endogenous analgesia until the full impact of pain and confusion surges forward to assault the sensory nervous system. When the strategy of selective consciousness fails to stop the onslaught of massive pain and fear, a child's nervous system reverts to the global strategy of stupor or complete unconsciousness. This collapse into profound non-awareness represents the lowest point in a cycle of trauma and shock.

Consciousness depends on a smooth reciprocal interaction among the cortex, thalamus and reticular activating system (which originates in the brain stem, Ropper and Martin, 1985). Disruption to this interaction and thus to consciousness can be caused by hypoxia (oxygen deficiency), ischemia (impaired blood flow) and hypoglycemia (low blood sugar). A fourth cause of unconsciousness is a direct disturbance of neural activity such as a concussion or electric shock.

Hypoxia can occur when there is simply not enough oxygen being circulated in the blood or when blood pressure is down and heart rate is too slow or erratic to support adequate

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The organism is seeking to "dose" this excessive stimulation in order to prevent the disruption of normal survival responses which, in the context of a violent home, might be life-threatening.
circulation. A small child who hyperventilates in response to abuse or who has been given a narcotic by a drug intoxicated parent can suffer the effects of oxygen deprivation in the brain. If cerebral circulation is impaired for 20 seconds or more, loss of consciousness (LOC) is a distinct possibility (Fowler and May, 1985).

Cerebral ischemia, caused by the interruption of blood flow due to excessive muscle tension, can happen if children habitually tense the muscles of the neck and shoulders in anticipation of being slapped or hit in the back of the head (entrapment, Travell and Simons, 1983). Such chronic tension can cause severe migraine headaches and impaired arterial circulation to the brain, both of which can produce dizziness, stupor or a complete LOC.

Hypoglycemia is the result of an actual lack of blood sugar (starvation) or the oversecretion of insulin needed to oxidize excessive amounts of refined sugar. In an effort to rid the body of this nutritionally suspect substance, the pancreas releases a large amount of insulin which may continue acting until all available glucose is depleted and the body suffers a complete energy collapse. Nutritional abuse has only recently been considered as a source of trauma, yet hypoglycemia can leave a child just as debilitated as an obvious insult or injury (Gold, 1986, Chap.4).

Direct physical abuse is, of course, the most dramatic cause of disorientation and unconsciousness. A blow or slap coming from a significant care-giver both psychologically stuns a child and physically disrupts the neurological mechanisms needed to stay conscious.

The extremes of immobility and sedation are found in the conditions of neurogenic shock (fainting and syncope) and true shock which vary only in the duration and depth of impairment. They cause the same degree of psychological damage in children if they are the result of parental neglect and abuse. This sudden and violent disruption of conscious control conveys a clear message to children that their primary care-givers cannot be trusted to shield them from significant danger, and children begin to doubt their own ability to maintain the psychic presence and physical control needed to survive in the world.

Neurogenic shock is usually a transient loss of consciousness brought about by a drop in cerebral blood flow. Pain, hunger and emotional upset can stimulate the discharge of nerve impulses that lead to a dilation of blood vessels and a marked decrease
in heart rate. Blood begins to pool in the enlarged blood vessels and the return of blood to the heart is considerably diminished. The combination of low heart rate and diminished blood flow (systemic vasodilation) significantly lowers blood pressure and cerebral perfusion, which may lead to a temporary loss of consciousness.

True shock is a severe condition that may lead to permanent brain damage or death. In neurogenic shock, heart rate and blood flow do not usually fall to a level that poses a serious threat to vital organs or peripheral tissue. Adequate circulation is normally restored by simply letting a person lie flat, a position that eases the work of the heart and improves the return of blood back to the heart from the rest of the body. The flow of oxygenated blood to the brain is also made easier and consciousness usually returns in a matter of minutes.

In true shock, cardiac dysfunction and vascular dilation may be so severe that the restoration of normal circulation cannot be achieved except by the emergency administration of blood volume expanders and medication that stabilizes the heart and constricts the greatly expanded blood vessels throughout the circulatory system. The selective constriction of blood vessels found in emergency arousal is no longer possible in a state of general systemic dilation. Both peripheral tissue and the organs that support central nervous arousal are in danger of being damaged during shock.

Among the things that can bring about a state of shock are: internal and external bleeding, burns, massive wounds and peritonitis, dehydration and diarrhea, infections, heat stroke and anaphylaxis (profound allergic reaction, Hardaway, 1985). In homes where there is a dominant attitude of violence, children may be traumatized and shocked by deliberate acts of abuse or through passive neglect. The damage to self-worth and ontological well-being is the same in either case.

Children need only experience the frightening extremes of panic and near or complete shock a small number of times before they recognize the need to distance or dissociate from the turmoil if they are to survive. To remain fully aware of the internal strain and pressure caused by the forced inhibition of survival behavior threatening to explode in protective rage or implode in acts of self-punishment would quickly reduce a child to psychic and somatic paralysis.

The vital energy used in maintaining an ability to reason and think during an emergency demonstrates the power involved in
dissociating from trauma. Successfully blocking the disruptive effects of pain and fear requires the fullest mobilization of both psychological and physical mechanisms that "buy time" for a child to assess and react to threat by preserving the delicate but essential function of conscious choice. Seligman (1975) in describing the reactions of naive dogs to electric shock reports that the dogs will initially howl, jump about, urinate and defecate but then will rapidly come to inhibit these reactions. Similarly, Hollingsworth (1973) writes that soldiers in combat for the first time show obvious signs of apprehension and fright. They may experience a rapid heartbeat, pain in the chest, problems with breathing, heavy sweating, dizziness or fainting, headaches, blurred vision and tremors. In the case of first time exposure to heavy artillery, soldiers may defecate in their clothes, urinate involuntarily and vomit because of the volume of noise and pressure from exploding shells. However, soldiers too are able to effectively inhibit these primitive fear responses and may, in fact, come to actively seek the endogenous stimulation and analgesia caused by pain and the imminent possibility of annihilation. Children living in violent homes must equally inhibit their awareness of and reaction to danger if they are to survive in a threatening and hostile environment.

Children who must live in a state of continuous dissociation are always searching for the "perfect high": a state of emotional and physical intoxication which allows unhindered movement and undisturbed rest while completely masking or anesthetizing the underlying pain and despair. They learn to dose the dissociation (Horowitz, 1976, 1979) much like a multiple addict seeks the perfect balance of arousal, sedation and anesthesia. The paradox of dissociation is that children are forced to continue in the family's pattern of traumatization in order to maintain a familiar and manageable dissociative state.

The Psychology of Trauma and Shock

The idea of addiction or habituation to a cycle of trauma and compensatory shock is inherent in all sado-masochistic relationships where painful arousal is followed by satiation (Reik, 1962). Redl and Wineman (1965) report that emotionally disturbed children can whip themselves into a state of "group psychological intoxication" that closely resembles a state of alcoholic inebriation. Milkman and Sunderwirth (1982) write that: "intense and repetitive childhood involvement in 'satiation' or 'arousal' activities (may be) precursors to adult craving for analogous ego states which are recaptured through specific patterns of behavioral excess." (p.178) Van der Kolk, et al. (1985) specifically link addiction to trauma and post-traumatic
stress disorder, while an addiction to "negative excitement" has been observed in adult children of alcoholics (The Problem, Adult Children of Alcoholics, 1984; Gernak, 1985). Hollingsworth (1973) makes perhaps the strongest statement about addiction to trauma: "...human beings who have been conditioned to need conflict ... find themselves in the position of having to create their own strife. Most of them would be outraged at being compared with alcoholics or drug addicts yet the similarity exists." (pp.14-15)

It is important to remember that living in a state of habitual dissociation is a continuous act of desperation. Dissociation in family based PTSD is a protective state of semi-conscious awareness which allows family members to function and to preserve some sense of control in the face of massive ontological insecurity. This struggle to modulate awareness, to avoid the crippling effects of pain while remaining alert and responsive to the demands of reality, reveals the distorted logic at the heart of dissociation and addiction -- the belief that "ignorance is bliss" and that damage occurs only when ratified by conscious acknowledgment. The fundamental problem with relating to the world through a haze of anesthesia and denial is the insidious circularity of the process. Continuing in the pain-producing pattern of living by masking and ignoring the effects of trauma leads to more damage and the ever increasing need to further mask the effects.

When children are consistently thwarted in their attempts to deal with crises, the nature of the defense system changes. The need to temporarily inhibit the message of pain to allow clear and rational thinking is transformed into the need to block the awareness of failing to be potent in protecting the self and to avoid being overwhelmed by the underlying sense of despair. The defense system becomes entrenched.

**Dosing Dissociation**

A tenuous dissociative balance is maintained by a combination of selectively attending to the original memories of trauma (or associated memories, thoughts and beliefs), by re-creating or staying in situations that continue the original pattern of abuse, and by using exogenous substances that mimic or stimulate endogenous arousal, sedation and analgesia.

Traumatic memory functions in the dosing of dissociation by means of stimulus generalization and the graded orders of conditioned stimulation found in classical Pavlovian conditioning. The fact that a remembered event, or an associated cognition, can bring about a close approximation of an original unconditioned reaction
is used by abused children to regulate the general level of stimulation, hopefully staying between the extremes of full arousal and total sedation. In their experiments with “Little Albert”, Watson and Rayner (1920) demonstrated that a conditioned fear response would generalize to a wide range of similar but previously neutral stimuli. Pavlov (1927), in his work with orders of conditioning, showed that a chain of several unrelated stimuli could be established that would elicit progressively weaker versions of the original unconditioned response. Wolpe (1973) found that a hierarchy of stimuli can be arranged that produces a carefully graded range of reactions just by thinking about the items in the hierarchy.

Traumatized children construct a “sensitization” hierarchy composed of unconscious and remembered stimuli that is used to control arousal and sedation and the consequent degree of dissociation. The first and most potent order of conditioning is the actual memory of a traumatic event. The strongest conditioned fear reaction possible for a child is an elicited response pattern of sensations and impressions that represent the original experience of trauma. The second order of conditioned stimuli are associated fears -- such as phobias, obsessions, nightmares and taboos -- that only partially cathet the energy of early trauma and bring about a lesser evocation of the original sensory pattern. The third order of conditioned stimuli are the worries, anxieties and concerns that beset everyone on a daily basis. By selectively focusing on this hierarchy of fear, abused children can summon up just enough energy and motivation to keep going in an atmosphere of ontological insecurity.

**Patterns of Spasm and Contraction**

The actual mechanism by which conditioned cognitive stimuli produce their affect is a physical response, the *flexor withdrawal reflex* described by Wilson (1987). When an area of the

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2Author’s note: For an excellent discussion of conditioned emotions, see Kolb, (1987). I did not learn of Dr. Kolb’s work until after this paper was presented.

3The limbic system’s role in adding emotional coloration to incoming stimuli, (Le Doux, 1986), by comparing them with past experience may support the generalized fear conditioning in abused children by labeling the broad category of “other people” as potentially dangerous as all interactions with significant others in the home were problematic. This would explain Laing’s observation that people who are primarily ontologically insecure regard other people as threatening.
body is in pain, this reflex acts to increase the muscle tension around, and diminish the flow of blood to, the pain site. This serves to “splint” the injured area and constrict the blood vessels flowing to it thus preventing hemorrhage. This response protects a child by withdrawing the painful area and keeping it from further movement. This primarily unconscious pain reaction may, however, lead to additional pain from constant tension and spasm in the muscles around the injured area.

Wilson notes that when a pattern of muscle contraction becomes well established, small and very painful knots of muscle (trigger points) begin to form in muscles in and around the pain sites as well as in muscle groups that “splint” the injured area. These painful trigger areas tend to accumulate muscle contraction waste products because the wastes cannot be pumped back out through the constantly constricted muscles. Muscle tissues fill with the acidic waste products which in turn stimulate nerves within the muscles and send pain signals back to the spinal cord. The pain signals elicit reflexes which send impulses back to the muscles and produce a reflex spasm. A vicious cycle is established where the muscle perpetuates its own painful spasm by means of the trigger points that develop within it (pp.16-17). Children who live with violence constantly tense all parts of the body in preparation for flight or fight stemming from abuse by parental authority. By selectively attending to representative symbols of fear in their sensitization hierarchy, they can precisely regulate the degree of tension and the resultant pain coming from muscle contraction and thereby precisely dose the degree of dissociation.

The pattern of muscle tension which activates the trigger points is created when the muscles of expression (face, throat, diaphragm, legs, arms and pelvis) must be inhibited out of a fear of retribution by abusive care-givers. This conditioned pattern of spasm-contraction applies, as well, to the sphincters of the alimentary canal, the somatic focal points of Freud’s psychosexual conflicts. For chronically frightened children, all points along the behavioral continuum of “flight or fight”, including paralysis, represent points of indecision. A true fight response is a spontaneous, unselfconscious expression of energy and rage where the sole purpose is to strike out and control the threat and injury. This talionic response (Jus talionis, Reik, 1962) is “an eye for an eye” matching of energy and form against the source of danger based on the biological wisdom of doing exactly what is needed to neutralize threat. True flight is also a spontaneous and unselfconscious expenditure of energy designed to simply escape from harm. When a child becomes conscious of being perpetually endangered and identifies the self as an object that is protected by neither fighting or fleeing, all outward effort
to secure safety is turned inward, what Perls, et al. (1977) calls retroflexion (retroflexion -- literally going against the reflex). The talionic response (from the same root word as retaliate) and the response of flight are blocked and the energy is turned back in on the self. The self shrinks, contracts and becomes paralyzed in the face of self-directed hostility and force, and the muscles of expression become rigid and tense seeking to inhibit all affect and motion.

Remaining in or re-creating a traumatic environment is a second strategy for regulating dissociation. The pain and fear provoking stimuli are concrete and external, and the level of dissociation is dosed by approaching or avoiding the situations and people who may cause injury and pain. Battered spouses and molested children who seem to willingly return to their abusers are the most vivid examples of this tragic attempt to function in a pain-racked environment.

The use of exogenous substances that excite, sedate and anesthetize is for many people essential for dissociation. The list of legal and illegal substances that mimic or stimulate arousal and sedation is endless but selectively combined with the mechanisms of selective attention and environmental choice, these substances offer a third way to control the semiconscious state of dissociated awareness needed to survive in an atmosphere of threat.

Pain Location

Because the sensation of pain can be generated from both inside and outside the body, a child becomes confused about the source or locus of pain. Frightened and abused children are unable to distinguish if pain is being caused by an outside agent or by stimulation of the flexor withdrawal response. Thus, through time, a child no longer knows if pain is the result of outside stimulation or inner tension that is a preparation for an imminent traumatic encounter. Because the source of pain is not readily identifiable, the response needed to end the pain is unidentifiable as well. The perceived locus of control passes to parental authorities outside the self who guide the fortunes of the family and provide both the substances and patterns of stimulation which bring about excitement (movement), sedation (rest) and analgesia (the killing of pain).

Children become addicted (in the case of substances with tolerance levels) or habituated to the family's cycle of arousal and sedation, reacting when the parents react and resting when the period of violent arousal has passed. Because there is no
governor on the level of arousal in a violent home except the exhaustion of available energy, children are pushed to the point of behavioral collapse. Unlike normal homes where rest is usually a matter of choice following a chosen period of effort, rest in a violent home is usually a matter of compensatory shutdown of arousal activity which approaches or actually reaches a point of physiologic shock. This state can be reached by the action of purely endogenous mechanisms or in combination with exogenous substances that mimic the action of the sympathetic nervous system and the compensatory antagonism of the parasympathetic system. In either case, the idea of choice in the normal sense of freely initiated action has no meaning.

The Superstitious Use of Pain

The role of pain in this cycle becomes superstitious as the child unconsciously believes that action, rest and analgesia are all dependent on the skillful dosing of pain. The use of pain changes during the cycle -- beginning as a stimulus for orientation and arousal, continuing as a motivator of ongoing behavior, and finally becoming the "fix" that heralds rest, collapse and a period of brief relief. Because arousal activity can only proceed for a limited duration, the body is brought to a point of real endangerment by the possibility of anoxia, ischemia and hypoglycemic shock; thus the sacrifice of physical well-being is a real possibility. Children become used to being abused and endangered. In the vernacular of the drug culture, they are "hooked on getting high as a kite and then crashing", and they unconsciously believe that the infliction of pain and the sacrifice of well-being is causally necessary for survival.

The connection between a pain-produced cycle of trauma and shock and the loss of ontological security centers around the loss of the ability to feel. People who are continually moving through the behavioral extremes of mania and depression in a desperate attempt to outrun or hide from pain or the underlying emotions of panic and despair are unable to identify or react to the normal range of emotions which guide and control behavior. They exist above and below the "feeling zone" (Janov, 1980). They are cut off from normal affect and, in fact, have no history of successfully managing these emotions before they were suppressed. Kübler-Ross (1969) writes that denial and isolation are the first stage of mourning and grief. Children who cannot escape trauma lose both a sense of adequacy in dealing with adversity and the ability to perceive that loss. They are doubly deprived because they must isolate the memory of the loss of adequacy from awareness and deny their feelings of loss which keep them trapped in a repeating cycle of denial and isolation.
The Elements of Ontological Security

Children who live in a state of continuous dissociation are unable to maintain the basic requirements needed for primary ontological security. The elements of ontological security are presence, prediction and causality. The problem of presence centers around whether a child is psychologically absent or present in the world. A child in a state of shock is, for example, "absent from the scene" in terms of effective and rational participation. Presence can be divided into present as an object or present as a subject. An abused child is aware of being in the world only as an unfeeling object that is moved about by the whim and caprice of unpredictable care-givers. In contrast, an ontologically secure child is subjectively present in the world. Decisions on how to behave are guided by rational analysis of events and are based on how the consequence of an action feels to the child.

The question of prediction centers around the ability to stay oriented in time and space. The parameters of time are before, during and after: while those of space are here, there and between. In order to take an effective action, the child must first know when and where the behavior is to take place. A child who is disoriented by pain and fear may, for instance, not recognize the need to move out of the way before a parent explodes in rage or to hide over there during a violent argument. Maintaining a stable orientation in time and space for the purpose of effective prediction is simply not possible for a child living in the chaotic environment of a violent home.

Causality focuses on the question of knowing what to do and how to do it -- the actual execution of behavior. To be causally effective, a child must be able to experiment and practice with new behavior and to feel the hedonic consequences (pleasure and pain) of an action in order to perfect a response and to learn from experience. Children who are dissociated from their feelings cannot perceive or evaluate the effects of their actions. Abused children are terrified of attempting any behavior outside of the habitual response pattern which has kept them alive for fear the disruptive consequences of new behavior could shatter their tenuous defense system and lead to complete extinction.

In the following section, I would like to look at a specific type of dysfunctional family in which children are traumatized and left feeling ontologically insecure.
Post-Traumatic Stress Disorder and Family Alcoholism
(The Alcoholic Home)

In recent years, several writers have recognized that the level of violence in an alcoholic home is sufficient to cause the kinds of post-traumatic reactions (DSM-III, 1980) usually found in the survivors of natural disasters and violent military conflicts (Identity Report, Adult Children of Alcoholics, 1984; Russell, 1984; Cermak, 1985). The idea that living in an abusive family can brutalize a person's mind and body to the same extent as being in a famine or a war is difficult for most people to accept. The following statistics from the National Council on Alcoholism (1985) may help clarify the violent nature of alcoholism:

1) Drinking is estimated to be involved in about 50% of spouse abuse cases and up to 38% of child abuse cases.

2) 54% of jail inmates convicted of violent crimes were drinking before they committed the offense. 62% of those convicted of assault and 49% of those convicted of murder and attempted murder had been drinking prior to committing those crimes.

3) In 1984, 53% of all highway deaths were alcohol related.

4) Fetal Alcohol Syndrome is the third leading cause of birth defects with accompanying mental retardation.

5) Alcohol abuse accounts for approximately 88,000 deaths annually (1983). This includes cirrhosis and other medical consequences, alcohol-related homicides, suicides and nonmotor vehicle accidents.

6) Chronic brain injury caused by alcohol is second only to Alzheimer's Disease as a known cause of mental deterioration in adults.

7) One out of three American adults -- 56 million Americans -- say that alcohol abuse has brought trouble to their families (1985).

Alcoholism is a progressive condition that if left unchecked will lead to physical deterioration, insanity and death (NCA Fact Sheet, 1985). Because alcohol abuse does not take place in a
vacuum but is actively or covertly abetted by important people in the alcoholic's life (particularly the spouse), children in an alcoholic home live in a surreal environment in which they are forced to watch their primary care-givers practice and support a pattern of self-annihilation. Alcoholism is, in effect, a protracted act of suicide, that is unacknowledged by the significant adults in a child's family structure. The violence and morbidity inherent in a family with progressive toxicosis (in this case self poisoning) in one or more significant care-givers combined with the aberrant behavior and capricious responding associated with family alcoholism, create a traumatizing environment in which homeostatic regulation is rigid and extreme.

Children who live in a family where there is a blatant disregard for the normal requirements of safety and security are robbed of a model for living that is based on a responsibility to sanity. Because behavior which leads to pain and despair is condoned and efforts to avoid injury and preserve well-being are thwarted and blocked, children find themselves existing in an "Alice in Wonderland" world where rational behavior is stood on its head. Parents who are engaged in consensual insanity cannot afford to have their children display any behavior that is contrary to the family's pattern of dysfunction for fear the pathological pattern will be revealed by its vivid contrast with sane behavior.

When children have been exposed to alcoholic insanity for any length of time, they no longer trust themselves to know what is real or trust those around them to correctly interpret reality. This sense of unreality can be further reinforced by the fact that alcoholics may not remember what they have done during a violent period of intoxication.

**Alcoholism and Dissociation**

Overton (1972) notes that: "...high doses of alcohol produce a dose-dependent defect in memory registration such that permanent engrams tend not to be formed... (and that) many ongoing events are forgotten within 2-30 min. If the short-term memory defect is severe, a blackout results covering the period of time when the short-term memory defect was present. Recall for both significant and emotionally trivial experiences is equally affected." (p.210) Overton states that at this stage of intoxication, the alcoholic passes from a state of dissociation (of remembered events) to a state of "nonassociation" because memories are not permanently registered and, therefore, cannot be retrieved whether the alcoholic is drunk or sober.
Children suffer profound psychological damage when they are abused or neglected by parents who are in a blackout or a dissociative stupor. Pattison (1976) writes that it is: “... paradoxical, yet understandable, that the alcoholic is perceived to act with intention and choice when he experiences within himself a lack of a sense of intention and choice.” (p.417) When parents fail to acknowledge the consequences of their violent behavior and act as if the violence never occurred, children are unable to comprehend what is happening to them and start to believe that they themselves are insane. Children then begin to search for ways to dissociate from their own sense of ontological despair and thereby perpetuate the family's pattern of insanity.

Because alcoholism is a collusive disorder that involves at least two people (Berne, 1976), I would like to suggest a new way of looking at family alcoholism that emphasizes the destructive influence alcoholism has on every member of the family. I would like to propose that family alcoholism is a dissociative disorder that is created and maintained by a consensual agreement (albeit forced in the case of children) of everyone in the family.

Traditionally, researchers investigating the alcoholic family have placed the alcoholic in the role of the primary substance abuser with the rest of the family members playing supporting roles. In Berne's terminology of life-games, the alcoholic is “it” while family members and outsiders play the part of persecutor, rescuer, patsy, agitator or “the connection”. More recently, Wegscheider-Cruse (1981) has proposed the terms dependent, enabler, hero, scapegoat, lost child and mascot. Greenleaf (1981) uses the broader categories of alcoholic, co-alcoholic and para-alcoholic. Although these authors have made an enormous contribution to understanding the plight of children of alcoholics and adult children of alcoholics (ACAs), it would seem that a more fruitful approach would be to see everyone in the family system as mutually addicted to the overall family cycle of mania and depression. The use of alcohol is a dramatic and visible way of inducing intoxication with its predictable cycle of “getting high” and “coming down”. Initially, during the ascending phase of the cycle, there is a sense of euphoria and well-being. Studies have indicated that adrenaline is released during drinking; presumably because the body recognizes that a poisonous substance has been introduced into the system (Gordian and Southren, 1977). The adrenaline, combined with the disinhibition of the central nervous system, contributes to the initial feelings of excitement and well being. As the true depressjve action of alcohol works on the central nervous system, there is a progressive decline into lethargy, stupor and unconsciousness (Himwich, 1968, pp.34-38). Even though no one else in the family
may be using alcohol, each person in the family, including the children, can fashion an idiosyncratic dissociative system that matches the alcoholic cycle of agitation, movement, decline and rest.

When a family lives in a continuous state of dissociation, children may be traumatized by a wide range of stressors. The stressors that cause post-traumatic reactions in children may be grouped into the following categories:

1) **Active abuse:** battering and assaulting the child, painfully excessive stimulation and inhibition (bondage and incarceration).

2) **Injury due to reckless child endangerment (inattention and passive neglect):**
   a) Inadequate temperature regulation -- exposure to extreme heat and cold;
   b) Nutritional or metabolic injury -- starving or stuffing, ingestion of stimulants, depressants and toxins;
   c) Excessive neglect: unsupervised activity bringing frequent injury that leads to hypervigilance, contraction, and anaclitic despair and the need for children to inhibit subsequent suicidal behavior.

3) **Retroflexive tension and taliotic rebound (chronic physical reactions):**
   a) Paralysis of the muscles of expression in an attempt to mechanically inhibit feelings;
   b) Hypoxia and ischemia;
   c) Migraines, referred pain, myofascial pain, musculoskeletal compression of nerves;
   d) Psycho-somatic illnesses.

Adding to the immediate effect of these stressors is the child's continuous awareness of a diminishing possibility for pleasure and joy -- the loss of genuine hope.

The following section is a summary of dissociative strategies used by adult children raised in the abusive environment of an alcoholic home.

**Dissociation**

To survive in the midst of confusion and to have any sense
of control, children in an alcoholic home must distance or
dissociate from feeling the loss of ontological security. The
dissociative process in adult children of alcoholics parallels
their childhood cycle of extreme arousal, sedation and analgesia.

ACAs use three forms of dissociation. (Identity Report, Adult
Children of Alcoholics, 1986):

Functional dissociation relies on the attentional defense
mechanisms of repression, projection and rationalization.
Repression is an outright denial of any existence of trauma as
found in amnesia and self-hypnosis. In projection, the pain and
loss are seen as happening “over there to someone else”.
Rationalization softens the impact of pain by interpreting it as
inevitable or deserved.

Direct physical dissociation depends on substances such as
alcohol, sugar, nicotine and caffeine to alter the perception of
feelings. Alcohol is a powerful depressant that both anesthetizes
feelings and triggers the release of adrenaline which stimulates
the body. Refined sugar can be used to induce a state of high
arousal with subsequent hypoglycemia. In many cases, adrenaline,
which is released in response to glucose exhaustion (Travell and
Simons, 1983), increases the dissociative effect by causing a
more severe cycle of agitation and hypoglycemic shock. Caffeine
is a strong CNS stimulant which may have its own analgesic
properties (Gilbert, 1976). Nicotine functions as both a
stimulant and a sedative depending on the dose and the rate of
ingestion. Nicotine also causes the release of adrenaline which
adds to its stimulating effect (Russell, 1976).

Functionally induced physical dissociation uses negative
excitement to bring about a state of physical dissociation. By
focusing their attention on phobias, obsessions, dreams and
taboo and by compulsively tending in response to these fears,
ACAs stimulate the pain mechanisms within their protective body
armor to bring about the release of adrenaline, endorphins and
melatonin (Brown, et al., 1985; Beck-Friis, et al., 1985; Lewy,
et al., 1979) to chemically block the painful perception of
fundamental insecurity.

All three forms of dissociation can be combined to preserve
a fragile base of stability by offsetting the extremes of panic
and ontological despair.

Trauma and Neophobia

One of the most difficult things to understand in treating
family-based PTSD is why people who were traumatized as children choose to remain in abusive environments as adults. The "law of effect" assumes that people will seek to minimize pain and maximize pleasure, yet millions of ACAs re-traumatize themselves by choosing to stay in situations that re-create their childhood experience of violence and abuse.

The convergent paradigm of optimal arousal and neophobia proposed by Mitchell et al. (1984, 1985) is offered to explain the seemingly paradoxical perseveration of ACAs in painful and self-destructive behavior and learned helplessness in general. Mitchell and his colleagues discovered that traumatized animals will continue their exposure to shock (trauma) by repeatedly making a familiar choice rather than exploring a novel alternative which could end their experience of pain.

In a brilliant series of experiments, these researchers found that animals which usually alternate choosing arms in a T-maze ~50% of the time will rapidly stop alternating and go in one direction if they are consistently shocked at the point of choice. The animals perseverate in choosing the familiar arm when they receive further shock after the choice. More provocative and significant still is the fact that they will perseverate even though they have experienced shock termination by choosing the alternate no-shock arm earlier in the learning trials.

Mitchell suggests that traumatized animals no longer make choices based on feeling pleasure and pain but revert instead to a more primitive form of nonassociative learning concerned with maintaining the familiar and avoiding the new (neophobia). This primitive form of learning operates along a novelty-familiarity continuum which is independent of the hedonic "law of effect" governed by pleasure and pain.¹

Animals and people who are numbed by the effects of trauma and are struggling to stay psychologically present must search for nonaffective cues to direct their behavior until they regain the affective capacity necessary for causal effectiveness. Neophobic perseveration and a reversion to primitive learning are forms of "treading water" until the ability to feel returns. In ontological terms, the predictive need for sameness and a stable orientation in time and space in order to minimize confusion precedes the causal requirement for effectively manipulating the

¹Mishkin believes that the non-associative habituation of a response to a stimulus is mediated by an evolutionarily ancient brain structure, the striatum, which is far older than the cortex or limbic system (Mishkin and Appenzeller, 1987).
environment to maintain homeostatic equilibrium (Bettelheim, 
1972). Tragically, the comforting predictability of a familiar 
choice leads to more pain and a further dissociation from 
internal direction which increases the need to hold onto the 
familiar pattern of trauma and shock. Traumatized people are thus 
"stuck" between presence and prediction and rarely reach the 
level of ontological security needed to risk attempting any new 
behavior that could free them from their self-destructive pattern 
of pain.

Neophobic perseveration in humans is most clearly seen in 
all sado-masochistic relationships where pain is intertwined with 
pleasure and survival. A graphic experimental example of painful 
necrophobic perseveration is seen in Milgram's work with obedience 
to authority. Milgram (1974) found that people would torment 
themselves by continuing to deliver what they thought were 
potentially lethal amounts of electric shock to helpless subjects 
rather than stop their habitual response of obeying external 
authority.

The next section outlines a method for treating family-based 
PTSD which can be used to carefully dismantle the pattern of 
necrophobic perseveration that helps to perpetuate the disorder.

Implications for Treatment of Family-Based Post-Traumatic Stress Disorder

The treatment goal for family-based post-traumatic stress 
disorder is to radically reduce the level of systemic tension and 
to maintain this new equilibrium by restoring an internally 
located sense of control.

Before any psycho-therapeutic work can be done with an ACA 
suffering post-traumatic stress, the variable of exogenous 
substance abuse must first be addressed. Clients who depend on an 
excessive use of substances to aid dissociation may undercut any 
progress made in therapy by reinforcing the dissociative process 
outside of the therapy sessions. Al-Anon cautions its new members 
not to argue with a drunk alcoholic and this concept can be 
extended to "do not do therapy with an intoxicated client". For 
severely addicted clients, a formal detoxification program may be 
needed to get the substance abuse under control. Because the use 
of exogenous substances can be an integral part of a protective 
denial system, immediate and complete withdrawal may not be 
possible or even desirable. However, habitual "overkill" can be 
stopped and the abuse brought within a tolerable limit. For less 
seriously addicted clients, Giller (1987) has designed an 
approach for withdrawing from many common addictions by using
a carefully dosed supplement replacement system. The important point to remember is that a client must be "psychologically available" for therapy to take place.

**Therapy As Disobedience**

Therapy for adult children of alcoholics is essentially an act of disobedience. Adult children are trapped in an inflexible pattern of self-punishing behavior, formed in childhood, and believe that the slightest deviation from this pattern will result in complete psycho-physical disorganization. Because they are alienated from their own internal processes, ACAs have come to depend on external authority to direct their behavior. They no longer trust that they themselves are capable of planning and controlling the actions that are necessary for survival. Successful therapy gives ACAs the confidence to confront and resolve the traumatizing events which imprison them in dysfunctional childhood reactions, and the courage to disobey the dictates of alcoholic authority (Identity Report, Adult Children of Alcoholics, 1987). Disobedience is breathing, relaxing and expressing the inhibited feelings and thoughts that make up the contractive self. Reversing any part of the defensive system that maintains a contraction of being brings an expanded awareness and the possibility of seeing that a pattern of childhood insanity does not have to be a permanent condition.

The adjunctive therapeutic approach of "active biofeedback" (Toomim, 1978), which uses simultaneous GSR (sweat gland activity) and EMG (muscle tension) monitoring during the therapy session, is suggested as a gentle and precise method for desensitizing traumatic material by addressing the cognitive, affective and voluntary motor aspects of the dissociative system and the underlying psychodynamic systems of dependency, trust and control. This approach facilitates mourning the loss of ontological security (the return of feelings) and establishes a more flexible basis for predicting the hedonic consequences of behavior.

M.K. Toomim, (Toomim and Toomim, 1975) has found that the Galvanic Skin Response (GSR—sweat gland activity) is a reliable guide to emotionally significant material. She has discovered that when an emotionally charged memory or thought is close to conscious awareness, the GSR (monitored by a biofeedback instrument) will suddenly rise and stay elevated or will paradoxically go flat. This "paradoxical flattening" seems to reflect a last-ditch effort by the body to prevent painful material from coming into consciousness. With continued exploration, the GSR will usually "spring loose" and swing high
on the scale and the material will surface along with the accompanying emotions which can then be released.

The following case history demonstrates the psychodynamic use of the GSR in conjunction with relaxation:

Susan woke in panic every morning at 4:30-5:00, and the anxiety did not subside until after breakfast. In a hypnotherapy session, she remembered being eight years old and hearing the screams of a neighbor dying of cancer. Tears came to her eyes and she reported feeling fear and tension, but the GSR was flat. Asked to be quiet and go deeper into the hypnotic state, the GSR tone suddenly rose precipitously. Questioned, she stated that the lullaby from Hansel and Gretel was running through her head. She thought it unimportant. The words to the remembered portion are “14 angels to guard her rest.” Further exploration revealed a repressed childhood fantasy that she must be very bad to need 14 angels to guard her rest every night, and death was in the closet waiting to get her when she masturbated. Yet she was in conflict. She could not stop masturbating. Further exploration revealed an elaborate fantasy of which only a few elements had previously surfaced in dreams. After working this material, she was able to sleep normally. (Toomim and Toomim, 1975, p.37)

The interaction between emotionally charged cognitive content and the dissociative pain mechanism maintained by trigger points and muscle contraction is clearly seen when both the EMG and GSR are used in a therapy session:

Bill, a 36 year old man with a dissociative disorder, came into the session experiencing extreme pain in his neck and shoulders. EMG electrodes were placed on his trapezius muscles and a GSR monitor was attached to his right palm. The EMG showed a consistently high tension level ranging between 16-18 microvolts. By contrast, a completely relaxed muscle will range between .5-2 mv. Bill was asked to use the EMG feedback to relax the muscle tension in his neck and shoulders and to allow whatever thoughts were in his mind to come through. After several minutes, he had reduced the tension level to 5 microvolts and began to softly cry. When asked what was there, he began to sob and the GSR, which had been perfectly flat, began to move towards
the top of the scale. He was immediately flooded with
the memory of being held down by the shoulders and
ritually abused by members of a religious cult to
which he had belonged as a child.

A sense of well-being and fundamental ontological security
evolves from a personal history of acting in a way which
consistently leads to satisfaction and pleasure and avoids
frustration and pain. ACAs who are used to being abused are
suppressing a personal history of frustration and failure in
their attempts to lead a full and happy life. They survive,
ironically, by the skillful infliction of tolerable pain which
motivates them and distracts them from underlying feelings of
hopelessness and suicidal despair.

Because the self-abusive pattern is unconscious, habitual
and superstitiously controlled, traumatized people are no longer
aware of the locus of pain production. The pain behavior seems to
be a reflexive and unconditioned response. They do not see that
it is both arbitrary and changeable. Therapy thus begins as an
educative process in which the idea of successful causality is
introduced and the ACA is gently shown the internal causal
connection of body and mind that results in self-inflicted pain.

Active biofeedback is a therapeutic method which allows
ACAs to end this pattern of re-traumatization and to complete
past traumatic experiences in a way that restores self-confidence
and changes the neophobic expectation of a collapse into
confusion and overwhelming pain.

By using active biofeedback, ACAs can clearly see the
tremendous amount of inner power and strength they have available
to escape from alcoholic insanity. Active biofeedback allows ACAs
to disconnect the energy they have cathected to the process of
dissociation and to re-direct this energy into a new, consciously
chosen pattern of living which leads to serenity and peace of
mind. As they slowly move out of denial, they realize that the
capacity to accurately perceive reality has not been lost but has
been restricted out of a necessity to rigidly focus on the
immediate requirements of survival. ACAs become aware that they
can trust themselves to know what is real and can depend on their
own ability to effectively interact in the world.

The therapist can introduce the idea of active biofeedback
using the EMG to inventory the muscles of the body in
establishing a muscle tension profile. When an area of tension
has been located, the therapist may ask the client to further
tense the muscle and to notice the discomfort and pain that
occurs. The therapist might then say: "Now let go of the tension and see how much better that feels." During initial exploration when the GSR starts to react, it is possible for a therapist to point out the connection between cognitive content and physical response by saying: "Look how your body is reacting to what we are talking about right now."

When painful material begins to emerge, it is important to break up the automatic action of stimulus-response by modifying both the stimulus (cognitive material) and the response (body tension). Suppressed cognitive stimuli are changed by bringing them into conscious awareness as they can then no longer be used in the unconscious dosing of dissociation. Response modification occurs when the body armor is relaxed and long suppressed feelings are released and expressed. When ACAs realize that they can confront and respond to the cognitive symbols of childhood trauma without experiencing disintegration, they are encouraged to continue in the process of recovery. The desensitization aspect of therapy is complete when there is no stimulus complex remaining in the unconscious that can bring about a response of tension and pain.

The loss of awareness and the ability to perceive reality is the single most tragic occurrence in a dysfunctional family. The anesthetization of feelings and cognitive nonattention conspire to make everyone in the family only marginally aware at best of the real damage which is occurring to every member of the family on a daily basis. Tragically, the lack of awareness in an emotionally intoxicated family, which is encouraged and enabled by society, is the reason why the damage and abuse first begins. The family is locked into an insane dance of death with full awareness and consciousness being both the enemy and, ironically, the source of freedom and escape.

The process of dismantling the defensive denial system of someone who has emerged from this insane cycle must be done slowly and intelligently with a full recognition that dislodging the carefully constructed dissociative system could unleash a volcano of suppressed emotions that might tear the person apart. The release of unbuffered pain with no clear understanding of how to soothe the hurt or prevent its reoccurrence may unwittingly reinforce the dissociative system by automatically bringing up the habitual pattern of defense. The therapeutic task is to carefully uncover and bring into consciousness the memories and impressions which make up the first order of conditioned mental stimuli, which symbolize and represent the historically earliest events in the traumatic stimulus chain, and to substitute a response consistent with peace and calm for the conditioned
response of tension and fear. This substitution may, of course, lead to a strong abreactive catharsis of feelings surrounding the traumatic events, but the return of feelings and a correct perception of reality is the basic therapeutic goal -- to radically reduce systemic tension and to restore an internal sense of control that is possible when there is a full range of emotion and a capacity to remain open to experience.

It is the child ego state that must be able to tolerate the re-minding and re-membering of the self by allowing the representative material that is deepest on the sensitization hierarchy (and is split off from consciousness) to come back into awareness, and by allowing the anesthetized parts of the body to come back into a feeling state, be re-integrated into a functional whole. The inner child has no history of successfully resolving emergency situations while staying fully present in mind and body. By systematically allowing the repressed representative symbols of early trauma to become conscious while modifying the habitual response of the contractive self, a person can slowly re-inhabit the body and regain the cognitive awareness needed to fully respond to the world.

Conclusion

In this paper, I have suggested a way of looking at family-based post-traumatic stress that sees the disorder as a profound loss of basic ontological security and have proposed a method of treatment that seeks to restore a fundamental sense of well-being.

The theory I am proposing rests on four basic ideas:

1) Post-traumatic stress is the tension created by suppressing unexpressed feelings of grief following the loss of ontological security.

2) The source of dysfunction in family engendered PTSD is an unconscious addiction or habituation to a conditioned cycle of trauma and shock. This cycle is held in place by an unconscious superstitious belief about the necessity for living with sacrifice and pain.

3) Dissociation in family-based PTSD is a protective state of semi-conscious awareness which allows family members to function and to preserve some sense of control in the face of fundamental insecurity. Paradoxically, this defense mechanism depends on continuing in the family's pattern of traumatization in order to maintain a familiar and predictable dissociative state.
4) The treatment goal for family-based PTSD is to radically reduce the level of systemic tension and to maintain this new equilibrium by restoring an internally located sense of control.

Although I have used an alcoholic home to illustrate the etiology of family-based PTSD, I believe this model of traumatization may apply to any dysfunctional family which is characterized by violence and abuse. I hope the ideas that have been presented in this paper will be of value to therapists working with adults who were abused as children.

In closing I would like to emphasize the difference between the habituated, dissociated responding that simply develops in the face of repeated abuse and the conscious consequence learning that is shaped by the subsequent effects of behavior.

ACAs know, at least on a subconscious level, that they are recreating their childhood pattern of insanity and they know what the result of this pattern will be. But once they have entered into a period of retraumatization, they are trapped in their habitual state of semi-conscious dissociation.

It is important for therapists to know when their clients are able to comprehend causal connections and can sense the affective result of their actions and when they are in a state of habitual nonawareness and to act accordingly. Clients who are in a state of near shock need to be soothed and comforted and gently brought back to conscious awareness. By remaining sensitive to ACAs' deep feelings of alienation and despair, and by being willing to stay with them in their isolation, therapists can establish the basic human connection that fosters the sense of confidence and trust required to be ontologically secure.
References


