

'Sticks and stones can break your bones, but words...'
**A psychoanalytic case study of the role of the body in trauma
and containment**

By

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SBTANY001

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:

Date: 20 October 2008

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FOR 'CHAD'

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ABSTRACT

The anaclitic relationship between psyche and soma is a basic premise of psychoanalytic thought, and is richly woven into classic and contemporary literature in this field. Yet there is limited work drawing together these disparate references, or focussing directly on the role of the body as anaclitic basis for the mind, particularly in relation to the reciprocal conditions of containment and traumatising. This qualitative case study aims to explore the usefulness of this particular body of psychoanalytic theory in making meaning of a two-year therapy process with a child who had been multiply maltreated. Clinical case material from this psychoanalytically-oriented therapy was analysed through the lens of the psychoanalytic literature reviewed. This analysis revealed four themes, which reflect the interplay between physical and psychic skins in the child's relationship to the maternal object (Theme 1) and in his sense of self (Theme 2), and the interaction between bodily and emotional digestion in his intake of goodness (Theme 3) and expulsion of badness (Theme 4). These findings point to the utility and robustness of this particular theoretical framework in understanding and integrating a large corpus of previously bewildering and disjointed case material with a multiply traumatised child. Implications for theory and for practice are indicated.

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CHAPTER ONE: INTRODUCTION

This study grew out of the very rich, at times overwhelming, and ultimately deeply privileged experience of a two-year therapy process with a seven year old boy who had been subjected to multiple traumas. These traumas included inadequate early maternal containment, material deprivation and emotional neglect, and chronic physical, psychological and sexual abuse. The concept of 'child maltreatment' encompasses all these acts of omission and commission, and is therefore useful in contextualising this study. In this introductory chapter, I briefly discuss the issue of child maltreatment in South Africa, and then outline my motivation for undertaking the current study, the aims of this research, and the structure of this dissertation.

1.1 Child maltreatment in South Africa

'Child maltreatment' is a general term denoting all forms of child abuse and neglect perpetrated by someone close to the child, including physical, sexual and emotional harm, and the failure to provide for a child's basic material, mental or emotional needs (<http://www.yesican.org/defined.html>; Kaplan & Saddock, 1998). Child maltreatment is associated with a wide range of psychological sequelae and psychiatric symptoms (Kaplan & Saddock, 1998). In 1990, the United States Advisory Board on Child Abuse and Neglect declared child abuse and neglect to be a national emergency (Dawes, 2002). Prevalence rates in South Africa are unclear and controversial, because of differing definitions of maltreatment and inaccurate record-keeping, as well as under-reporting. Despite this, there is consensus amongst experts in this field that here too, "we in this country have an emergency on our hands" (Dawes, 2002, p.2, emphasis in original). A recent study points in particular to the pervasiveness of child maltreatment in the Western Cape, and calls for urgent responses (Dawes, 2006). In their review of a decade of literature in the journal *Child Abuse and Neglect*, Lachman & Poblete (2002) found that, while research on child maltreatment in Africa as a whole has increased over this period, this has been predominantly epidemiological in nature, focussing on documenting the prevalence and incidence of different forms of abuse. Thus there is little documented knowledge about the psychological impact of child maltreatment in the South African

context, or about psychotherapeutic interventions with children who have been multiply maltreated.

1.2 Impetus for the current study

This study is rooted in the richness of the therapy process with a young client I shall refer to as Chad¹. Digestion, both physical and psychic, was a central theme and process during this two-year psychoanalytically-oriented therapy, and after therapy terminated I felt that there was still so much to metabolise. Particularly as the dynamics of the trauma to which Chad had been subjected were re-constellated in the therapy, I felt that I owed it to Chad and to myself as a trainee therapist, to continue reflecting on and processing, integrating and containing, this material after termination. I was particularly moved, as well as mystified, by the importance of physical phenomena, including my own and Chad's bodies, in the therapy process. The driving motivation of this dissertation is therefore to explore the relationship between material and psychic, body and mind, under conditions of containment and traumatisation. These conditions are understood to be reciprocally related: psychological trauma being defined as a rupture to containment, and containment being recognised as the process through which this rupture can repair.

The 'digestive' work of this thesis has included immersing myself in psychoanalytic literature on the role of the body in relation to trauma and containment, synthesising this into a historic review to be used as a lens through which to read the case material. In this process the theory has functioned as a container which has enabled me to think about and make meaning of the clinical material, which often felt chaotic, fragmented and cryptic during the therapy process. While I understand that this state of 'not-knowing' was central to Chad's experience, and therefore important for me to be in and bear, it feels equally important, even in retrospect, to metabolise and make meaning of this. Alongside this personal motivation, the recognition that child maltreatment constitutes a crisis in

¹ The name of the participant and his family members have been changed in order to protect confidentiality.

this country and globally, provided strong impetus for closer examination of this particular case.

1.3 Research aims

In this study, I hope to develop a clinically and theoretically useful understanding of the relationship between physical and psychic phenomena, and particularly of the relationship between therapist and client's bodies and minds, in a therapeutic process with a child trauma survivor. In analysing the case material through the lens of psychoanalytic literature on the role of the body in containment and trauma, I seek to gain insight into shifts from physical to psychic processes in the light of the layered implications of inadequate early maternal containment and chronic traumatisation. More specifically, I seek to understand how Chad's relationship to the maternal object plays out in relation to my body in the therapy space, and how his sense of self manifests in relation to his own body. Of focus will be the dual processes of intake of goodness and elimination of badness, and shifts between concrete and psychic means of doing so, through incorporation and expulsion, introjection and projection.

My aim in so doing is to draw together and integrate the disparate psychoanalytic literature in which concepts of the body converge with those of trauma and containment, in order to create a coherent theoretical frame through which to analyse the case material. This attempt to fill a gap identified in the existing literature will be done in three ways: in Chapter 2, I provide a historical review of different theorists in whose work these key concepts converge; secondly, I apply an integrated understanding of these to the analysis of case material in Chapter 3, using the theory as a coherent lens through which to 'read' the data; thirdly, in Chapter 5 I make explicit links between the case analysis and the reviewed psychoanalytic literature, examining the 'goodness of fit' between these and identifying points of convergence and divergence.

1.4 Dissertation structure

This dissertation is structured as follows:

Chapter 2 provides a historic review of psychoanalytic literature on the role of the body in trauma and containment by tracing the overlaps between these concepts in the work of key theorists. Of focus are the dual relationships between psyche and soma, and between mother and child, and the processes of mergence, separation and reconnection between these two sets of entities, under conditions of containment and traumatisation. The motif of the skin on the one hand, and metabolisation on the other, are discussed in relation to the bodily and psychic processes of incorporation/introjection and expulsion/projection.

Chapter 3 outlines the methodology of this psychoanalytic case study, situating this design in relation to qualitative clinical research. The context of the study, details of the child participant, and the nature of the therapeutic intervention are outlined, and the method of data collection and analysis described. Ethical considerations are also addressed here.

Chapter 4 comprises an analysis of the case material through the lens of the literature reviewed in Chapter 2. After outlining the case history, four inter-related themes in the case material are identified and explored: Chad's relationship to the maternal object; his attempts at incorporation and introjection of goodness; Chad's sense of himself; and his evacuation and projection of badness. These themes are discussed in relation to the layered implications of inadequate early material containment, and of the chronic subsequent trauma to which Chad was subjected.

Chapter 5 summarises the findings of this study through a discussion of the usefulness of the literature reviewed in Chapter 2 in making meaning of the case material analysed in Chapter 3. Various limitations of this study are then outlined, and finally recommendations are made for future research and clinical practice.

CHAPTER TWO: THE ROLE OF THE BODY IN PSYCHOANALYTIC UNDERSTANDINGS OF TRAUMA AND CONTAINMENT

Trauma is a kind of wound. When we call an event *traumatic*, we are borrowing the word from the Greek where it refers to a piercing of the skin, a breaking of the bodily envelope. In physical medicine it denotes damage to tissue. Freud (1920) used the word metaphorically to emphasise how the mind too can be pierced and wounded by events, giving graphic force to his description of the way in which the mind can be thought of as being enveloped by a kind of skin, or protective shield (Garland, 1999a, p.9).

This chapter provides an historical review of the role of the body in psychoanalytic conceptions of trauma and containment, tracking key theorists in whose work these concepts converge. As the excerpt above suggests, these themes are entwined: the workings of the mind mirror those of the body, both of which are implicated in trauma, which is itself a rupturing of containment. Of focus are the changing relationships between psyche and soma, and simultaneously between mother and child, in early development. Both sets of relationships will be explored through the psychoanalytic concept of *anaclysis*, and discussed through the stages of initial mergence, gradual differentiation, and on-going connection. It is through containment, initially maternal and then internal, that this mysterious, almost alchemical transmutation from physical to psychical, and from absolute dependence to selfhood, will be shown to take place. Disruption to containment, which constitutes trauma, will be shown to result in a reversal back into the initial state of indistinction between body and mind, self and other, so that symbolic thought becomes concretised.

Two central motifs weave through all these themes and across the different theorists discussed: the physical and psychical role of the skin on the one hand, and of metabolisation on the other, during the early oral stage of development. In particular, this review will explore the role of the mother's body and mind in functioning *as* a skin for her child, in digesting *for* her child, before these capacities are internalised, and the

implications if this does not go well. These motifs will be discussed in relation to the psychological processes of internalisation and projection, based on corporeal incorporation and expulsion, and their role in constituting the boundaries of the self, enabling separation and communication with m/other, and thus in the evolution of inner psychic reality. In addition to the consequences when this process is disrupted through trauma, I explore 'benign' disruptions in the form of manageable frustration which gives rise to symbolic thought, and through which physical and psychical are differentiated, and in the form of abjection, or that which is inassimilable, where states of mergence and separation between mother and child are held in tension.

2.1 Definitions of trauma

In discussing the theme of psychological trauma, I accept the contemporary psychoanalytical definition of this as the internal implications of external events that overwhelm the psyche by breaking through its protective barrier and thus disabling processes of assimilation (Garland, 1999). Historical changes in psychoanalytic understandings of trauma are discussed in relation to particular theorists, but space constraints preclude a dedicated discussion of contemporary psychoanalytic trauma theory - instead, implications for this are mentioned in relation to relevant theorists. While the central psychoanalytic debate regarding the relative weight of the internal or external worlds, of fantasy or reality, in determining traumatisation is implicit in much of what will be discussed, this is also not of focus here.

For the sake of clarity, I distinguish in the discussion that follows between what I (somewhat unsatisfactorily) term 'developmental' and 'external' trauma². The first, which psychoanalysis has historically emphasised, relates to incremental disruption within the primary caregiving relationship, usually involving separation and loss. This may be caused by factors stemming from mother and/or child, which range from overt events such as maternal illness or absence, to more subtle complications such as the

² While this distinction is central to the historical development of psychoanalytic thinking on trauma, I have found no clear terminology or definitions by which it has been clarified.

infant's envy, or a failure to bond (Temple, 1999). The second form of trauma, which is the focus of contemporary psychoanalytic theory as well as psychiatric approaches to trauma, relates to (the internal consequences of) extreme, concrete, external events. These may range from a single devastating event to chronic situations of prolonged physical, sexual or psychological abuse, or neglect and deprivation (Herman, 1997). The case to be analysed in this research study involves both 'developmental' and 'external' trauma.

2.2 Defining the boundaries of the review

In focusing on the relationship between psyche and soma, this review is situated within the historical philosophical 'body-mind' debate, which remains a central question across the social- and neuro-sciences. The legacy of Cartesian dualism meant that body and mind were split in modern Western thought, a divide which post-modernism has sought to problematise and bridge (Grosz, 1994). While it forms the backdrop to this chapter, the direct exploration of this debate is outside its bounds, which are restricted to psychoanalytic literature. This means omitting beyond brief mention literature from the contemporary cross-disciplinary body theory field that situates psychoanalytic thought within the body-mind debate (see Grosz, 1994). A major figure in this field, feminist writer Elizabeth Grosz (*ibid.*, p.27-8), understands that the contribution of psychoanalysis to this debate lies in its "radical presumption of a correspondence or correlation between the forms of the body and the forms of mind", which challenges and subverts the Cartesian divide.

In so doing, psychoanalysis recognises what Grosz (*ibid.*, p.27) calls "a two-way determination or overdetermination, a clear interaction of the biological and psychological". This two-way interaction involves the role of the body in generating the psyche, and the role of the psyche in shaping the body. Although in some ways an artificial distinction, I limit this discussion to the *first half* of this interaction: the evolution of the psyche (and its defences) from out of the soma, rather than the effects of the mind on the body. This means omitting the substantial field of psychosomatic symptomatology (although a few exceptions are made when directly applicable to the case material), as well as the field of body work (which has particular application with trauma survivors). Despite the fact that the corporeal basis of psychical functioning is a

basic premise of psychoanalysis, there is a dearth of literature within this field that elaborates on this premise and so explicitly explores this 'loop' of the body-mind relationship. In addition to the few theorists who do address this theme directly, I therefore examine its implicit presence in the work of key psychoanalytic theorists. In so doing, I follow a conceptual trajectory from Freud to Klein; post-Kleinians Bion, Segal, Bick and Anzieu; Winnicott and finally Kristeva.

2.3 Freud

Psychoanalysis is premised on a particular understanding of the relationship between body and mind; this school of thought grew out the study of psychological trauma. These two fundamental themes, of the body-mind relationship and of psychological trauma, will now be traced in Freud's thinking³, with emphasis on places of overlap, which is where the third theme of containment emerges. The concept of anaclisis, identified as central to this thesis, is explored in relation to the organic and psychic components of (oral) instinct; the growth of emotional love from its basis in bodily nourishment; the development of psychological internalisation and projection from the corporeal model of incorporation and expulsion; and the evolution of the psychical ego from out of the bodily ego. The relationship between physical and psychical is then tracked through Freud's three formulations of psychological trauma.

Freud is acknowledged as one of the great twentieth century thinkers to challenge and subvert Cartesian dualism through his formulation of a complex and irreducible interrelationship between body and mind (Grosz, 1994). While there is a tension in his work between neurological and psychological paradigms, Freud always sought to integrate the two (Anzieu, 1989). He famously proposed that "the ego is first and foremost a bodily ego" (Freud, 1923/1995, p.636), founded upon "a person's own body, and above all its surface" (ibid.). Freud never elaborated on this significant and highly condensed statement, and although it is often quoted in secondary sources outside of

³ While this discussion moves between different stages of Freud's thinking without making this explicit, I acknowledge that his theorising is not unified (Greenberg & Mitchell, 1983).

psychoanalysis, the implications of this assertion have not been explored within this field - with the notable exception of Didier Anzieu (Grosz, 1994). According to Anzieu (1989, p. 84, emphasis added), this statement assumes what he identifies as “one of the fundamental tenets of psychoanalysis, which states that *every psychical phenomenon develops in constant reference to bodily experience*”. This relationship between physical and psychical takes a particular form, captured in the psychoanalytic concept of ‘anaclisis’ which stems from the Greek word meaning “to rest upon, to lean on” (Laplanche & Pontalis, 1973, p.29).

Freud first used the idea of anaclisis to explain the relationship between physical and psychical process in the development of instincts, which he understood to exist “on the frontier between the mental and the physical” (Freud, 1905/1995, p.256). What he termed the ‘source’ of the instinct is somatic (in the prototypical case of hunger, this would be the bodily need for nourishment), but the ‘aim’ (to eat and so satisfy the hunger) and ‘object’ (in this case, food) of the instinct transports it into the psychical realm. This object to which the instinct attaches itself is understood as a precursor to internal object relations, which emerge out of the fulfillment of the oral instinct (Greenberg & Mitchell, 1983). This means that instincts “are not only the *mechanisms* of the mind, they are also its contents” (ibid., p.23, emphasis in original). Instincts therefore undergo “vicissitudes” (Freud, 1915/1995, p.568) from physical to psychic, in which the relationship between these is

... neither parallelistic nor causal; rather, it is understood by analogy with the relationship between a delegate and his mandator (Laplanche & Pontalis, 1973, p.364).

This analogy illustrates the nature of the anaclitic relationship: the delegate carries out the instructions of the mandator, but in so doing modifies these such that they *both stem from and depart from the initial directions*.

An equivalent relationship is understood to exist in the evolution of emotional love from its basis in bodily nourishment during the oral stage. This occurs through the gradual

differentiation of sexual instincts from ego instincts⁴. As Freud (1905/1995, p.263) explains in relation to oral activity during breast-feeding, initially “sexual activity attaches itself to functions serving the purpose of self-preservation”. Gradually, the erotic pleasure becomes distinct from the pleasure derived from the satisfaction of hunger, and becomes associated instead with emotional love which is independent of the bodily need for nourishment. The departure of the drive from the instinct on which it is based occurs (like the instinct from its somatic source) through the nature of its object, which is now in the realm of fantasy: love as opposed to food (Grosz, 1994). Freud termed this psychological side of the sexual instinct ‘libido’, which “stands in the same relation to love as hunger does to the nutritional instinct” (Laplanche & Pontalis, 1973, p.240). He identified specific developmental stages characterised by particular forms of libidinal energy, and dominated by different erotogenic zones (including oral, anal, phallic and genital stages). At each stage, specific modes of object relating emerge out of the particular developmental activity and the associated forms of pleasure experienced. For example, during the oral stage:

The activity of nutrition is the source of the particular meanings through which the object-relationship is expressed and organised; the love-relationship to the mother, for example, is marked by the meanings of *eating* and *being eaten*... Furthermore, the *experience of satisfaction*... is an oral experience; one may therefore advance the hypothesis that desire and satisfaction are forever marked by this first experience (ibid., p.287-8, emphasis in original).

Thus, just as the sexual pleasure here located in the mouth and lips develops through an anaclitic relationship to feeding, so the particular relational model emerges out of the satisfaction of the instinctual aim. ‘Incorporation’ is both the instinctual aim and the relational mode during the oral stage, and involves the phantasy of taking an external object inside the body, of retaining it there, and of adopting its qualities (ibid.). This is

⁴ This terminology follows Laplanche & Pontalis’s (1973) distinction, in keeping with Freud’s. Grosz (1994) explores the same relationship with reference to drives and instincts. I understand the latter to be a generalisation of the former, and use the two sets of relationships interchangeably in this discussion.

associated with pleasure to the self, as well as destruction of the penetrating object. While incorporation is modeled on the oral ingestion of food, it may be transferred to other functions such as hearing, touch or sight, seen for example in the phantasy of “devouring with the eyes” (ibid., p.237). Incorporation provides the “corporeal model” (ibid., p.211) for the psychical process of introjection, which similarly involves the phantasy of transposing objects, along with their intrinsic qualities, from outside to inside, but is now independent of “the body’s real boundaries” (ibid., p.229).

Projection is the complementary psychical process to introjection, and is based on the bodily experience of expulsion. In this primitive defense against unpleasurable internal excitations, objects or desires which “the self refuses to recognise or rejects” (Laplanche & Pontalis, 1973, p.349) are ‘put into’ another person or object, and so treated as external. While experiences of expulsion occur in the oral stage of development, it is during the second, anal, stage that evacuation, alongside retention, becomes the focal process. During this stage (occurring around two to four years of age), object relating is shaped by meanings associated with the functions of defecation. On the one hand, evacuation provides a model for destruction of the object; on the other hand, retention is associated with possessive control. Observing that the activity of defecation gives rise to “the symbolic meanings of giving and withholding” (ibid., 1973, p.36), Freud came to see faeces as the child’s first gift.

The psychological processes of introjection and projection are therefore anacritically based on corporeal incorporation and expulsion. Freud (cited in Laplanche & Pontalis, 1973, p.230) illustrates this relationship in relation to orality:

“I should like to eat this’, or ‘I should like to spit it out’... [becomes] more generally: ‘I should like to take this into myself and to keep that out’”.

It is through⁵ these dual sets of processes that inside and outside become distinguished, and through their generalisation from bodily to psychological that this separation comes to include that of subject and object, ego and other. In relation to the first set of processes:

In psychoanalysis the bounds of the body provide the model of all separations between an inside and an outside. Incorporation involves this bodily frontier literally. Introjection has a broader meaning in that it is no longer a matter only of the interior of the body but also that of the psychical apparatus, of a psychical agency, etc (Laplanche & Pontalis, 1973, p.230).

Freud understood the passage from one libidinal stage to another to occur through a “translation’ that may be more or less successful” (ibid, p.237). When successful, the child is able gradually to develop from dependence to autonomy by renouncing the particular ties associated with each stage (Greenberg & Mitchell, 1983). When unsuccessful, ‘fixation’ occurs at a particular stage, and functioning continues unchangingly to be determined by the forms of satisfaction and object relating specific to that stage (Laplanche & Pontalis, 1973). Fixation is therefore the aetiological root of mental illness and the point to which regression recurs. Freud understood fixation to result from constitutional and/or environmental factors, the latter including both ‘developmental’ and ‘external’ trauma. When specific developmental tasks have not been successfully negotiated, the ability of the psyche to manage subsequent traumas is impaired. For example, in the case of mourning, when the distinction between inside and outside has not been adequately established through the processes discussed above, the lost object cannot be internalised. Instead, Freud understood that “the shadow of the object fell upon the ego” (cited in Greenberg & Mitchell , 1983, p.71), which Ulnik (2008, p.37) translates into ““the shadow of the object *surrounding* the ego””. Although in a pathological form, this suggests the idea of containment (Greenberg & Mitchell, 1983).

⁵ Whether these processes are dependent upon, or actually usher in the differentiation between internal and external is subject to debate.

In his structural model of id, ego and superego, Freud (1920/1995, p.606) understood the ego to be situated “on the borderline between outside and inside” such that it is both “turned towards the external world and must envelop the other psychological systems”. He saw that this reflected the physical functions of the skin⁶, which he therefore understood to be the anacritic root of the psychic functions of the ego:

the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body (ibid., p. 637).

The psyche is therefore understood to both arise and depart from the physical body; it is neither reducible to, nor completely divisible from, its somatic source. Rather, the ego emerges through transformation of matter into mind: “an actual psychological operation consisting in the ‘projection’ of the organism into the psyche” (Laplanche & Pontalis, 1973, p.141). Freud did not resolve the question of *how* this transmutation takes place, terming it “the mysterious leap” (cited in Grosz, 1994, p.51) from soma to psyche. It has been left to later theorists to contextualise his thinking in relation to the philosophical body/mind debate, which is beyond the scope of this discussion [See Grosz (1994) and Hinshelwood (1989)]. In thus picturing the ego as an envelope, Freud ushered in a new era in psychoanalysis, and one considered essential for its later development: While previously psychoanalysis had focussed on the (unconscious and conscious) *contents* of the psyche, the *containing function* of the psyche itself now assumed centrality (Houzel, 1990). As such, the ego as ‘limiting membrane’ is understood to protect the psyche from both external and internal excitations. Those that break through this shield Freud defined as traumatic. It is to Freud’s three theories of psychological trauma that this discussion now turns.

⁶ It was left to later theorists to develop this link, principally involving *distinction* and *integration* (see Anzieu and Winnicott below).

Freud's first theory of psychological trauma, known as the 'seduction' theory, grew out of his early work on hysteria. Hysteria was a widespread public health problem in nineteenth century Europe in which women presented with a range of physical symptoms for which no organic causes could be found. These symptoms (such as paralysis of limbs, loss of perceptual functioning and intestinal disturbances) mystified medical experts, and were frequently disbelieved (Likierman & Urban, 1999). The celebrated neurologist, Charcot, was the first to systematically study hysteria, which he came to understand as a neurological disorder with a psychogenic aetiology. His followers, Freud and Breuer, expanded on this understanding in their important work, 'Studies on Hysteria' (1896/1995), where they outlined their findings that hysteria is rooted in psychological trauma. This they defined as "the overwhelming of the ego..." (Freud & Breuer, 1896/1995, p. 96) by "external events".

Through a process of historically tracing back their patient's symptoms, Freud and Breuer found that these 'external events' all related to early sexual abuse, which they concluded to be "the aetiological precondition for hysterical symptoms" (ibid., p.100). These symptoms were therefore seen as somatic symbols of the sexual trauma which remained repressed as a 'foreign body' within the psyche. Psychic conflict was therefore understood to be both expressed and repressed through the body, making hysteria a condition which "travers[es] the body/mind split" (Grosz, 1994, p.38). Right at its inception, therefore, the study of psychological trauma was intertwined with the question of the relationship between body and mind⁷. The 'talking cure' of psychoanalysis arose from the recognition that these hysterical symptoms improved when the underlying traumatic event, and the feelings associated with this, were made conscious, remembered and verbalised (Herman, 1997).

⁷ Exploration of this question in relation to hysteria is beyond the scope of this discussion, as it relates to symptomatology. See Grosz (1994) and Anzieu (1990).

In his second theory of psychological trauma, Freud (1897/1995, p.111) came to understand that “neurotic symptoms were not related to actual events but to wishful phantasies”, and therefore that “psychical reality was of more importance than material reality” (ibid.). These phantasies, understood to be of an Oedipal nature and so involving forbidden desires, Freud understood to be traumatic in themselves (Freud, 1905/1995). They were therefore repressed, giving rise to hysterical symptoms. While the reasons for this reformulation have been much debated [see Herman (1997) and Gay (1995)], it was of great significance for the development of psychoanalysis, which turned attention away from the internal implications of external events, to the internal world of unconscious phantasy (Garland, 1999). Thus, “psychic conflict replaced psychic trauma as the major theoretical and clinical paradigm of psychoanalysis” (Ulman & Brothers, 1988, p.2).

In his third formulation of psychological trauma, Freud, prompted by his witnessing of combat neurosis during and after World War 1, returned to his original emphasis on external reality, but now with a greater recognition of the interplay between inner and outer worlds. Freud drew a parallel between what he termed the ‘traumatic neurosis’ of war, and hysteria, which he called “the traumatic neuroses of peace” (Freud, 1920/1995, p.598). He now understood both post traumatic conditions as “a consequence of an extensive breach being made in the protective shield against stimuli” (ibid., p. 608). This barrier, which Freud pictured as “a special envelope or membrane”, protects the psyche from excessive external and internal stimuli, in order to maintain psychic equilibrium according to the pleasure principle. Freud defined as traumatic “any excitations from the outside which are powerful enough to break through the protective shield” (ibid., p.607).

This theory of psychic trauma was modelled on that of physical wounding as a consequence of rupture to the body’s boundary. In the case of bodily injury, excitations move from the surface where the skin has been broken, to the brain, and it is here that the pain is registered. Analogously, Freud understood that psychic trauma results not from the traumatic event itself (as ‘shock theory’ held), but from the

effects produced on the organ of the mind by the breach in the shield against stimuli and by the problems that follow in its train (ibid., p.608, emphasis added).

Anxiety is understood to be the psychic equivalent of physical excitations that communicate the traumatic rupture to the mind (Garland, 1999b). The psychological implication of this is the triggering of unresolved unconscious fantasy, particularly that of an Oedipal nature. Thus Freud's final formulation of trauma brought together his initial recognition of its origins in external events and his subsequent exploration of the role of unconscious fantasy, now understanding that it is the *internal meaning* of the *external event* that is psychically traumatising. This forms the basis for contemporary trauma theorist's understanding that trauma arises through a "combination of internal and external factors" (Bell, 1999, p.167), external events being rendered traumatic according to the specific internal meaning that they hold for a particular person at a particular time, according to their internal object relations, anxieties and defences.

Freud's theory of psychical healing was also modelled on that of physical repair. He proposed that excessive, free flowing excitations that break through the protective shield undergo a process of psychic 'binding'. Although inconsistent in his use of this term, Freud understood binding to be a defensive linkage of dispersed energy to form a cohesive "mass" (Laplanche & Pontalis, 1973, p.50), which can then be discharged through "dreams, sublimations and neurotic symptoms" (Bell, 1999, p.173). This process is understood by contemporary theorists as that by which traumatic material is given meaning in relation to existing internal object relations (Garland, 1999c). This process, however, is dependent on an already developed ego (Laplanche & Pontalis, 1973). In cases of early and enduring trauma in which this is not yet established, binding may be replaced with what Garland (1999b, p.19) calls "fusion", where present and the past collapse into one another in such a way that each "not only makes sense of the other, but each seems to confirm the most pathological features of the other". This underlies the 'repetition compulsion'⁸, which Freud understood to stem from the process of binding (Laplanche & Pontalis, 1973).

⁸ The evolution of this 'stimulus barrier' theory of psychological trauma out of Freud's understanding of the 'compulsion to repeat' is beyond the scope of this discussion.

2.4 Klein

Melanie Klein, writing between the years of 1921 and 1960, developed a new school of psychoanalytic theory and practice that built upon the basic tenets of Freudianism but moved well beyond these. In contrast to Freud's retrospective understanding of early development through the analysis of adult patients, Klein specialised in the psychoanalysis of children, and it was from this clinical experience that she developed her theory of the inner world of early childhood and infancy. Klein believed that a primitive, fragile and poorly integrated ego exists from the time of birth, containing both benign and malevolent internal objects. These objects evolve through the dual processes of introjection and projection in the interplay between internal phantasy and external reality. This early ego oscillates between states of disintegration and integration according to the predominance of the paranoid-schizoid and depressive positions (Bell, 1999). The paranoid-schizoid position is dominated by part-object relations, in which bad is split off from good and projected outwards, giving rise to paranoid anxiety. In the depressive position, with the advent of whole object relations, these disowned parts can be reintegrated into the ego, and good and bad held in ambivalence (Segal, 1973). For Klein, these positions represent both specific stages of development, and configurations of intrapsychic functioning which we continue to move between throughout life (ibid.). Segal summarises the particular patterns of object relations, anxieties and defences characteristic of each position. In paranoid-schizoid functioning:

The object is seen as split into an ideally good and a wholly bad one. The aim of the ego is total union with the ideal object and total annihilation of the bad one, as well as of the bad parts of the self. Omnipotent thinking is paramount and reality sense intermittent and precarious. The concept of absence hardly exists. Whenever the state of union with the ideal object is not fulfilled, what is experienced is not absence; the ego feels assailed by the counterpart of the good object – the bad object or objects... A leading defence mechanism in this phase is projective identification (Segal, 1954/1988, p.164).

During depressive position functioning,

... the main characteristic of object relation is that the object is felt as a whole object. In connection with this there is a greater degree of awareness and differentiation of the

separateness between the ego and the object. At the same time, since the object is recognized as a whole, ambivalence is more fully experienced. The ego in this phase is struggling with its ambivalence and its relation to the object is characterized by guilt, fear of loss or actual experience of loss and mourning, and a striving to re-create the object. At the same time, processes of introjection become more pronounced than those of projection, in keeping with the striving to retain the object inside as well as to repair, restore and re-create it (ibid., p.166).

Klein's understanding of the development of inner psychic reality is based on what has been termed a "body function model" (Davis & Wallbridge, 1981, p.66). In keeping with the psychoanalytic concept of anaclisis explored above, the processes of introjection and projection through which internal objects are constituted are understood to evolve on the basis of the bodily experiences of taking in nourishment and expelling waste. Thus goodness is 'eaten' into the body/psyche, and badness 'excreted' out beyond its borders. Klein understood the mother's body to be paramount in these processes: as the infant's first object (initially in the form of the breast as part-object), it is the earliest source of gratification and love, as well as of frustration and envy: "The child turns to his mother's body all his libidinal desires but... also all his destructiveness" (Segal, 1973, p.5). Thus it is the maternal body (and initially it's parts) from which the infant seeks to take in goodness, and into which he⁹ seeks to expel badness.

Klein extended Freud's understanding of instincts in emphasising the role of phantasy that emerges in direct response to them, as, for example, a hungry infant, instinctually seeking to satisfy this hunger, phantasises an object able to do so. These first phantasies, like the instincts they accompany, are experienced as "somatic as well as mental phenomena..." (Segal, 1973, p.13). This means that both the object conjured through phantasy to satisfy the instinctual desire, and the actual satisfaction gained through this

⁹ The masculine pronoun is used throughout as this enables easier distinction from the (feminine) mother, and because the case examined in this research project is a boy. This by no means implies that the processes discussed are no less relevant for girl children.

phantasy, are experienced as “physical happenings” (ibid.). Segal (ibid.) provides two examples of this:

... an infant going to sleep, contentedly making sucking noises and movements with his mouth or sucking his own fingers, phantasies that he is actually sucking or incorporating the breast and goes to sleep with a phantasy of having the milk-giving breast actually inside himself. Similarly, a hungry, ranging infant, screaming and kicking, phantasies that he is actually attacking the breast, tearing and destroying it, and experiences his own screams which tear him and hurt him as the torn breast attacking him in his own inside.

With regard to the first of these processes, the good breast is introjected through “imaginative eating” (Davis & Wallbridge, 1981, p.66), the psychological experience of intake being anacritically based upon the physical one. As Klein explains: “...the infant feels that he *concretely* internalises the breast and the milk it gives (Klein, 1957/1975, p.180, emphasis added). Klein understands the mysterious transmutation from bodily to psychical experience to occur *through* unconscious phantasy, in which the infant “imbue[s] the breast with qualities going far beyond the actual nourishment it affords” (ibid.). When it has been adequately introjected in this way, the good breast becomes integrated into the ego, forms its core and enables its development and cohesion (Hinshelwood, 1989). Therefore: “the infant who was first inside the mother now has the mother inside himself” (Klein, 1957/1975, p.180).

The second psychic process, that of projecting out badness, Klein similarly understood to be rooted in, and experienced through, bodily expulsion. As in the case of introjection, physical experience is imbued with psychological qualities through unconscious phantasy. This takes the form of what Klein (1957/1975) terms ‘urethral-’ and ‘anal-sadism’, in which the mother’s body is, in the first case, drowned or burned and, in the second case, exploded or poisoned. These phantasied attacks leave the child with immense anxiety in relation to the broken and revengeful objects felt to be left in the mother’s body. This anxiety is therefore displaced from the mother’s body to the external world, a process which Klein understood as the start of symbolisation. She saw play as the primary medium of this, which, along with activity in general, “serves to express,

contain and canalise the child's unconscious phantasy" (Segal, 1973, p.9). Klein therefore believed symbol formation to be the basis of ego development (Segal, 1954/1988).

A more complex illustration of the relationship between unconscious phantasy and bodily experience is found in Klein's understanding of, and distinction between, greed and envy. Both involve phantasied attacks on the maternal body, the first through introjection and the second through projective identification:

Greed is an impetuous and insatiable craving, exceeding what the subject needs and what the object is able and willing to give. At the unconscious level, greed aims primarily at completely scooping out, sucking dry, and devouring the breast: that is to say, its aim is destructive introjection; whereas envy not only seeks to rob in this way, but also to put badness, primarily bad excrements and bad parts of the self, into the mother, and first of all into her breast, in order to spoil and destroy her... This process... [can be] defined as a destructive aspect of projective identification (Klein, 1957/1975, p.181).

Here introjection and projection are used for destructive rather than productive purposes, and with this the focus of phantasied action turns from the ego to the object: good is greedily *taken away from* the m/other (not just taken into oneself), while bad is *put into* the envied object (not just gotten out of oneself). In this anomaly of attacking the maternal body that is at the same time "the source of life" (Segal, 1973, p.40), Klein saw the first expression of the death instinct. Klein's understanding of the primitive defence mechanism of projective identification is closely associated with that of envy. It can be defined as an "anal attack on the object by means of forcing *parts of the ego* into it in order to take over its contents or to control it" (Hinshelwood, 1989, p.179, emphasis in original). This situation of one person felt to contain parts of the another makes Klein's understanding of projective identification a pre-cursor for conceptions of containment central to contemporary psychoanalysis (ibid.).

While Klein herself did not directly address the topic of psychological trauma, her thinking is drawn on extensively by contemporary psychoanalytic trauma theorists (Garland, 1999). Her understanding that events in the external world are filtered through the dynamics of the internal world implies that psychological danger is internally

generated through persecutory anxieties and fears of retaliation in response to destructive impulses. In this way,

[i]nner realities shape the way external realities are perceived by the child so that frustrations and discomforts feel as if they are hostile, attacking forces (St. Clair, 2004, p.46).

It follows that the external traumatic event is felt to be caused by internal objects, either in the form of hateful bad ones or neglectful good objects (Young, 1999). At the same time, chronic early trauma disrupts the internalisation of good empathetic objects. This leads to a self-perpetuating cycle in which reality confirms rather than disconfirms intense early internal fears of annihilation, persecution and fragmentation (Bell, 1999).

2.5 Bion

Wilfred Bion (1897 – 1979) drew on and developed classical Freudian and Kleinian theory to create his own formulation that has changed the course of psychoanalysis. While he insisted that his thinking “does not replace any existing psycho-analytic theory but is intended to display relationships which have not been remarked” (cited in Sandler, 2006, p.190), Bion has come to be seen as the key figure in post-Kleinian thought, argued by some to have surpassed her in influence (Hinshelwood, 1989). Bion worked with psychotic patients, and his thinking is based on this experience. This discussion focuses on Bion’s model of psychic functioning as a mental metabolic system rooted in the oral phase of development, the application of this in the container-contained relationship, and the implications when this relationship is ruptured. I then look at the differentiation between physical and psychic in the evolution of thought, and the collapse in distinction between these under conditions of ‘developmental’ trauma. I conclude by mentioning the applications of Bion’s work in contemporary psychoanalytic understandings of ‘external’ trauma.

Bion’s (1962) theory of psychical functioning is modelled on that of physical digestion. He understood that the bodily processes of metabolism forms the concrete basis upon which mentalisation evolves. This occurs through the “adaptation” (ibid., p.57) of physical alimentation in response to the requirements of reality. Through this adaptation,

the physical digestive system is “abstracted” (ibid., p.62) into what Bion terms the “mental alimentary system” (ibid., p.102). This system is adaptive in its capacity to psychically digest raw sensory and somatic material and so transform it into meaningful psychical components. Bion termed the “undigested” (ibid., p.7) units of experience ‘beta-elements’. Through the process of psychical metabolisation that he named ‘alpha-functioning’, these are transformed into mental products known as ‘alpha-elements’. Alpha elements link together to enable thinking and the capacity to dream, daydream, imagine and remember, and so can be likened to “food for thought” (Bléandonu, 1994, p.152). These linked-together alpha elements, which Bion called the ‘alpha-screen’, at the same time serve a protective function in filtering out excessive internal and external stimuli. The alpha-screen, to which Bion referred alternatively as the ‘contact barrier’, is therefore the psychical equivalent of Freud’s neurophysiological ‘protective shield’, and alpha functioning an elaborated understanding of Freud’s concept of ‘binding’ (Hinshelwood, 1989). When this process is seriously disrupted, the absence of alpha-functioning is understood by Bion as “mental indigestion” (1962, p.8). Bion understood the mental apparatus to be constituted through the cumulation of linked together alpha-elements. His answer, then, to the mysterious question of how “a biological organism becomes an experiencing psyche” (Hinshelwood, 1989, p.229) lies in alpha-functioning which effects “a conversion process of some kind across the body/mind discontinuum” (ibid., p.217).

Bion’s model of psychological functioning is thus based both analogously and actually, in terms of its evolution, on its bodily “background” (Bion, 1962, p.64). The model itself he inversely saw as “a concretisation of an abstraction” (ibid., p.79). This model grew out of Bion’s understanding of the oral phase of development, based on but departing from that of Freud and Klein. Bion saw that together with the physical sustenance of breast milk, the infant receives psychic qualities of “love, understanding, solace” (ibid., p.10). Initially, the infant makes no distinction between milk and love, and introjects both in a form experienced concretely as the ‘good breast’. But, Bion asked, just as the milk “is received and dealt with by the alimentary canal; *what receives and deals with love?*” (ibid., p.33-4, emphasis added). His answer is the ‘mental alimentary system’ upon which

psychic development is as dependent as physical development is upon the bodily digestive system (ibid.).

Initially, the infant digests his raw and overwhelming anxieties *through his mother's mental metabolic system*, and only later, if all goes well, is he able to internalise this to form his own alpha-function. Before this happens, the only way for the infant to manage his devastating fears of fragmentation and annihilation, of being dropped, abandoned, or left to starve, is by evacuating these beyond the body's boundary (Garland, 1999c). This is achieved through projective identification, which Bion, following Klein, understood in terms of a relationship between container and contained, but to which he added the function of communication. Thus the infant transfers these terrible fears 'into' his mother not only to be rid of them, but to make them known. The mother contains these not only by receiving, but by understanding them. The elimination of overwhelming anxieties is initially based on bodily expulsion, so the infant feels he can "evacuate this indigestible matter as if it were a physical product like faeces or urine" (Taylor, 1999, p.50).

The containing function of the mother depends then on her ability to psychically take inside herself these projected beta-elements, to emotionally think about them, and to bear this experience. In order to do so, she must be in a state of "calm receptiveness" (Hinshelwood, 1989, p.420) which Bion termed 'reverie'. Through reverie, the mother operates as a "psychological receptor organ... [for her] infant's needs for love and understanding" (Bion, 1962, p.36). It is through this emotional metabolisation that containment takes place, by which the mother uses her own alpha functioning to transform her infant's raw feeling into meaningful, mental form, which she returns back to him through "the channels of communication, the links with the child" (ibid.). This may be as simple as cooing over her crying baby, wondering aloud with sensitive curiosity what may be the matter, gently trying a few possibilities and eventually arriving at one that settles the infant, which she can then communicate back to him in words. In this way, the filtering function of the Freudian stimulus barrier is initially performed by the mother, who "acts to protect her baby from the extremes of experience, both environmental and emotional" (Garland, 1999b, p.9).

Yet Bion (1962, p.36) wondered what psychological process is needed for the infant

to be able to profit from reverie as it is able, thanks to the digestive capacities of the alimentary canal, to profit from the breast and the milk it supplies.

His answer was that the infant is able to introject not only the product of reverie (his initial anxiety made bearable through containment) but the containing function itself. This enables the development of 'internal containment', of the infant's own alpha function, through which he becomes able to think about and symbolise his own anxieties without being overwhelmed by them. This internalised state of maternal reverie (in which the mother sought to understand her child's experience) forms the basis of all learning, stemming from the child's sense of curiosity and desire to know, which Bion designated 'K'.

The container-contained relationship may be disrupted by the infant's envious attacks on the containing function, and/or by the mother's inability to bear her infant's intense projected feelings, which may arise from her own under-established alpha functioning, or because she is too distracted to perform this function for her infant. In either case, the infant's overwhelming anxieties will be returned to him stripped of whatever meaning they had held, and so magnified, rather than modified through maternal metabolism. This leaves the infant in a state Bion understood as 'nameless dread', of unknowable, incommunicable, uncontainable terror. In this case,

instead of an experience being mediated through the mind of the mother, it is returned to the baby, in phantasy, as persecution. It is as if the original projection, together with the mother's 'refusal' is re-deposited into the baby as an unthinkable bad and terrible thing (Frenkel, 2004, p.153)

When this occurs repeatedly, the infant is likely to feel himself to be made up of this unthinkable badness. This sense of inherent badness would be reinforced by the failure of the containing object of which Bion believed that we have an innate expectation – impairment to which is therefore experienced as the fault of the infant. This is associated with the internalisation of an abandoning and punitive, rather than empathic and responsive, maternal object, which “destroys meaning and leaves the subject in a

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mysterious meaningless world” (Hinshelwood, 1989, p.354). All knowing and understanding now becomes denuded, a state Bion designated -K, which results in a stunting of the child’s own curiosity and desire to know, and therefore of the capacity to learn. The container-contained relationship is then characterised by “without-ness” (Bion, 1962, p.97):

It is an internal object without an exterior. It is an alimentary canal without a body... In short it is the resultant of an envious stripping or denudation of all good and is itself destined to continue the process of stripping (ibid.).

Under conditions of manageable, or optimal frustration, Bion (1962) understood that thought develops as the means of managing this frustration. While Bion’s theory of thinking is extensive, this discussion will be limited to the differentiation and collapse of distinction between physical and psychical on which this faculty depends. Bion, in keeping with psychoanalytic thinking, saw that when the breast is temporarily unavailable to supply the infant it with both milk and love, the infant feels frustration. This need for the good breast in its absence is experienced by the infant as the presence of a bad breast, which it therefore wishes to evacuate. This expulsion of the bad breast occurs through the return of the good breast, when, on feeding, “the taking in of milk, warmth, love, may be felt as taking in a good breast” (ibid., p.34). Thus the absence of the good breast was felt as the presence of the bad breast, and the presence of the good breast felt as the expulsion of the bad breast. Initially, both the “good and bad breasts are felt as possessing the same degree of concreteness and reality as milk” (ibid.). Eventually, however, the desired but absent breast is experienced not as a “bad breast present”, but as the “*idea* of a breast missing” (ibid., emphasis added). As the gap of frustration is filled with thought, the two breasts become differentiated in quality: the good (present) breast remains associated with the real milk that satiates the infant, and so continues to be experienced as concrete and physical, while the bad (absent) breast

is much more likely to become recognised as an idea than the good breast which is associated with... a thing-in-itself (Bion, 1962, p.34).

This led Bion to wonder, “Is a ‘thought’ the same as an absence of a thing?” (ibid., p.35). Mental thought therefore depends on the ability to distinguish the thought from the object itself, and the distinction between physical and psychical is in turn dependent on the evolution of thought.

Under situations of *unmanageable* frustration that amount to ‘developmental’ trauma, the gap of a wanted but absent (good) object cannot be filled with the idea of this, so the psyche remains full of bad (absent good) objects. These bad objects come to replace thoughts, and in their concrete state, as beta-elements in the absence of alpha functioning, can only be managed by evacuation:

What should be a thought... becomes a bad object, indistinguishable from a thing-in-itself, fit only for evacuation (Bion, 1967, p.112).

This evacuation occurs through direct discharge, acting out, or ‘excessive’ (as distinct from normative) projective identification. Despite these attempts to rid the psyche of beta-elements, when un-thinkable frustration is ongoing they accumulate, and the mind itself then becomes “an apparatus for ridding the psyche of accumulations of bad internal objects” (ibid.). In this reversal of meaning-making, alpha-elements revert back to beta-elements and attempts to cohere these dispersed beta-elements results in a concrete, rigid and yet chaotic organisation, which Bion called the ‘beta-screen’. In beta-screen functioning, understanding itself becomes threatening as a link that could lead to knowledge too painful to know. This link is therefore attacked, and “the experience of being understood... [is] split up” (Bion, 1967, p.96). This leaves the psyche fragmented by its own destructiveness, and in need of further projective identification to get rid of the splintered pieces.

This reversal in functioning is associated with a collapse in distinction between physical and psychical, which occurs initially in relation to bodily and emotional forms of nourishment. When an infant, either because of inadequate containment or his own attacks on this function, fears his own or mother’s aggression, his desire for psychological sustenance will diminish; at the same time, fears of physical starvation will compel this infant to resume feeding. This means that sucking becomes based on bodily

but no longer emotional need, which leads to “[a] split between material and psychical satisfaction” (Bion, 1962, p.10). The infant may then attempt to get rid of the bad breast or unpleasant feelings by expelling it concretely:

... if it passed a motion while taking milk... it would associate a physical act with a result that we would call a change in its state of mind from dissatisfaction to satisfaction (ibid., p.35).

Similarly, this dissolving of psychical back into physical would later in life result in the concretisation of thoughts, which would revert back to their bodily basis. Bion (ibid., p.62-3) illustrates how in certain patients this gives rise to

the belief that they digest thoughts and that the consequences of doing so are similar to the digestion of food. That is to say that if they attempt what might ordinarily be regarded as meditating on an idea, they believe that the thoughts so treated suffer a change analogous to that undergone by food that is turned into faeces: some ideas, or their verbal representations, survive and if expressed emerge not as evidence of the possession of an idea, but as evidence embedded in a matrix of gibberish, that their thoughts have been destroyed and denuded of meaning in the way that faeces and its undigested particles can be regarded as food that has been destroyed and denuded of its value as food.

Through this collapse of distinction between physical and psychical, the child and later adult continues his “insatiable... search for material comforts” (ibid., p.11) in the place of emotional love and understanding. But these physical means (which Bion refers to in this context as beta-elements) can never satisfy the craving for the mental quality (or absent alpha-functioning). Inversely, therapeutic interpretations may be experienced as concrete intrusions or empty evacuations, as “flatus” (Bion, 1962, p.12). In such cases, the patient

... feels able only to establish the counterpart of a relationship in which such sustenance can be had as inanimate objects can provide (ibid., p.12).

The patient would therefore establish a strong relationship with what Bion terms “the material comforts... of the consulting room” (ibid., p.13), of which the patient needs increasing more. At the same time, Bion (1967) understood that the provision in

psychoanalytic treatment of experiences of containment unavailable in infancy may mean that,

... the poignancy of [the patient's] deprivation is thereby rendered the more acute and so are the feelings of resentment at the deprivation. Gratitude for the opportunity coexists with hostility to the analyst as the person who will not understand and refuses the patient the use of the only method of communication by which he feels he can make himself understood [direct discharge/projective identification] (Bion, 1967, p.105).

While Bion did not himself explore the application of his thinking to 'external' rather than 'developmental' trauma, his theories of containment and of thinking, and specifically of beta-screen functioning, have been applied by contemporary psychoanalytic trauma theorists (Brown, 2006). These build on Freud's last formulation of trauma, understanding trauma to rupture alpha functioning and lead to the pattern of beta-screen functioning explored above. This breakdown in alpha function is understood both as a direct result of the trauma and a defensive means by which the survivor avoids meaningfully 'knowing' the experience that is by definition unbearable. This rupture constitutes a failure of both external (the world) and internal (internal objects) containment, that for Garland (1991c) is the defining feature of trauma. This results in a self-perpetuating cycle in which trauma erodes containment, and lack of containment leads to vulnerability to trauma. Trauma therefore disenables that which it requires to heal¹⁰, and the experience instead becomes locked into a rigid, chaotic beta-screen, or traumatic organisation that precludes repair and new learning:

New experiences are seen as carbon copies of the original trauma and the hope of enrichment from a reality experienced as fresh and new is dashed. The trauma remains an '*undigested fact*' and cannot be transformed into memory; instead, the traumatic experiences are registered as ego alien and concretely encoded dissociated incidents (Brown, 2006, p.1573, emphasis added).

¹⁰ See Ingham (1999) for a discussion on the complex and reciprocal relationship between trauma and mentalisation.

2.6 Segal

Hanna Segal was a follower of Klein writing in the 1940's to 1980's, with a particular focus on the process of symbol formation – explored here as it stems from and, under conditions of trauma, returns to, bodily experience. Following Klein, Segal (1954/1988) understood symbolisation to be rooted in the infant's early experiences of his own and his parent's bodies (which is then gradually displaced onto the external world), but she was the first to link this process to that of containment. This link has provided an important basis for contemporary psychoanalytic trauma theory (Garland, 1999). Segal (*ibid.*, p.163, *emphasis in original*) conceived of symbolisation as what she termed a “*three-term relation*”:

... a relation between the thing symbolised, the thing functioning as a symbol and a *person* for whom the one represents the other. In psychological terms the symbol would be a relation between the ego, the object, and the symbol.

Symbol formation occurs as a means for the ego to manage anxieties about its relationship with the object. These anxieties include fear both of bad objects, and of the loss or unavailability of good objects. Symbolisation therefore reflects object relations, and disturbance in the latter manifests in disturbance in the former. Such disturbance stems from a lack of differentiation between ego and object, and thus between symbol and symbolised object, which gives rise to concrete thinking.

Segal (1954/1988) distinguished between two forms of symbolisation, a more primitive ‘symbolic equation’ associated with the paranoid-schizoid position, and a more mature capacity for the ‘symbol proper’ that is achieved with the depressive position. She understood the primitive defence mechanism of projective identification to be the first form of symbolisation, in which parts of the self and internal objects are projected out onto objects which become identified with, or come to represent, the projected parts. These projections and identifications form the first symbol equations and so are felt to *be the actual original object* rather than to be a substitute for it (and are therefore not seen to have properties of their own). The purpose of the symbolic equation is therefore “to deny the absence of the ideal object, or to control a persecuting one” (*ibid.*, p.168).

In contrast, symbol formation in depressive-position functioning “is used not to deny but to overcome loss” (ibid., p.168-9). This occurs with the capacity to recognise whole objects and therefore to experience ambivalence, as well as to distinguish between ego and object. Instinctual drives to incorporate good and expel bad can then be inhibited and displaced, through symbolisation, which serves now to save the object from this possessiveness and aggressiveness and so to decrease both guilt and fear of loss. This ‘symbol proper’ is therefore further removed from the original object than the ‘symbolic equation’, as its purpose is now to protect it. Such symbols are “created in the *internal* world as a means of restoring, re-creating, recapturing and owning again the original object” (ibid., p.167, emphasis in original). This more mature form of symbolisation is therefore dependent on separation between subject and object, on the ability to experience and tolerate this loss, and on the desire to re-create the lost object internally. This creation, recognised as the ego’s own and distinct from the original object, can then be projected into the real world and used freely. The shift from concrete symbolic equation to symbolisation proper is not absolute, but can reverse under anxiety when,

in massive projective identification the ego becomes again confused with the object, the symbol becomes confused with the things symbolised and therefore turns into an equation (ibid., p.168).

Segal (ibid., p.172) came to understand the relationship between what she terms “the projected part and the object projected into” in terms of Bion’s theory of the container and the contained discussed above. Understanding symbol formation as the basis for both internal and interpersonal communication, Segal saw language acquisition as a form of containment in which the infant’s experiences are ‘bound’ through the mother’s provision of words which “contains, encompasses and expresses the meaning [of the experience]” (ibid., p.175). The infant can then internalise the words, their meaning and the ability to verbalise and so think about an experience. When containment is inadequate, Segal saw that there is an inability to progress from, or a regression back to, symbolic equation, where words are experienced as concrete things. In therapy, this loss of distinction between the symbol and symbolised may mean that interpretations are felt to be

physically intrusive, or to have concrete effects on patients' bodies. In this way the symbolic returns to its source in the somatic.

While Segal understood this breakdown in symbolisation proper as a result of inadequate containment, she, like Klein, did not explore this in terms of psychological trauma. This has been done by contemporary psychoanalytic theorists, who understand trauma to erode the capacity for symbolisation proper, leading to a collapse of distinction between symbol and symbolised characteristic of symbolic equation (Garland, 1999c). This makes therapy with trauma survivors very challenging, as words are felt to be things in themselves rather than symbols standing for things. This means that,

To utter the word is at some level to recreate the traumatic event, which, as it has before, overwhelms the containing object with catastrophic anxiety... (ibid., p.111).

This gives rise to a self-perpetuating cycle in which the traumatic experience, by rupturing internal containment, erodes symbolic functioning, on which psychic repair is dependent. The therapeutic task in such cases would be the re-establishment of the capacity to symbolise. Segal (1954/1988, p.171) reminds us that the word *symbol* stems "from the Greek term for throwing together, bringing together, integrating". She goes on to say:

The process of symbol formation is, I think, a continuous process of bringing together and integrating the internal with the external, the subject with the object, and the earlier experiences with the later ones (ibid.).

2.7 Bick

Post-Kleinian Ester Bick (1901-1983) conceived of a very early form of containment when the primitive psyche is not yet differentiated from the body or integrated in itself. Bick's theorising grew out of a technique of infant observation she initially developed as a training method for child psychotherapists and through which she sought to validate Klein's conception of early infancy, but which led her to new discoveries. She departed from Klein's understanding of an ego from the start able to introject and project (which presupposes a distinction between internal and external), as well as from Bion's

assumption of the innate existence of a sense of internal space into which the containing function can be introjected. She understood both as developmental achievements dependent on this earlier form of containment.

Bick observed a period very early in life, when the primitive, not-yet cohered personality is “not as yet differentiated from parts of the body” (Bick, 1967/1988, p.187). She understood that these disparate, bodily-based personality fragments are felt to lack a “binding force” (ibid.) between them, and therefore seek out external objects by which they can feel passively held together, and so in existence. The “optimal object” (ibid., p.188) for this is the mother’s nipple, which, alongside the skin contact generated through her holding and soothing, performs a containing function through the stability of its form, which provides a stability of meaning and a focus for the infant’s oral instincts (Houzel, 1990). Other external objects that capture the infant’s attention, such as a repetitive sound, a light, a smell, may operate as temporary containers, felt to hold the personality parts together by engaging its awareness. Bick proposed that all such external containing objects are “experienced *concretely* as a skin” (Bick, 1967/1988, p.188, emphasis added). She therefore calls this form of containment the “primal skin function” (ibid.).

When this primal skin function operates adequately, the infant is able to introject the experience of being *externally* cohered, and to transfer this holding function to his own skin. Thus the physical skin, functioning “as a boundary” (ibid., p.187) to the psychological self, serves an “*internal* function of containing the parts of the self” (ibid., emphasis added). This experience of being bounded by his own skin enables the infant to develop a “concept of a space within the self” (ibid.). Bick understands this to be a prerequisite for the ability to introject and project, and therefore for the establishment of internal objects. When the primal skin function fails, either through inadequate maternal containment, or the infant’s phantasied attacks on this, there is a corresponding failure in the infant’s capacity to introject a containing object, and to use his own skin as a boundary. This lack of boundary means that “the personality simply leaks uncontainedly out into a limitless space” (Hinshelwood, p.428). This is associated with a ‘flattening’ of internal space and ‘two-dimensional’ object relationships which Bick characterised as ‘adhesive’. This

entails “the experience, and phantasy, of sticking *to* an object as opposed to projecting *into* it” (ibid., p.215, emphasis in original).

Under such circumstances, Bick (1967/1988, p.188) understands that a defensive “second skin’ formation” develops to compensate for the absent “skin container function”. This takes the form of omnipotence and pseudo-independence which attempt to hold the self together without the need for external support (Hinshelwood, 1989). The second skin formation therefore masks “a passive experience of total helplessness” (Bick, 1967/1988, p.188) which Bick terms ‘unintegration’. This manifests physically through body (such as posture or skin disease) and in “corresponding functions of mind, particularly communication” (ibid., p.190). In such cases, Bick emphasises the importance of what she terms “the containing aspect of the analytic situation [which] resides especially in the setting” (ibid., p.191).

2.8 Winnicott

Donald Winnicott was an English paediatrician and psychoanalyst writing in the 1930s to 1970s. Although he drew on Freud and Klein, he is credited with developing his own school of thought, which remains close to his clinical experience. Winnicott famously proposed that there is no such thing as a baby as distinct from a mother, and that there is no such thing as a psyche separable from a body. His understanding of processes of differentiation and integration between these two anaclitically related pairs is the focus of this discussion. These are explored in conditions of good-enough maternal holding (a concept distinct from yet related to that of containment¹¹), and of trauma that results when the holding function fails.

Winnicott (1949/1958) believed that the historical splitting of body and mind was an illusion which future scientists would reveal. His own conception of a “bodily self” as “the imaginative elaboration of somatic parts, feelings, and functions” (ibid., p.244) has

¹¹ See Ogden (2004) for a distinction between Bion’s concept of containment and Winnicott’s concept of holding.

arguably gone some way towards doing just that. In keeping with psychoanalytic thought, Winnicott believed that at the earliest stages of life “physiology and psychology have not yet become distinct, or are only in the process of doing so” (cited in Davis & Wallbridge, 1981, p.107), and that the psyche develops out of the body by anaclisis (Anzieu, 1989). But significantly, to this he added that the linkage, or integration, between body and mind is essential for human wellbeing. In this way, he extended Freud’s notion of the ego as body-ego by specifying that it is only under conditions of health that the self is experienced as dwelling within the body:

The ego is based on a body Ego, but it is only when all goes well that the person of the baby starts to be linked with the body and the body-functions, with the skin as a limiting membrane (Winnicott, cited in Anzieu, 1989, p.30).

Winnicott understood the distinction between psyche and soma to rest on the gradual cohesion of the former, which comes about through the mother’s quality of physical and emotional ‘holding’ of her infant. This occurs during the early stage of absolute dependence, when both infant and mother experience themselves as merged: the good-enough mothers’ intense identification with her child enabling maximum attunement, and this attunement allowing the infant the experience of omnipotence. Through the mother’s unique quality of sensitive, attentive, tender holding (involving all the activities of care and protection as well as her individual expression of love), the infant gradually feels his own body to be cohesive. This sense of bodily wholeness provides the basis for psychological integration that enables ego development. Through this, the child begins to be able to ‘hold himself together’. As the emerging psychological ego becomes cohered in itself, it begins to differentiate from the bodily ego, on which it therefore becomes gradually less dependent.

As counterpoint to this differentiation between psyche and soma, Winnicott emphasised the simultaneous importance of their linkage, or integration (without loss of distinction). This he understood to be rooted in an aspect of the ‘holding environment’ that he termed ‘handling’. Through this, the mother brings together her own bodily and emotional involvement with her infant in such a way that he begins to experience a “linkage” (Winnicott, cited in Davis & Wallbridge, 1981, p.51) between his own physical and

psychical selves. This linkage enables the infant to gradually “accept the body as part of the self, and to feel that the self dwells in and throughout the body” (ibid., p.109). Winnicott evocatively called this experience the “indwelling of the psyche in the soma” (ibid.).

Just as the cohesion of the psychical ego enabled its differentiation from the bodily ego, so this integration between body and mind enables a growing distinction between this ‘bodily-self’ and others. Winnicott understood the skin, as “limiting membrane” (ibid., p.20), to play a central role in this differentiation between what he termed ‘me and not-me’. This boundary of the ‘bodily self’ enables the corporeal functions of “intake and output” (Winnicott, cited in ibid., p.51) to become imbued with psychological meaning. In this way, inner psychic reality evolves through the processes of introjection and projection. Central to Winnicott’s thinking was his conception of ‘transitional phenomena’ which mediate this process of separation between mother and child. Such phenomena exist in the intermediate realm between inner and outer worlds, between fantasy and reality, in a ‘potential space’ which “initially both joins and separates the baby and mother” (Winnicott, cited in ibid., p.77). (It is here that Winnicott understood psychotherapy to take place).

Winnicott understood psychic trauma in relation to impingement (Davis & Wallbridge, 1981). Under good enough circumstances, contact between mother and child evolves in such a way that inevitable impingement is incremental and manageable, and the infant slowly establishes a “continuity of being” (ibid.). When impingements (stemming from deficiencies either in the ego-support of the infant and/or in environmental protection) interrupt this continuity of being by provoking a reaction in the infant, and when this is not adequately repaired, these impingements become traumatic. This early trauma was understood by Winnicott to elicit “unthinkable anxieties” (ibid.) including ‘Going to pieces’, ‘Having no relation to the body’, and ‘Complete isolation because of there being no means of communication’ (ibid., p.58). These primitive anxieties lead to a fragmentation of the growing self that disrupts the process of cohesion essential to maturation. Under such circumstances the potential space cannot develop. Winnicott saw that prolonged and severe traumatic impingements lead to what he termed the ‘sustained

traumatic condition'. The form of this that he focussed on was antisocial acting out, which he understood to result from situations where a child's early testing of his own destructive power is not withstood by the home environment, which therefore fails in its holding function at this stage of development. The child will then look beyond the home for constancy and security, and so test the holding capacity of institutions or social environments. Winnicott therefore understood this condition to be "really a search for a boundary or framework" (ibid., p.77).

2.9 Anzieu

French psychoanalyst Didier Anzieu is one of the few contemporary psychoanalytic theorists to elaborate on and systematise the relationship between psyche and soma implicit in psychoanalytic thinking. Through his model of the Skin Ego, Anzieu (1989) attempts to move beyond reductionism and polarisation of body and mind. The Skin Ego exists on the border of body and mind, and so acts both as "a bridge and as an intermediary screen between the psyche and the body, the world, and other psyches" (1989, p.4.). This theory, based on both empirical and theoretical data from across various disciplines, is a reformulation of traditional Freudian and Kleinian conceptions of the oral phase of development, and is situated alongside post-Kleinian's Bick and Bion, drawing respectively on their work on second skin formations and containment. Anzieu also draws on Winnicott's concept of transitional phenomena and the maternal holding function.

Anzieu (1989, p.21) identifies the body as "the great missing, unrecognised, unacknowledged element [of our time]", arguing that since the time of Freud the part of individual and collective selves that is most repressed has shifted from sexuality to the body. He understands this shift to underlie changes in the nature of human suffering. In keeping with psychoanalytic thinking, Anzieu (1991, p.61-2) understands that "the body is the bedrock of the mind":

as Freud guessed and as we can now systematise it... psychic functions, psychic organs, and psychic agencies spring from a concrete basis in organic functioning.

Anzieu builds on Freud's (1920/1995, p.637) brief statement that the bodily sensations from which the ego derives are "chiefly... those springing from the surface of the body". Understanding that "[e]very psychological activity is anaclitically dependent upon a biological function" (Anzieu, 1989, p.40), Anzieu conceives of a Skin Ego arising from the physical functions of the skin, which he understands to be "of both an organic and an imaginary order" (ibid. p.3). The Skin Ego is thus,

... an intermediate structure of the psychical apparatus: intermediate chronologically between the mother and the infant, and intermediate structurally between the mutual inclusion of psyches in the state of primitive fusion and the differentiation of psychical agencies (ibid.).

Anzieu argues that Freud's formulation of incorporation and repletion (based on the bodily experiences of the mouth and abdominal cavity) during the oral phase of development, leaves out a key third function. This function stems from the formative experience of maternal holding and touching during feeding, washing, playing etc. This skin contact between mother and child Anzieu understands to underlie the principle of "internal differentiation and containment" (ibid., p.5) which he identifies as an addition to Freud's principles. Through this, the infant is able

progressively to differentiate a surface which has both an inner and an outer face, in other words an interface, permitting a distinction between inside and outside, and an encompassing volume in which he feels himself bathed, the surface and the volume affording him the experience of a container (Anzieu, 1989, p.37).

While basing his thinking on Klein's understanding of the oral stage of development, Anzieu recognises two omissions in this. Firstly, in focusing on the role of phantasy in relation to the breast as first object, Klein neglects "the qualities belonging to bodily experience" (ibid.). Secondly, in emphasising the infant's early experience of the maternal body through part-objects, Klein disregards "what joins these parts together in a unifying whole, namely the skin" (ibid.). This omission is curious, Anzieu points out, as Klein's theory, centered on the dual processes of introjection and projection which are modeled on the bodily processes of incorporation and excretion, "presupposes the setting

up of a boundary differentiating outside from inside” (ibid.). Anzieu fills these gaps by bringing the surface of the body to the forefront of his theory, understanding the psychic functions of Skin Ego as anacritically derived from the physical functions of the skin. These include the skin as container of internal space, allowing the experience of psychic fullness; the skin as interface between inside and outside that protects the former from penetration by the latter; and the skin as inscriptive surface onto which the inside communicates with the outside through symptoms, and upon which the marks of the external are registered¹².

The Skin Ego evolves through a combination of physical contact and emotional attachment between mother and infant, spanning the realm of fantasy and reality. Like other psychoanalytic theorists, Anzieu (1989, p.42) conceives of an early stage of “symbiotic union” between mother and child. He understands this state to be experienced through a “tactile... image in which the two bodies of child and mother have a common surface”. What he terms the ‘phantasy of a common skin’ between mother and child is pictured as an ‘interface’ between two ‘envelopes’: the ‘external envelope’ being the maternal environment, the ‘inner envelope’ the surface of the infant’s body. If all goes well, the external envelope fits itself with flexibility to the inner envelope, allowing both contact and space between mother and infant. The phantasy of shared skin can then facilitate both communication between them (registering their sensations, feelings, and vital rhythms) and the gradual differentiation of their own skins, which is “represented by the tearing away of that common skin” (ibid.). If both connection and separation are successfully negotiated, the child is able to internalise both the external skin/mothering environment, which enables the establishment of an internal psychic reality, and the experience of a common skin, which comes to envelope the psychical contents. In this way, the child gains a Skin Ego of his own¹³.

¹² Anzieu (1989) identifies nine functions in total.

¹³ The central role of thought in this process, which Anzieu (1989, p.64) likens to an “inner skeleton”, is beyond the scope of this discussion.

When there is a mis-fit between external and internal envelopes, the development of the Skin Ego is impaired. Should the external envelope be too closely adhered to the inner envelope, the child's ego development is "invaded" and "suffocated" (Anzieu, 1989, p.62). Should the external envelope be too loose, the child's developing ego is devoid of consistency, and so the child must create her external envelope. This Anzieu understands to take the form of Bick's 'second muscular skin', which develops to "both compensate for, and mask, the deficient Skin Ego" (ibid., p.60). In this 'second skin formation', the external layer is "rigid, resistant and closing" while the inner layer is porous and pierced. Damage to the skin ego through either form of mis-fit between external and internal envelopes would result in a fragile Skin Ego oscillating between anxiety of being abandoned (if the object of attachment is no longer close), and persecution anxiety (if that object is too close). This pattern Anzieu associates with borderline pathology characterised by "uncertain... frontiers between the psychical and bodily Egos". This, he understands, leads to a tendency to "remain glued to others" while at the same time "fear[ing] penetration" (ibid., p.24).

2.10 Kristeva

French psychoanalyst, linguist, philosopher, feminist and novelist Julia Kristeva has made a major contribution to contemporary thought across disciplines. While her work is rooted in a wide range of sources from philosophy to anthropology, Kristeva's psychoanalytic thinking draws on, and at the same time critiques and departs significantly from, Freud, Lacan and Klein. This discussion focuses on her conception of an archaic, pre-verbal and 'preobjectal' relationship to the maternal body as that which contains us and as that from which we must part in order to become, that is always in tension between mergence and differentiation; and the ways in which this is retained in our own bodies through what is un-metaboliseable.

Kristeva understands the infant's psychic being to exist in relation to the maternal body as its container, before clear boundaries are established between them. This she terms the 'chora', borrowing from the ancient Greek word meaning "the original space or receptacle of the universe" (McAfee, 2004, p.19). The chora reflects the pre-verbal space of mother and infant which is inherently bodily and "inaccessible to the mind" (Smith,

1998, p.60). Kristeva understands that the chora enters and is retained in language through what she termed the 'semiotic' aspect of signification: the extra-verbal rhythms and intonations of language that make up its materiality, as distinct from the 'symbolic', which is the grammatical or structural aspect of language through which unambiguous meaning is communicated. Through what she calls the 'semiotic chora', communication remains connected to the maternal body, and the drives which are rooted in this relationship continue to be discharged through the rhythms and tones of language¹⁴. Language acquisition itself Kristeva understood to be based on the dual processes of differentiation and incorporation first experienced in relation to the maternal body (Oliver, 2002). Thus the process of metabolisation (intake, assimilation, expulsion) is seen as an early bodily blueprint for signification.

Undercutting and disrupting the chora, Kristeva conceives of the abject as that which is indigestible, uncontainable, which hovers between integration and separation. The abject is inherently difficult to define, it is contradictory and always shifting. I understand the abject *as* anaclisis: it is the inherently contradictory relationship to the maternal body as that from which we emerge, and from which we must part in order to become separate selves. At the same time, it is the 'anti-anaclisis', that which disrupts or reverts this process, the simultaneous horror of and yearning for the early state of mergence with the maternal body, the crisis of at once desiring and fearing distinction and autonomy. It is the "uncertain boundary" (Oliver, 2002, p.225) between the infant and the maternal *chora*, the "fragile limit" (Kristeva, 1980/2004, p.243) between fusion and differentiation that is never absolute, and is always threatening to give way. The act of abjection is that of rejection, the first awkward attempts to break free of the maternal body to which we

¹⁴ Kristeva revolutionised understanding of the relationship between language and the body: In contrast to traditional conceptions of language as *representation* of bodily experience, she proposes that language is a *manifestation*, or direct expression, of bodily drives (Oliver, 2002).

are still attached, the ongoing expulsion of that which both is and is not ourselves: spit, pus, excrement. Abjection is that which is

radically excluded but never banished altogether... [for it] hovers at the periphery of one's existing, constantly challenging one's own tenuous borders of selfhood (McAfee, 2004, p.46).

Rejecting traditional psychoanalytic understanding of the maternal body as the infant's first object, Kristeva identifies in abjection a far more complex relationship which is prior to the existence of a subject with objects, and yet which sets the possibility for this in motion. This is an archaic form of relationship which Kristeva (1980/2004, p.236) calls "preobjectal", and which she characterises as "[i]ntrinsically corporeal" (ibid., p.238):

Before the mother or the maternal body becomes an object for the infant, it is an abject. It is neither object nor nonobject, but something in between" (Oliver, 2002, p.226).

This is:

Not at all an other with whom I identify and incorporate, but an Other who precedes and possesses me, and through such possession causes me to be (Kristeva, 1980/2004, p.237).

Later in life, the abject remains and is remembered in our own bodies through that which crosses, and so makes permeable, its boundaries: food, which is incorporated into or rejected from the body; bodily waste, which is expelled from it; and dirt which threatens to contaminate it. Food loathing, for Kristeva, is "the most elementary and most archaic form of abjection" (Kristeva, 1980/2004, p.230). It involves repulsion towards, and expulsion of, matter that would become part of oneself, and which, in abjection, becomes oneself, so that "I spit *myself* out, I abject *myself* within the same motion through which 'I' claim to establish *myself*" (ibid., p.231, emphasis in original). The bodily matter that leaks, washes, bleeds or erupts out of the orifices and skin is simultaneously part of oneself and yet "permanently thrust aside in order to live" (ibid.). Kristeva (1980/2004, p.231) sees the abject in a "wound with blood and pus, or the sickly, acrid smell of sweat, of decay... refuse and corpses". Filth, the underside of the "clean and proper (in the sense of incorporated and incorporable)" threatens the body because it resists assimilation, and so threatens to contaminate it with its own properties. Dirt defiles because is out of place,

has traversed a boundary (ibid.). Purification rituals are based on re-establishing this boundary and so “enact symbolic separation from the maternal body” (Smith, 1998, p.33).

The abject, then, is most broadly manifest in all that threatens the boundaries between inside and outside, self and other, individual and world:

what disrupts identity, systems, order. What does not respect borders, positions, rules. The in-between, the ambiguous (Kristeva, 1980/2004, p.232).

As such, abjection exists, “beyond the scope of the possible, the tolerable, the thinkable. It lies there, quite close, but cannot be assimilated” (Kristeva, 1980/2004, p.230). It is what we can never quite get rid of, and also never quite integrate: that which hovers between expulsion and incorporation, but is processed by neither, is unmetabolisable. At the same time, the abject is also that which keeps us alive, keeps us ourselves, keeps us growing. “It is an alchemy that transforms death drive into a start of life, of new significance (ibid., p.241). For Kristeva, the aim of therapeutic treatment “is to reconnect soma and psyche” (Oliver, 2002, p.xxiv).

2.11 Conclusion

This chapter has provided a review of psychoanalytic literature on the role of the body in the reciprocal processes of containment and trauma, focussing on the anaclitic relationship between body and mind, mother and child, during early development. While the theorists discussed in this review share an understanding of an initial state of mergence in both these sets of relationships, they offer specific understandings of the subsequent processes of differentiation and integration, as well as the consequences when these are not successfully negotiated. In a sense they can be seen as anaclitically related: each theory being rooted in, yet departing from, its predecessors. There are some threads across these relationships: Bick, Anzieu and Kristeva all depart from traditional Freudian and Kleinian thinking in their understanding of earlier, archaic experience. Bion and Segal emphasise distinction between body and mind as essential for development and how this goes wrong under trauma, the collapse back into indistinction. While Winnicott emphasises integration, Kristeva brings into focus what cannot be integrated. Winnicott,

Anzieu and Kristeva in different ways conceive of that which hovers between these processes: the transitional realm, the Skin Ego, the abject which suggests that the passage from mergence to differentiation to integration is never neat or absolute, but is always in tension. The psychoanalytic concepts reviewed in this chapter will be used as a lens through which to analyse the process of therapy in the case of a multiply traumatised young boy.

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CHAPTER THREE: METHODOLOGY

This chapter provides a rationale for the use of the qualitative clinical case study in this research, which is theoretically and methodologically situated in psychoanalysis. It begins with an outline of the purpose of this study, and then delineates the research design. After noting the context in which this study took place, details of the child participant and the nature of the therapeutic intervention are described. The method of data collection and analysis are then discussed. Finally, ethical considerations are addressed.

3.1 Research aims

This clinical case study aims to develop a clinical and theoretical understanding of the relationship between physical and psychic processes in a two-year psychoanalytically-oriented therapy with a child trauma survivor. The anaclitic relationship between psyche and soma is a basic premise of psychoanalytic thought, and is richly although implicitly woven into psychoanalytic thinking. However, the historical review of psychoanalytic literature on the role of the body in the reciprocal conditions of containment and traumatisation revealed a dearth of writing explicitly addressing this topic in its own right, or drawing together the many references to it as a building-block in psychoanalytic thinking. In analysing the case material through the lens of this reviewed literature, I integrate these disparate theories on the role of physical and psychological processes in containment and traumatisation, drawing on points of resonance between them. More specifically, I explore the roles of, and interactions between, the therapist and child client's bodies (as well as the material things that come to represent these), in repeating and repairing processes of early maternal containment (or 'developmental trauma') and chronic exposure to deprivation, punishment and sexual abuse ('external trauma'). My aims are twofold: firstly, in reading the therapeutic process through this theoretical lens, I seek to gain a deeper understanding of this and other such clinical processes; secondly, I hope that this empirical material can be fed back to enrich theoretical conceptions of the relationship between body and mind in containment and traumatisation.

3.2 Research design

This research constitutes a qualitative, clinical, psychoanalytic case study. Below, I briefly define and outline qualitative research, case study design in general, clinical case studies in particular, and then the specifically psychoanalytic case study. After explaining why I have chosen this design for the current research, I examine the limitations of each of these forms of case study, as well as rationales for their use with reference to the current case.

Qualitative research is acknowledged as difficult to define, as its meaning differs across contexts, while it crosses paradigms, disciplines and methodologies (Banister, Burman, Parker, Taylor & Tindall, 1994; Denzin & Lincoln, 1994; Silverman, 2000). Attempts at a broad definition include several key elements. Qualitative research is interpretative, and focuses on human and social experience and processes, particularly meaning-making. These experiences and processes are investigated in their natural settings. In so doing, the role of the researcher in shaping the research is acknowledged, and research is ethically and politically positioned. The findings of qualitative research are understood not as singular, static truths, but as attempts to make sense of the subject matter in ways that hold multiple and often contradictory meanings (Banister et. al, 1994; Denzin & Lincoln, 1994). In conceptualising the qualitative researcher as *bricoleur*, Denzin & Lincoln (ibid., p.3) therefore speak of the “product of the *bricoleur*’s labour” as,

... a bricolage, a complex, dense, reflexive, collagelike creation that represents the researcher’s images, understandings, and interpretations of the world or phenomenon under analysis. This bricolage will... connect the parts to the whole, stressing the meaningful relationships that operate in the situations and social worlds studied.

The case study in general is also recognised as difficult to define, as the term is used widely and inconsistently, both within and beyond the research arena (Hammersley & Gomm, 2000; Stake, 1994; Yin, 2003). Broad definitions of the case study focus on the following features: This research design investigates relatively few (and often just a singular) case/s, but does so in an in-depth way. The case/s occur naturally in social reality rather than being constructed by the researcher as in the laboratory (therapeutic

interventions are considered 'natural' in that they are not set up for the purposes of research). Case study data is usually analysed through qualitative means, although this is not always the case (Stake, 1994). These factors mean that, "the case study method allows investigators to retain the holistic and meaningful characteristics of real-life events" (Yin, 2003, p.2). The case study design is therefore considered most fitting for research questions which ask 'how...' or 'what...', and which focus on current, real-life phenomena which the researcher seeks to understand but not control (ibid). Within the social sciences, the case study design is currently acknowledged as an appropriate methodology for investigating complex social and psychological phenomena (Yin, 2003).

Clinical case studies examine particular therapeutic processes, and can be defined "heterogeneously to denote several different things, including the focus on the individual, reliance on anecdotal information, and the absence of experimental controls" (Kazdin, 1981, p.184-5). The clinical case study has been central in the development of psychoanalysis and of clinical psychology, in which individual cases, as well as series of cases, "have exerted remarkable influence on subsequent research and practice (Kazdin, 1981, p.184). Despite this, clinical case studies have historically been marginalised and criticised within psychological research for their limited capacity to support scientific inferences (see below). In response to this, there have been recent calls to re-centralise and legitimate the clinical case study within this field, and so "for restoring the case study to its former prominence as a vehicle for systematically reporting and evaluating clinical observations, exploring theory, and documenting advances in professional effectiveness" (Fishman, 2005, p.2). The case study is argued to be particularly appropriate in this field as "the basic unit of psychological practice is the case" (ibid., p.1). Clinical case studies therefore have the potential to bridge the widely recognised – and lamented – divide between psychological research and practice (Barlow, 1981; Hayes, 1981). It is argued that this form of research is compatible with clinical practice as "[b]oth the science and the practice of psychotherapy involve at their core a hypothesis-testing procedure" (Kiesler, 1981, p.214), and it is this scientific aspect of clinical work that case study research utilises:

There can be no doubt that most of what the field has learned about psychotherapy since Breuer treated his famous patient Anna O. a century ago has come from astute and creative clinical observations. In other words, the human observer in this as in other areas of scientific work reigns supreme. As participants in and observers of immensely intricate human interactions, we have the opportunity – if we are sufficiently ingenious, perceptive, and sensitive – to make observations, discern connections, form hypotheses, and, within limits, test them... In an important sense, as advocates of the single case studies reconfirm, each therapeutic dyad constitutes an experiment, albeit an experiment with built-in limitations (Strupp, 1981, p.216).

Since Freud, the psychoanalytic case study has been the principal method for presenting psychotherapeutic material, and psychoanalytic knowledge has evolved largely through the accumulation and cross-examination of single cases to form a meta-theory (Attwood & Stolorow, 1993). Although it is therefore the tradition upon which the field of psychoanalysis has been built, there is a surprising dearth of literature on the psychoanalytic case study as research methodology. Psychoanalytic case study research enables both depth and specificity through the recognition and exploration of meaning as layered and as shaped by unconscious processes (Gibson, 2002). The goal of what Attwood and Stolorow (1993, p.27) call the “intensive, in-depth case study”, or “psychobiographical research” (ibid., p.31), is therefore “the illumination of the inner pattern of a life, the distinctive structure of meanings that connects the different parts of an individual’s world into an intelligible whole” (ibid., p.28). They identify three distinguishing features of this methodology: Firstly, it is “inherently *personalistic* and *phenomenological*” (ibid, p.27, emphasis in original), assuming that the topic under investigation can best be understood “in the context of the individual’s personal world” (ibid., p.27-8). Secondly, this personal world is conceived as a “life-historical phenomenon” (ibid., p.28), the research therefore being temporally situated in relation to individual development (rather than a comparison across a population of different individuals). Thirdly, the case study method is “*clinical* and *interpretive* (rather than experimental or deductive)” (ibid., emphasis in original), understanding of individuals being arrived at through the analysis of existing clinical material rather than the testing of pre-specified hypotheses. This process gives rise to what Attwood & Stolorow (ibid.,

p.28) identify as “provisionally identified meanings”, which are then contrasted, compared and linked together to make up the overall case analysis.

The qualitative single-case study has been chosen as the most appropriate design for capturing the complex clinical processes under examination in this research, which is focussed on meaning-making rather than arriving at a singular truth. A single case has been used to enable sufficiently in-depth exploration of the therapeutic material.

I now examine critiques and limitations of these various forms of case studies, as well as the ways in which proponents of this form of research answer to these, making reference to the current study. Broad critiques of the qualitative case study as a form of research design focus on its lack of objectivity and limited generalisability (Hammersley & Gomm, 2000; Hollway & Jefferson, 2000; Stake, 1994; Yin, 2003). A counter-argument in relation to the former is that qualitative case studies do not claim to be objective, but rather explore, and make explicit, the subjectivity of the researcher and the ways in which this shapes the research (ibid.). This means that, “Subjectivity is a resource, not a problem, for a theoretically and pragmatically sufficient explanation” (Banister et al., 1994, p.13). Reflexivity is therefore fundamental to qualitative case study research, in which the role of the researchers’ own assumptions and motivations is acknowledged, as is the more basic premise that the act of research will always change what is being studied (Denzin and Lincoln, 1994). In the current study, I draw on my counter-transference experiences in making meaning of the therapeutic material.

In response to the second critique mentioned above, it is argued on the one hand that the strength of case studies lies in their particularity rather than generalisability (Stake, 1995), and on the other that case study findings are generalisable to theory rather than populations (Hammersley & Gomm, 2000; Silverman, 2000). Yin (2003, p.32-3) calls this ‘analytic’ (as opposed to statistical) generalisation, in which “a previously developed theory is used as a template with which to compare the empirical results of the case study”. Theory therefore plays a central role in most qualitative case study designs, providing a frame through which the data is selected, gathered and interpreted, as well as being the (evolving) end-point into which the findings are fed. Particularly in single-case

studies, this end-point may include attempts to “confirm, challenge, or extend” (Yin, 2003, p.40) particular theories, which the single case critically tests. The present case study design is based on what Hollway & Jefferson (2000, p.107) call “theoretically driven research questions”: it is in the light of the reviewed literature on the role of the body in psychoanalytic understandings of trauma and containment, that I explore the relationship between physical and psychic processes in the therapy process with a child trauma survivor.

With regard to clinical case studies in particular, limitations centre on the ability to draw valid inferences about anything with a sample size of one on the one hand, and on the other to draw inferences about changes in personality and functioning, as inevitable confounding variables may mask what change is in fact due to the therapeutic intervention (Kazdin, 1981). With regard to the first, it is argued that accumulations of case studies over time can be compared and contrasted within and between groups of homogenous patients/participants, from which valid inferences can be drawn, and through which the “ $N = 1$ study achieves a legitimate place in the confirmatory aspects of scientific activity” (Kiesler, 1981, p.213). More recently, Fishman (2005, p.1) argues for the systematic organisation of individual case studies into “journal-databases” through which they can be utilised in a coordinated way. While both these limitations are acknowledged with regards to this study, this research is concerned with psychological change in relation to the shifting role of the physical in relation to the psychic, rather than in measuring or making claims about the efficacy of the treatment as a whole.

Turning to the limitations of the psychoanalytic case study, Attwood & Stolorow (1993, p.9) note that “It might appear that this kind of work creates a paradox, in that the proposed interpretations might depend, like the mythical snake that devours itself by swallowing its own tail, on concepts from the very theories being analysed”. While the validity of particular insights can be established by assessing the coherence of these ‘provisionally identified meanings’ with the analysis as a whole, validity of the complete analyses can therefore “only be tentatively established, as it relies upon interpretive criteria pertaining to coherence of argument, comprehensiveness of explanation, consistency with accepted psychological knowledge, and the aesthetic beauty of the

analysis in disclosing previously hidden patterns in the material being investigated” (ibid., p.29). Attwood & Stolorow (ibid., p.29) understand that it is this complexity that has led psychological research to turn to forms of analysis that yield “more certain results”, but they believe this “abandonment” of psychoanalytic case analysis to be “based on a deplorably mistaken understanding of the purposes and rationale of the case-study approach, the goal of which is not arrive at final truths and incontrovertible general principles, but rather at significant theoretical ideas and promising lines of research”. They conclude that “This approach is primarily a strategy of discovery and not a strategy of proof” (ibid.). In this study I read the clinical material through the lens of the reviewed literature, and seek in so doing in some way both to further understanding of the therapeutic process and to contribute to theory-building in this field (rather than to use either data or theory to prove one another). It is hoped that this will enable a mutually enriching, rather than circular or ‘self-devouring’, process.

3.3 Context of study

This study took place at the Child Guidance Clinic (CGC), a University Clinic where I did my first year of training in clinical psychology in 2006. It involves a single child participant, who was my ‘long-term’ therapy client during the two years of my clinical psychology training. The therapy itself spanned 19 months, from April 2006 until November 2007, and included 69 weekly therapy sessions, as well as regular feedback and psycho-education sessions with Chad’s aunt and primary caretaker, Natasha, and his teachers. During this period, I attended weekly clinical supervision sessions. Chad was seven years old, and repeating Grade 1, when we began therapy, and nine, and completing Grade 2, at termination. He is a coloured¹⁵ child, living with his paternal aunt Natasha, her husband and his adult daughter, in a lower-middle class suburb on the Cape Flats (further details regarding the case history will be discussed in Chapter 4). While

¹⁵ This term reflects the racial categorisation of apartheid, and is used here because it still has descriptive meaning in South Africa, but its racist implications are rejected by the researcher. The particular meanings and implications of Chad’s skin colour will be explored in Chapter 4.

Chad had spoken Afrikaans with his biological parents, he spoke only English with Natasha and her family, and attended an English-medium school.

3.4 Intervention

This was a psychoanalytically oriented therapy with an emphasis on free play¹⁶, but I drew on some narrative therapy techniques, particularly at the start of therapy when some structure was needed to contain Chad's anxiety. These included the making and decorating of a box in which to keep his drawings and other objects he made in therapy, and a book in which to draw and write. In this section I briefly outline the evolution and nature of child psychotherapy, with emphasis on a particular adaptation of this for work with traumatised children that was drawn on in this therapy.

Freud ascribed central importance to early childhood in his understanding of adult suffering, and applied some of his techniques for adult psychoanalysis to children, ushering in a new era of taking children and their struggles seriously (Glenn, 1992). In so doing, however, he tended to treat children as 'little adults', and it was left to Anna Freud and Melanie Klein to systematically develop psychotherapeutic techniques appropriate for children (ibid.). These made central use of play as the natural form of expression of children. While their work differed in some respects, Anna Freud and Melanie Klein shared

a strong belief in the importance of the child's imaginative life as developed in the matrix of family relationships and as expressed symbolically through play... Thus play, as the

¹⁶ I follow Boston's (1977, p.23) distinguishing between psychoanalytic psychotherapy with children and what she notes is "popularly referred to as 'play therapy'" by the fact that for the former, play is understood to be "only one of many of the child's ways of conveying his feelings and thoughts to the therapist. It is the understanding of the communication rather than the opportunity for free play which is therapeutically important."

crucial idiom of childhood, remains the medium through which child analytic therapy is conducted (Likierman & Urban, 1999, p.29).

Play is understood to exist in the intermediary realm between fantasy and enactment (Marans, 1993). Here, “wishes and their consequences, conflicts and their solutions, can be manipulated or tried in multiple forms and configurations... [which] allows the child to titrate fantasy and real life” (ibid., p. 183). Closely associated with play, the capacity for symbolisation is considered crucial in child psychotherapy, and “is linked, psychoanalytically, to the perception of separateness from the mother and the need to bridge that gap” (Horne, 1999, p.34). For Melanie Klein (1979, pp.137-8), symbolisation was both the medium and objective of the technique of play therapy she developed, in which she “made full use of the archaic language of symbolisation, which I recognised to be an essential part of the child’s mode of expression... the capacity to use symbols enable[ling] the child to transfer not only interests but also fantasies, anxieties and guilt to objects other than people”. As Horne (1999, p.35) articulates,

This ability to symbolise what has been feared and to place it outside, for perusal and hence to acquire control, is important for later adolescent and adult capacities to think, to gain mastery and not be overwhelmed, and helps in the process of not having to act out what might otherwise feel uncontrollable (Horne, 1999, p.35).

The central aim of psychoanalytic work with children is to address and unblock areas of development that have become stuck, and so to enable normal developmental processes to resume (Lanyado & Horne, 1999). As growth towards independence always involves loss of a prior state of dependence, which is then regressed to under stress (Horne, 1999), child psychotherapy involves a central interplay between progressive and regressive tendencies (Anderson, 2002). The role of the child psychotherapist is therefore to “reach and effect change in the child’s inner world” (Boston, 1977, p.22), while holding and sometimes working with their external world in so far as this impinges upon their internal world. This role echoes that of parenting, and it is often a form of re-parenting that children need in therapy. It is therefore this “constantly evolving relationship between the therapist and the patient [that] lies at the heart of all psychoanalytic work and is the main vehicle for psychic change” (Lanyado & Horne, 1999, p.56). Through this transference

relationship, the child is able to “*re-experience*, in relation to the therapist, anxieties and conflicts that originated in the crucial early interactions (or perhaps lack of them) between the parent and himself” (Boston, 1977, p.25, emphasis in original). Thus, although the problems children present usually relate to their current external worlds, and are rooted in their early parental relationships, therapeutic change is understood to occur through “the ‘here and now’ of the meeting of two people, the therapist and the child” (Lanyado & Horne, 1999, p.56).

Interpretation also plays an important, and related, role in child psychotherapy, entailing the “putting into simple words, appropriate to the patient, the therapist’s understanding of what is taking place in the developing relationship between the two of them” (Boston, 1977, p.24). Through such interpretation, it is hoped that the child will gain insight into the feelings and actions arising in the therapeutic relationship. This insight, which needs to be emotionally located and not just intellectual, should enable the child to gradually come to contain his or her own anxieties and so internalise the role of the therapist (ibid). Alongside this introjection of the containing function of the therapist, projection is recognised as central to psychoanalytic child therapy, as it is through this process that the internal world of children is revealed and engaged with in symbolic play and in the transference relationship (ibid.). The physical setting is of central importance in psychotherapeutic work with children, regularity in time and space providing consistency and containment. This physical space reflects the space in the therapist’s mind which is uninterruptedly available for the child for the duration of the session (Lanyado & Horne, 1999; Sternberg, 2006). Play material is designed to be used as an aid to symbolic expression (ibid.).

Assessment for child psychotherapy involves gauging the child’s ego resources and thus their capacity to confront their struggles and bear distress, as well as to form and sustain a therapeutic alliance (Anderson, 2002). Both the internal and external worlds of the child are therefore examined in an attempt to ascertain the child’s “capacity to cope with mental pain” (ibid., p.19). While initially psychoanalytic psychotherapy was only undertaken with neurotic children, more recently this approach has been applied and adapted for psychotic, traumatised and deprived children (Horne & Lanyado, 1999). In

her work with chronically abused children, Anne Alvarez (1992) problematises the notion of psychological trauma, as it “assumes some degree of previous trauma-free development, and, in the case of abused children, some notion of non-abuse, of self-respect and self-valuation” (p.153). Instead, Alvarez understands that,

something may need to grow *for the first time*. This is a slow delicate process and may be more akin to the way mothers, by attunement and shared mental states, provide alpha function for their babies, than to older psychoanalytic models of recovering lost splits and lost projections” (ibid., p.91, emphasis added).

This is associated with the concept of the therapist as a new developmental object (and not just a transference object) central to the work of the British Independent School (Sternberg, 2006). According to this thinking, change is understood to occur through the new relational experience in therapy (rather than only through insight or understanding). Thus, “psychoanalysis depends on the repetition of some aspects of the mother–infant relationship, such as attunement, holding in mind and containment” (Sternberg, 2006). Anne Hurry’s work in particular explores the role of the therapist as new developmental object, which involves re-parenting so as to enable the child client to go through developmental processes that did not happen at the appropriate age. It is the role of maternal container that the therapist often assumes, through which:

The patient learns to experience acute emotions in the presence of another, the therapist, whose capacity to bear them and think about them gradually enables the patient to introject the possibility of doing the same... The therapist who is able to bear staying with the unbearable feelings creates both a space within which it becomes safe to think and a model of that capacity which can be developed over time (ibid., p.46)

This role is,

not about making up deficits in a gratifying way but about providing a relational framework so that these representations and processes can unfold in a relational context. It could be thought of as the relationship within which experiences of mentalisability can arise (ibid.).

3.5 Data collection

The data used in this case study were generated as an inherent part of the therapeutic process, constituting the various means by which this process was documented for clinical, supervisory and record-keeping purposes. This documentation took the form of clinical case notes, supervision notes, video footage, transcripts, and drawings. Firstly, detailed clinical case notes were written from memory after each weekly therapy session. These document and explore both the content and process material arising in each session, including counter-transference responses. Secondly, notes were taken during weekly supervision meetings, in which each therapy session was reviewed (often while replaying video footage). These included technical and theoretical input into the therapeutic process, as well as exploration of 'micro-moments' within a particular session, and counter-transference experiences. Thirdly, each session was recorded with video footage. Fourthly, this footage was used to transcribe various key sessions for academic and supervisory purposes. Finally, the drawings made by the child client over the course of therapy were kept in his file along with any comments he made about these. Thus multiple sources of evidence are drawn on in keeping with recommendations for qualitative case studies (Yin, 2003).

3.6 Data analysis

The data in this qualitative case study are interpreted through the psychoanalytic framework, which emphasises the exploration of layered, subjectively constructed and unconsciously influenced meaning, as opposed to the finding of objective 'facts' (Gibson, 2002). This form of data analysis makes use of the concept of interpretation comparable to, yet distinct from, that used in the clinical setting, and is centred in theory on the one hand and reflexivity on the other (Hollway & Jefferson, 2000). This interaction between theory and reflexivity in the analysis of data is expressed in Attwood & Stolorow's (1993, p.9) understanding that psychoanalytic research "always entails a complex back-and-forth movement between theoretical constructions and the phenomena being studied", and so involves,

a series of inferences into a person's psychological life, ideally alternating and interacting with the investigator's acts of reflection upon the inevitable involvement of his own

personal reality in the ongoing investigation. By lifting the particularising impact of his personal subjectivity into reflexive awareness, the investigator seeks to deepen and broaden the interpretations that are brought to bear on the case material (ibid, p.28-9).

Attwood & Stolorow (1993) identify two phases in the psychoanalytic data analysis. Firstly, the individual's internal psychic world must be formulated according to "the unique dimensions of which his experiences are organised, the central concerns and dilemmas that are for him subjectively salient, and the recurrent thematic configurations of self and other (and associated affects) that pervade his world" (ibid., p.31). This is based on the psychoanalytic assumption that "subjective experience, viewed across a variety of situations and over a sufficient span of time, is always thematically organised around some more or less coherent set of nuclear concerns and, furthermore, that these concerns arise out of critical formative events in the person's life" (ibid., p.32). The second phase of analysis involves the "clarification of the developmental origins and of the functional significance of the particular organising configurations in the person's subjective world" (ibid.). This entails historically locating the central themes and concerns that have been identified in the first phase, in relation to individual development. This reconstruction of "the genesis of his psychological world" (ibid.) occurs with reference to factual information about the individual's life history and circumstances. The two phases of analysis are clearly inter-related as

understanding of the person's present experiential states will to some extent guide... inquiry into developmental history, and it will influence the determination of which formative events we should regard as critically important. Conversely, information about critical developmental situations may alter and transform the provisional characterisation of a subjective world. Every case thus involves a dialectical process in which the descriptive and genetic phases reciprocally interpenetrate and illuminate one another (ibid.).

The credibility of psychoanalysis as an analytic tool in the research setting has been problematised (Hollway & Jefferson, 2000). Critiques rest on the subjective nature of psychoanalytic interpretations, which are shaped by personal and social characteristics of the researcher. However, proponents of this form of analysis emphasise the importance of

acknowledging the limitations of objectivity and utilising, rather than trying to exclude, subjectivity (ibid.). Counter-transference and intersubjectivity thus become tools in a psychoanalytic analysis, which enables a “tolerance for paradox and uncertainty” (Hollway & Jefferson, 2000, p.78) so important in this form of inquiry. Psychoanalytic interpretation therefore requires exploration of unconscious motivations in both researcher and participant/s, as well as the dynamics between them. In this way, psychoanalytic data analysis can be seen, like therapeutic interpretation, as more of an ‘art’ than a ‘science’ (ibid.).

In this study, I interpret the clinical material in relation to my formulation of Chad’s psychic functioning which has been shaped through the reviewed literature, as well as through my counter-transference experiences. The clinical case notes, along with supervision notes, transcripts and drawings, were analysed thematically, and organised into four predominant, although inter-related, themes. Clinical vignettes illustrating these themes are included in the findings and discussion section of this thesis (Chapter 4). This process of reviewing, sifting through, analysing, synthesising and writing up the therapy material has felt analogous to the central theme of psychic digestion. Thus this academic process has held echoes of the therapeutic one in which I took into myself, felt, thought about, made meaning of, and eventually returned, feelings that were given to me in their raw, undigested, often chaotic and overwhelming form. In so doing, I have found the theory to be containing.

3.7 Ethical considerations

As with all clients of the CGC, Chad’s aunt as primary caretaker was informed at the first intake that this is a teaching institution and that all clinical material may be used for training or research purposes. At this time, Natasha signed a written consent form giving permission for this eventuality. When it was decided (a year into the therapy process) to write up this case for the current study, this was discussed extensively with Natasha. The nature and purpose of the study were explained to her in general terms, and she was given time to think through any concerns she might have. After reflection, her written consent was given (see Appendix for copy of consent form). It was explained to her that should she wish to withdraw this at any point, this would be respected and the study would be

discontinued. She was also assured that all personal information would be changed so as to protect the identity of her nephew and herself. Thus voluntary participation, confidentiality and informed written consent were secured from the primary caretaker in keeping with American Psychological Association guidelines on research with children (<http://www.apa.org/division/div7>).

While these guidelines indicate that child participants of psychological research should be informed of the research and give verbal assent, this was complexified in the current study by the fact that the child participant was in an ongoing therapeutic process with the researcher as therapist. After careful thought and discussion with clinical and research supervisors, the decision was made not to inform the child client about this study. This decision was based on concern regarding the therapeutic implications that this information might hold for this particular child at that juncture in the therapeutic process, as well the understanding that given his cognitive developmental stage, the child client would not really be able to understand the concept of a research study such as this. This decision was made in keeping with the recommendation that such decisions regarding informed consent in research drawing on clinical material, particularly in cases of child clients, are made on an individual basis, and with flexibility, wisdom and discretion in order to balance the therapeutic needs of the patient with the profession's need for research on the clinical process (Lanyado & Horne, 1999).

The concept of 'informed consent' has in itself been problematised, particularly in the context of psychoanalytic research, where, it is argued, this "cannot be reduced to a conscious, cognitive process" (Hollway & Jefferson, 2000, p.88). Moreover, it is acknowledged that, "There are occasions when consent is not the primary ethical principle, but is contradicted by another" (ibid. p.94). In such cases, it is arguably sufficient to get consent from some but not all parties involved (ibid.). In the current study, consent from the child client was understood to have posed a potential risk to the therapy process, and so to contradict the ethical principle of avoidance of distress. In keeping with Hollway and Jefferson's (2000) guidelines, and given that all other ethical principles were met, it was therefore deemed sufficient to get informed consent from his primary caretaker.

The need to obtain informed consent from Chad's biological parents was considered, and discussed with clinical and research supervisors. Consensus was that under the circumstances of both parent's psychological instability and impaired functioning (associated with their continued substance abuse and the fact that at the time Chad's father was in and out of psychiatric institutions), they would not have been in a position to give meaningful informed consent. Their incapacitated state also meant that Chad's parents were not at all involved in his care, and had not been for the two years of Chad's therapy. The decision was therefore reached that, although not ideal, it was adequate under these circumstances to have obtained consent from Natasha in her role as Chad's primary caretaker and effective, although not legal, guardian. In addition, before giving her consent, Natasha consulted with other members of the family directly involved in Chad's caretaking.

3.8 Conclusion

This qualitative research entails a clinical, and specifically psychoanalytic, case study that seeks to enrich both clinical and theoretical understandings of the relationship between physical and psychic processes in relation to conditions of containment and traumatisation during a therapeutic process with a child trauma survivor. This is embarked on in the light of identified gaps in psychoanalytic literature on this topic, and of the relevance of this question for therapy with multiply traumatised children in South Africa. This chapter has articulated these aims, outlined the research design, detailed the context of this study and the nature of the therapeutic intervention, described data collection and analysis, and noted ethical considerations.

CHAPTER FOUR: FINDINGS AND DISCUSSION

This chapter is an analysis of the therapeutic material through the lens of the literature reviewed in chapter two. I begin by outlining the case history, and then discuss the therapeutic material through four inter-related themes: firstly, Chad's relationship to me and my body as maternal object, through themes of breaking and sticking; secondly, the taking in of external goodness through bodily incorporation of food and symbolic introjection of care and understanding; thirdly, Chad's sense of himself and his body in relation to the revealing and concealing of internal badness; and finally, the getting rid of badness through physical expulsion and psychic projection, with a move towards communication rather than evacuation of Chad's internal world. The shifting relationship between body and mind, self and m/other, will be central threads through this discussion. These will be explored in relation to Chad's 'developmental' trauma of inadequate early maternal containment, layered with 'external' traumas of deprivation, punishment and abuse, which are understood to have ruptured whatever degree of internal containment he may have internalised. Throughout this discussion, I draw on psychoanalytic concepts reviewed in the literature to make meaning of the case material. In order to retain something of the immediacy and aliveness of the therapeutic process in this discussion, and to avoid repetition, the theoretical lens will be applied in an implicit and integrated manner, with references to concepts from specific theorists being bracketed but their theories not explicitly reiterated. Explicit linkage between the findings emerging from this analysis and the reviewed literature will be the focus of the concluding chapter.

4.1 Case history

Chad is very small for his age (which may reflect a stunting of growth due to early malnourishment). He has a Malaysian-looking complexion, with dark skin, dark eyes and dark hair which is neatly cropped (the significance of his skin colour will be explored below). Chad's general appearance and posture differed markedly on different days, seeming to shift according to changing internal states: sometimes he arrived full of energy and excitement, his body upright and clothes neat, moving with a vividness and agility, his speech rapid and engaged; at other times his whole being seemed to 'flop', his

body sagging in a strangely awkward way, as though he was experiencing internal pain, and he seemed terrible fragile, his clothes worn sloppily, his speech slow and almost slurred; at other times, as will be explored below, he acted as a punitive, very angry and controlling, even malicious adult; at yet others as a weeping, forlorn, distraught, or accusatory child. The feeling of vulnerability that Chad projected seemed to elicit nurturing and protective responses in all who set eyes on him at the Child Guidance Clinic - so many people who saw him walking to or from the therapy room told me they just wanted to hug him! My counter-transference responses to Chad will be explored in relation to the case material below, but in general they ranged from a similar sense of intense maternal protectiveness and warm affection, to a sense of intimidation and real terror, to feelings of helplessness, of being overwhelmed, in despair and shock and sorrow. For a long time I seemed to fluctuate between feeling saturated or too full, at times even physically nauseous, with all I felt I was carrying, and a sense of emptiness, of blankness, of being unable to think, and a profound not knowing.

Chad was referred to the CGC in February 2005, by his paternal aunt and primary caretaker, Natasha, but on the recommendation of his class teacher. The reason for referral was concern by his aunt and class teacher about his inability to cope academically, behaviourally, socially and emotionally. They attributed these problems in particular to his history of sexual abuse (see below). In 2005, Chad was assessed at the CGC, and psychometric testing was undertaken. The results of the cognitive assessment indicated that Chad was functioning in the range of Mild Mental Retardation. However, it was acknowledged that the emotional impact of his traumatic history (see below) was probably affecting his performance. The emotional assessment pointed to Chad's insecurity and experience of himself as 'bad' or 'damaged'. It was recommended that he repeat Grade 1 and be referred for long-term play therapy at the CGC the following year. This history was obtained from the file records of the clinician who had seen Chad during 2005, which he obtained from interviewing Natasha and Chad's class teacher. To this was added information that arose during my own contact with Natasha and the teacher over the course of 2006 and 2007. Our knowledge of Chad's early development is therefore limited through lack of contact with his biological parents, who in most likelihood would not have been able to provide a coherent history.

Chad has a history of extreme deprivation, neglect and abuse. His parent's relationship, which had centred on substance and alcohol abuse, ended soon after his birth. Chad and his three older siblings (a girl and two boys), about whom Natasha did not know anything further, remained with his mother. They lived in impoverished, overcrowded and chaotic conditions, where Chad witnessed drug-taking, sex and violence. He was physically and emotionally neglected, often going hungry and unwashed, and unattended to when distressed. Chad was at the same time emotionally and physically abused: in particular, he was subjected to malicious forms of punishment such as being made to stand in a corner for long periods of time, often for no particular reason or for the 'entertainment' of the adults. When he was five, Chad was sexually abused by his maternal uncle, who was living in the same house. Chad told his father, who visited periodically, that this man had been "rubbing himself" against him. His father reported this to his sister Natasha, whom Chad visited over weekends. She arranged a medical examination for Chad, which showed evidence of attempted penetration. A case was lodged but no action was taken.

After this, Chad reportedly pleaded with Natasha not to return him to his mother's house. A family decision was taken that Chad live with Natasha and her family, and that she undertake all the duties of primary caretaker. He continues to live with Natasha, her husband and his daughter, where he is loved, very well cared for, and comfortably provided for. Chad's parents continue to abuse substances and according to Natasha to be severely debilitated by this. His father was in and out of Valkenberg Psychiatric Hospital during the course of our therapy. Over these two years, Natasha attempted to establish a regular visiting arrangement for Chad with both his parents, but this was frequently disrupted when either were in too unstable a state to see Chad, and he therefore went for long periods without seeing his biological parents. Natasha reported that he would sometimes ask to see his father, but never even mentioned his mother, and seemed reluctant to see her.

Natasha reports that for a long time Chad was terrified of being abandoned by her and returned to his mother, and was very compliant and withdrawn, apparently trying to get everything 'right' to avoid punishment and abandonment. Chad began Grade 1 in 2005, and here too was initially very 'good' as well as extremely anxious about possible

punishment. He gradually developed a very close and trusting relationship with his class teacher, who was exceptionally caring and committed to Chad. Because he reportedly remained very anxious around other adults at school, this teacher decided to remain with him when he had to repeat Grade 1 (see below), rather than proceeding with the class to Grade 2 as would ordinarily be the case, so providing him with continuity and safety. Chad's initially compliant and 'good' behaviour gradually changed, apparently as he felt safe enough at home and at school, as well as at the CGC, to express what he called his "bad behaviour". This extreme acting out was considered the most serious of his various presenting symptoms, which will now be discussed.

4.1.1 Presenting problem

When I first saw Chad in April 2006, he presented with the following (inter-related) symptom clusters: Firstly, Chad's behaviour was the most urgent source of concern. At school, he was victimising smaller children, teasing and bullying them, as well as initiating frequent fights in which he would kick, box and bite them. He was at the same time extremely disruptive and disobedient in class, swearing, screaming and laughing inappropriately. Although the school was aware of, and understanding about, the implications of Chad's traumatic history, his behaviour became so unmanageable that they threatened to expel him. At home, Chad was defiant and unmanageable, throwing frequent tantrums when he didn't get his way. Despite her genuine love for him and concern about his wellbeing, Natasha felt unable to cope and threatened to return Chad to his mother. Both at school and at home, Chad showed extreme anticipatory anxiety in relation to punishment, which led to inconsistent discipline. In both settings, the adults around him reported feeling overwhelmed and desperate. As will be discussed, psycho-education and supportive work with Natasha and Chad's teacher was undertaken, and eventually seemed to help alleviate this crisis.

Secondly, Chad displayed a marked deficit in social skills. He was unable to share with other children, and would become easily jealous and vindictive. Together with a very low frustration tolerance, this left him socially isolated. Thirdly, Chad was emotionally volatile, with periods of intense anger and hostility interspersed with times of withdrawal and weepiness, during which he would become overly compliant, apparently seeking to

be 'good' at get things right all the time. At the same time, Chad was extremely anxious about being abandoned by his aunt, teacher or therapist, and terrified of punishment by them. Chad also had an intense fear of the dark, and was preoccupied with the colour black, which he associated with his own skin. His teacher further reported that he would become distressed when the topic of sex was mentioned at school. Chad had a stutter, which his aunt, teacher and therapist all noted occurred when he became upset or anxious. Finally, while academically Chad was managing his second year in Grade 1 better than the first, he still struggled significantly with concentration and memory, which impacted on his performance. His teacher also reported that Chad would become very distressed during tests, and that he was hypersensitive to failure.

By the end of therapy, all of Chad's presenting symptoms had stabilised, and he was thriving in many areas. During the second year of therapy, Chad's behavioural problems settled completely. His teacher and aunt reported no problems in either setting – there was no longer any need for disciplining beyond a first warning! However, for a few weeks after termination was raised in therapy, Chad began acting out again (while he had only received two 'demerits' over the entire year, he accumulated 15 in the following two weeks). This was understood to be a response to the anxieties raised by termination. Socially, Chad had established a number of close friendships both in and out of school, was reported to interact well in group settings, and, according to his teacher, showed remarkable "compassion" towards other children. Emotionally, Chad's tantrums and specific fears disappeared completely. He displayed no anticipatory anxiety towards punishment, and diminished anxiety about separation and abandonment (although Natasha reported that he became more "clingy" towards the end of the therapy process). While Chad was no longer compliant and withdrawn, he did become weepy during particular stages of the therapy, most notably at termination. Chad's stutter cleared almost completely. Academically, Chad was assessed by his teacher to be an "above average student", producing "really high quality work" across all subjects, and leaving her with "no concerns" regarding his cognitive capacity. He also evidently enjoyed (mostly!) his school work, and was reported by his aunt and teacher to be self-motivated and confident.

4.1.2 Diagnosis

Chad was initially diagnosed with *Oppositional defiant disorder* and *Posttraumatic stress disorder (Chronic)* on Axis I of the DSM-IV, as well as the *Neglect of Child, Sexual Abuse of Child, Physical Abuse of Child* and *Parent Child Relational Problem*. Symptoms of the first condition included Chad's pattern of defiant behaviour, such as frequently losing his temper, arguing with adults, actively defying rules and deliberately annoying others, while at the same time being easily annoyed by others, angry and resentful. Chad displayed all the symptom clusters of Chronic PTSD. Firstly, he appeared to be *reexperiencing* his traumatic past through reenactment (in his behaviour towards other children as well as his play), recollections (through his drawings and play), distress at exposure to cues (such as during sex education) and apparent dissociative flashbacks. Secondly, Chad showed a pattern of *avoidance* of thoughts, feelings, and conversations associated with the traumas he had experience. Finally, *hyperarousal* was evidenced through Chad's irritability and angry outbursts, concentration difficulties and exaggerated startle response. Differential diagnoses on Axis I included *Dysthymic Disorder* (symptoms of which included irritable/depressed mood, fatigue, low self-esteem and poor concentration), and *Dissociative Identity Disorder (DID)*. The first was not diagnosed as the duration specification could not be established. Although Chad did display evidence of distinct personality fragments (such as a fierce, self-protective child and a punitive, angry adult), these were not sufficiently pervasive or stable to warrant diagnosis of DID. Chad's stutter was not diagnosed as it was not found to be severe or pervasive enough to impair his functioning. On Axis II, Chad was initially diagnosed with *Mild Mental Retardation*. No diagnosis was made on Axis III. On Axis IV, the following was diagnosed: *Problems with primary support group, Problems related to the social environment, Educational problems* and *Economic Problems*. Chad was given a Global Assessment of Functioning (GAF) score of 55, indicating moderate symptoms and moderate difficulty in functioning.

At the time of crisis in his home and school environments, Chad was given a Children's Global Assessment Scale (C-GAS) score of 40, indicating major impairment in

functioning in several areas and inability to function in one of these areas (at home, at school, with peers).

On termination of therapy in 2007, Chad's only remaining diagnosis was of *Parent Child Relational Problem*. All the symptoms of his previously diagnosed Axis I disorders had stabilised, and his diagnosis of *Mild Mental Retardation* was ruled out when Chad's scholastic performance as well as adaptive functioning improved markedly – the results of his initial assessment were understood to be reflective of his traumatic history and post-traumatic state. On Axis III, *Problems with the primary support group* remained his only diagnosis. Chad's C-GAS was 80, indicating good functioning in all areas (family, school, peers), with transient difficulties that occasionally become more debilitating but then stabilise.

4.1.3 Intervention

Regular feedback sessions were held with Natasha, on a roughly monthly basis (although less frequently and more flexibly during the second half of the first year, when Chad became extremely anxious about confidentiality being breached between his therapist and aunt during these meetings). These included general feedback to Natasha regarding Chad's progress in therapy (which was formulated together with Chad during our prior therapy session), feedback from Natasha about how Chad was doing at home and school, as well as support and parenting psycho-education for Natasha. (She was referred to the Parent's Centre for parenting skills and supportive therapy, but was unable to take this up). Roughly quarterly feedback meetings or telephone conversations were held with Chad's teacher, in order to find out how he was doing at school, as well as to provide her with support and psycho-education. A crisis meeting was also held with the school principal when Chad was threatened with expulsion. These were all attempts to provide containment for those functioning as Chad's 'containers'.

The decision to take Chad into long-term individual psychoanalytically-oriented therapy was made largely on the basis of his remarkable capacity for symbolic expression witnessed during his psychometric assessment in 2005. The clinician and his supervisor felt that Chad was not only able to, but communicated a strong *need to*, express himself

symbolically. He was also found to be able to create and sustain a therapeutic alliance. Furthermore, despite the fact that his biological parents were in unstable conditions, Chad was placed in a very caring and stable home environment, with the additional care and support of his teacher and school. It was therefore considered that both the internal and external worlds of this child would be able to provide the ego- and environmental-support necessary for him to deal with the raised levels of distress likely to occur during therapy (Anderson, 2002). This decision was made despite, but with some cognisance of, various contra-indications to this choice of intervention, particularly his cognitive functioning within the range of Mild Mental Retardation. However, the validity of this diagnosis was in question given his trauma history.

The broad aim of this therapy process was to unblock the places where Chad's development was understood to have become 'stuck', and so to enable his normal developmental processes to resume. It was hoped that this could arise from a reparative experience of emotional containment that it was understood Chad had lacked early in his life ('developmental' trauma), and that whatever degree of internal containment he had managed to internalise was eroded through the 'external' traumas of deprivation, neglect and abuse. In this way, I sought as therapist to act as a new developmental object, in particular to allow, receive, feel, think about and survive the intense feelings he communicated to me. The hope was that Chad could internalise this into his own containing function that would enable him to think about, and so manage, his own feelings, enabling a shift from direct discharge through enactment and bodily expulsion, to mentalisation and emotional expression.

4.2 Case material

I turn now to the analysis of the case material through the lens of the literature reviewed, looking at four inter-related themes:

4.2.1 Theme 1: Relationship to maternal object

In this section I explore Chad's expressions of having lacked, and of now needing, the inter-related maternal functions of containment (Bion, 1967), holding (Winnicott in Davis & Wallbridge, 1981) and 'primary skin' functioning (Bick, 1967/1988) (these terms are

used interchangeably at times during this discussion to indicate general impaired early maternal care, while at others their different implications are explored). These are examined in relation to Chad's expression of a sense of brokenness within him, and a fear of losing the newly found maternal object – both of which manifest in the theme of fixing and sticking together. His negotiation between connection and separation with me as maternal object, and his gradual expression of a capacity to internalise the maternal functions, are then explored in relation to play sequences with the telephone and the toy snake.

To begin with, I examine Chad's preoccupation with brokenness during therapy. From the very first session he sought out "broken things", such as toys or bits of clay or paper, which he would then "stick together" with glue or plastersine. He communicated over and over again his need for me to fix what he felt to be a brokenness inside him. Chad's body had a strange and remarkable 'floppiness' to it at times, suggesting a struggle to 'hold himself up', or to hold himself in. As shall be explored, this seemed to communicate both a need to cohere what felt broken within him, and at the same time a desire to merge with, or become stuck to, me as maternal object.

During my first meeting with Chad and Natasha (1)¹⁷, while playing alone when I was talking to Natasha, Chad stuck two wooden blocks together with pink plastersine. He repeated this image of two things being held together by a warm, fleshy, common sticky stuff during a number of early sessions. For example, in our first therapy session (2), the following play sequence took place:

Giving me one of the toy telephones and holding the other to his ear, Chad said he was phoning to ask if I was going out or if I would "be there"¹⁸. I said I would be here, and

¹⁷ In order to locate therapy material in relation to the process as a whole and other examples, I indicate in brackets the session number out of the total of 69 sessions over the course of 2006 and 2007.

¹⁸ Session material is italicised and quotation marks reflect actual quotes as recalled and recorded in session notes.

asked why. He said he had "some stuff" of his that he needed to "bring" to me. I said that would be fine and asked what it was. He said it was a towel of his that was "broken" and that he wanted me to "fix". I asked how that had happened, and he said "it was a little thing that was trying to be big, but it couldn't be, so it stretched and got broken". I asked if he would like to help me fix it and he said he couldn't. I said that was okay. He brought me his blue tracksuit top that he had taken off and said this is the towel. He then asked me to pretend to take out a circular hole in a toy and to stitch it into the towel. He went and got a pink crayon and said that was my needle. I sat at the table and stitched up the hole in the towel, and stitched in the hole from the toy, while he played in the corner and waited for me. After a while he came to see if it was fixed, and said it was. After that he began looking at the toys and said he was looking for something broken. He fetched the scissors and cut a small square out of a piece of paper, and stuck press-stick onto each corner and made out of this a roof for a wooden car.

I understood that at this first therapeutic contact Chad was telling me what he needed of me: to be there, present with him, not going away, and through this containment (Bion, 1962), to repair what felt broken in him. This question of whether I would be there became later in therapy a question of whether I could bear, withstand, tolerate, survive all the brokenness and 'badness' he brought. The thing that Chad here feels to have broken for him is his towel and then his warm top, which are both comforting external skins, associated with early maternal care, with being cleaned and dried and warmed. But instead of being allowed to be a little boy, looked after, Chad had to stretch into a defensive 'second skin' (Bick, 1967/1988) of 'bigness', which he feels to have broken him. He seems to be communicating that this defence is not working, in his 'bigness' he has not been able to really grow, and he is hoping that through therapy, in providing him with a maternal mantle, another chance at the 'primary skin' (Bick, 1967/1988) experience, he can be 'mended', and return to his interrupted development. He is asking if I can bear to be there with his littleness. This littleness returns him to an early state in which he needs to be passively held, needs me to do the fixing for him, and so to stitch up, link and cohere, the broken bits inside him. Chad then continues this act of sticking together broken things himself.

A second manifestation of this theme of sticking was Chad's apparent attempts to stick to me, symbolically and literally. This theme emerged particularly around the time of termination, perhaps reflecting his anxieties about losing the good maternal object he had experienced during therapy, and so wanting to stick us together to avoid the pain of parting. In a session (66) during the period prior to termination, when we were talking a lot about having to say goodbye,

Chad arrived with two pieces of paper from the waiting room which he had folded intricately, saying he needed some glue and scissors. He began trying to slot and stick the two paper objects together. I said "there are two things which you're trying to keep together" He said "yes!" enthusiastically, and then became very frustrated when they failed to stick. I said "you don't want them to come apart". I reminded him that last week he had said that he wished he and his best friend could be stuck together forever like blood brothers. He agreed with this, saying he remembered. I went on to say that maybe he'd also like for us to carry on seeing each other each week and not to have to say goodbye so soon. He said tentatively, "yees". Later in the session, Chad made a ball from the rolled-up paper, adding lots and lots of glue to it. He then instructed how we must throw it to and fro between us in a rhythmic movement. He kept on adding more glue, and I said "my hands are getting very sticky!" He laughed delightedly and said "mine are also!"

Here the theme of two things that Chad was earnestly trying to keep together repeated itself throughout the session. I understand his apparent attempt to stick our actual skins together, through the glue that passed between us, as a concrete manifestation of an adhesive attachment pattern (Bick, 1967/1988) here activated by the pending termination, in which Chad tried to prevent the loss of the good maternal object by sticking himself to me. A second example of this theme in the period prior to termination was during a session (31) in which:

Chad asked me to leave some of the juice he had given me (see Theme 2), which he poured in the water jug and to which he then added some glue, stirring this mixture and then attempting to drink from it through the straw.

This sequence similarly seems to reflect Chad's attempts to hold us together, here combining something of mine with his own, sticking and stirring this, and attempting to physically ingest this (the theme of bodily incorporation and psychic introjection is the focus of the following section).

The recurrent motif of sticking is closely related to that of a 'phantasy of common skin' (Anzieu, 1989) with the maternal object, which I understand Chad to have sought with Natasha as another sort of new maternal object. At the start of therapy, Chad was reported by Natasha to be extremely preoccupied with the difference between his and her skin colours, his being darker than hers and her family's (Chad never made direct reference to the difference between our skin colours). This difference was a source of massive distress for him, perhaps because it gave physical, visible 'evidence' to the fact that Natasha was not Chad's mother, at a time when Chad needed to be 're-mothered'. This would have disallowed the recreation of a phantasy of common skin (Anzieu, 1989) between them and so forced Chad into a state of differentiation between himself and his new mother figure prematurely, before he had re-experienced the early state of mergence with a mother of which he was initially deprived.

I now explore various manifestations in therapy of Chad's sense of having been deprived of early maternal care, and his attempts to experience this newly through me as maternal object. This was expressed on the few occasions that Chad played with the baby doll and pram. During a session (27) in which he repeatedly asked me to "watch him" while he performed all sorts of "tricks", seeming to crave an admiring maternal gaze (whereas usually he scolded me for looking at him – to be discussed in Theme 3 below):

Chad went up to the baby doll's pram for the first time and started pushing it around, saying "how do they do it?" I asked who they are, and he said he didn't know. I said, "the mommies?" He then spoke of his own mother, for the first and only time during therapy, tentatively telling me her name and surname. Immediately after this he took a toy and tried to break it, saying that he wanted to break it. I said that the toys are not for breaking, but maybe he is wanting to break things to tell me he wants things to be fixed.

At the end of this session, Chad did not want to leave the room, whereas usually he tried to leave before the time.

Chad seemed to be expressing his unfamiliarity with what a mother would do with a little baby in a pram, which he linked immediately with his own mother. His desire to break something in response can be understood simultaneously as an expression of anger at this absence, a demonstration of the internal consequences of this for him, and a call for a reparative experience here (which is what I picked up on in my comment). Through this expression of his internal sense of brokenness, Chad showed his vulnerability and 'littleness' (which is usually masked by a 'second skin' (Bick, 1967/1988) of bullying control, also to be discussed in Theme 3), and so his need for the therapeutic space, expressed in his reluctance to leave it.

On one of the other rare occasions when Chad played with the doll's pram (48), in a somewhat similar play sequence during the following year:

Chad walked over to the pram, said he wanted to play with it and then attempted to climb into the pram. I said he wanted to "be in the pram like the baby is". He said, "Ja, 'cause it's nice in there". I asked what it feels like to be in there, and he said, "I don't know, it's just nice". He then took the baby doll out the pram and started hitting it violently, saying "it's so hard". I said he seems very cross with the baby, maybe 'cause he couldn't fit in the pram? He then worked himself into a frenzy in which he took off the baby's clothes, threw these on the floor, and then kissed the baby's bottom aggressively and hysterically. I said, "you're kissing the baby's bum", and he laughed more and more hysterically, turning the doll around and kissing it's genitals, but now saying "I'm kissing the baby's privates". After this he calmed down and started an elaborate play sequence with the toy animals. At one point he took the cow and said "we could burst her and all the milk would come out".

Once again Chad seemed to be expressing his desire for the unknown niceness of the little baby inside it's pram. When he did not fit, his 'bigness' belying the littleness he feels inside him, he became furious with the baby, it's "hardness" perhaps reflecting both the pain of this experience for Chad, and his sense that the baby was impenetrable,

wouldn't let him in to it's experience. This attempt to 'be' the baby, to get 'inside' it's skin, then collapses into sexualisation, Chad adopting the role of perpetrator in what appears to be a re-enactment of his sexual abuse. It seems that my making meaning of his actions by putting them into words, which he then does himself, contains (Bion, 1962) him so that he can return to his initial feeling of deep craving for maternal provision, now richly symbolised through the cow's milk (this will be returned to in the following theme).

The only other occasion on which Chad played with the doll's pram was earlier in the second year (35), during a session in which he became— as was very often the case — very upset when I did not have anything for him to eat (this is to be the focus of the following theme):

He started crying and shouting that he "hates coming to this room" because it makes all his "problems come". When I say gently that I hear it feels very hard to be in this room, he says that I am nice to him when he cries, but only when he cries, and he has to cry for me to be nice to him. I say I will try to be here for him no matter how he is. In a fragile-feeling state he then looks into the baby doll's cot and says he wants to sleep, and taking the pillow from the cot begins an elaborate activity of creating a bed with all the red chairs, in which he instructs me how to help him. He is particularly careful to stop up the openings between the chairs, and saying he needs something to "cover" him, uses the table cloth to act as blanket. When it is ready, he lies down and snuggles up inside his bed. I sit on the floor and watch over him. He pretends to fall out the bed and I say I wonder if he is checking if I will catch him if he falls out. He settles, checking every now and again to see if I am looking at him, and eventually actually falls asleep. I feel a strong sense of maternal warmth and protectiveness towards him, and a calmness as I sit and watch over him. When the session time comes to an end I go up to him and say it is time to wake up. He turns over and says he was "lekker sleeping now".

Here Chad does perhaps manage to 'get back inside' the baby's experience, recreating it's cot to fit his own body, and so feeling it's "lekker" sleep of safety. This seems to occur after he has expressed in words his anger at the absence of maternal provision, here

experienced in relation to lack of physical nourishment (the role of which will be explored in relation to maternal love below). His 'hatred' of the therapy room is perhaps a combination of the provision of an experience of emotional containment making his deprivation feel more acute, and the feeling that this provision will never be enough, cannot replace the early absence, leaving him with an insatiable craving (Bion, 1967). This provision also does not feel secure, feels conditional on his behaviour, in this case his distress. It is when he is able to trust that I as maternal object will 'be there' whatever state he is in, that he is able to enter perhaps the most vulnerable condition: that of actual sleep, like an infant. In so doing, he ensures that he is physically enclosed or 'held', the elaborate bed and covers seeming to stand in for maternal arms (Winnicott, in Davis & Wallbridge, 1981), and he needs to be sure that I am right there. Chad's falling asleep could also be understood as a defensive means of withdrawing from his painful feelings of vulnerability, but I have interpreted it in this way largely because of my counter-transference experience of calm protectiveness, rather than emptiness or agitation.

However, once he had experienced this initially absent, currently called-for maternal presence during therapy, Chad repeatedly expressed anxiety that I as maternal object would not continue to 'be there' for him, that my presence was conditional on his behaviour, or that his badness would drive me away. One such expression of his anxiety about the loss of the good object was in relation to the soft ball he played with almost every session. This seemed to represent the therapy space for Chad, and can be understood as a symbol of the breast that was alternatively good and bad (Klein in Segal, 1981). On a number of occasions, when dissatisfied with the therapy space, Chad became angry with the ball, kicking it very hard and calling it "pap" and "small", telling me that he had seen "bigger" and "better" ones. Here the breast seemed to be bad and withholding, empty of goodness. At other times, Chad communicated in various ways, and once (36) said directly, that "the ball is very important to me", suggesting that the ball now represented the good breast. Chad's anxieties about losing this good breast were expressed in relation to the ball going out the window, and occurred particularly after breaks in the continuity of our sessions, suggesting that the containing structure of the therapy room might be pierced and so the goodness disappear out of it (Bion, 1962). During the first session of 2007 (33), after a long holiday break:

Chad became distraught while playing soccer, saying I didn't remember all the things he'd taught me about the game. He then cried out that I was going to "kick the ball out the window" and that we "wouldn't get it back". I said I know it's been a long time since we saw each other but I want him to know I haven't forgotten the things he told me and I thought about him a lot during the holidays. He became increasingly distraught, weeping and screaming and saying over and over that Natasha would hear him and then he would not get his treat, and at the same time demanding that Natasha come into the room (which he had never done before). I became increasingly overwhelmed myself, and after trying various ways of calming Chad, left the room briefly to get him some tissues (again something I had never done before). Outside, I saw my supervisor and asked his advice. He said that I should end the session early, which we did.

The rupture in the continuity of our sessions, during which Chad seems to have feared that I have not held him in mind, but rather forgotten him, is experienced as a rupture to the physical structure of the therapy room, out of which all the goodness threatens to be lost (Bion, 1962). This piercing of the containing function of my mind, concretised through the break in therapy and the openings of the room, left Chad in a terribly uncontained state. In trying to reassure him that I had held him in mind, trying to bind up the rupture of the break, I did not hear and receive and digest the feeling of rupture that Chad was trying to communicate to me, but rather, out of my own anxiety, tried to 'fix' them. This clearly heightened his distress, and seemed to confirm his fear that I could not bear to hold his feelings in my mind. This he again experienced as a rupture to the container of the therapy space, through which he worried that Natasha would witness his weeping and then that further goodness would be withheld. And through my own distress at being unable to contain him, I did in fact further break the continuity of this space, leaving the room and seeking containment myself. The early ending of the session (the only occasion in which this happened over the course of therapy), while considered necessary under the circumstances, might have felt like a further confirmation for Chad that his overwhelming feelings could not be contained, and that the good object would disappear (Bion, 1967).

Chad continued to test my capacity to 'be there', particularly when he brought what was felt to be 'bad' material into therapy. This testing sometimes occurred through a return to the use of the telephone to communicate during symbolic play, as well as the use of the toy snake, both of which will now be explored. For example, in a session during the second half of the first year (20), during a period of lots of acting-out and testing behaviour:

While playing with the ball, Chad suddenly asked me if I "talk a different language". I asked him what he meant, and he made a whole lot of funny sounds and spoke about different ways of talking and different languages. Then he said he was "just giving me an example, so that we can..." He trailed off, and I asked: so that we can understand each other and speak the same language? He said yes, and then went straight to get the two toy telephones, and sat across from me at the table, putting one in front of each of us. He instructed how we must dial each other, and then he turned away from me and said in a faint 'telephone' voice, "hello, how are you?" I said I'm fine. He asked what I was "doing", and I said I was talking to him. He asked "what else" I was doing, whether I was "busy". I said "I'm not busy, I am here, talking with you". He said "good" and put down the phone. After this Chad looked through some magazines and paused at all the revealing pictures, naming and pointing to the places where the "bottoms", "breasts", "penises" and "vaginas" would be. I sat with him and evenly repeated the words after him. He then got up and climbed onto the shelves, saying he "almost fell". Then he climbed onto the chair, and rocked it so that he did almost fall. Then he said that I "must catch" him if he falls, and that I "must care for" him, that that is why he is here, and that I must "look out for" him as well. I repeated that he is here for me to catch him if he falls, to care for him and to look out for him. He said yes, and I asked how it is for him when that happens. In response, he told me a story about when Natasha had "hurt her arm" and there were "broken bones and blood", but the doctors "made it better and fixed it up". I asked if that is what he feels happens to him here. He lay down on the floor and in a dreamy voice said "one must say thank you to that person". I asked what he meant, and he said "that person has saved your life, and you want to say thank you". I felt very moved.

Here Chad is again using the telephone, with its associations of a physical, almost umbilical, link to facilitate our communication, to ask again whether I am still 'there', still present to him, not busy. He then goes on to test whether I will still be there even if he shows me 'bad' material, but which he is beginning to speak of and name rather than enact. When I am still there, he expresses again his need for me to catch and care and look out for him, all the functions of early maternal care. As in the first example, psychic repair is pictured concretely, here in terms of bodily healing. And as in that first example, I again feel that Chad is saying that it is through my (continued) presence, through being present to him, able to bear what he brings, and digest this, through this reverie, that the repairing takes place (Bion, 1967). It is through this that Chad feels his brokenness to be bound, and in this sense his emotional life to be saved. While his emotional needs are still expressed through the physical, the body is now a metaphor for the mind, not collapsed into it.

In the interplay between Chad's attempts to stick himself to me to keep me near, and his growing trust that I would continue to 'be there' (however he might be), the soft toy snake seemed to be a transitional object (Winnicott in Davis & Wallbridge, 1981) through which he negotiated our separation and connection. This was intimately tied to the theme of maternal holding, and the gradual capacity to hold, and so feel cohered within, himself (ibid.). During the second half of the first year Chad started to wrap the large soft toy snake around himself at times when he seemed to need comforting, in what felt like a form of self-soothing. Early in the second year (37) he developed a game in which he would lie on the floor holding one end of the snake, and I would stand up, holding the other end and swinging him around with it. Curling up into a ball, in a foetal position, he said over and over while I spun him around, "hold me, hold me!" This game was repeated frequently, especially after breaks in therapy, and always with a feeling of warmth and closeness between us, expressed by Chad through a number of references to positive, providing maternal figures, for instance (40) speaking of "mother Christmas" during the game, and in another instance (37) saying "I want to be a baby!" The snake seemed to create an umbilical link between our bodies, through which Chad was able to feel held as a baby might, (as well as nourished and provided for, as shall be seen in the following theme), which he used particularly to reconnect with me when this has been

disrupted by a therapy break. When the toy snake itself began to break, we made our own one out of a strong rope and brightly coloured material which Chad enthusiastically stitched and wound together (44). This snake was used for the same game, and seemed to become a transitional object used to negotiation separation and connection between us (Winnicott in Davis & Wallbridge, 1981).

Towards termination, Chad used this snake to express both his anger at being 'abandoned' by me, and a sense of being ready now to hold himself. For example (65):

Chad took the snake we made and started hitting it violently against his own reflection in the mirror, and then wildly into the room. I said that's the snake that was for holding and now it's being used for hitting. He replied, with feeling, "yes it is!"

It seems that the snake as that which had linked us was now being used to attack that link, perhaps expressed in Chad's attempt to destroy his physical reflection as a manifestation of the containing function of the room, the place where his image was held. This seems then to have been transferred into an attempt to hit out at and so destroy the actual space of the room. In an example of Chad's apparent expression of having internalised the maternal holding function (62):

After planning how we would spend our last session together, Chad tied the snake around his middle, and with pride said that it was his "trophy", and went on to show me how he could count up until very big numbers.

Here he seemed to be expressing the part of himself that did feel ready to leave, that felt big enough to be holding himself with the snake now wrapped around him rather than being passively held by me from the other end of it. (This could also be understood as a defensive communication that he no longer needs me, to avoid being hurt by my leaving him, but the atmosphere of genuine celebration and pride, rather than pain and punitiveness, led me to the current reading). This motif of being able to hold himself recurred in a session (59) where the two umbilical symbols, telephone and snake, seemed to converge:

I had been talking about bad things that adults do to children that make them feel very angry and bad. Chad appeared to listen attentively and (unusually) to be carefully thinking! Then he wandered over to the toy telephone. Holding onto the dial, he twisted this around and then let the whole phone uncoil in a circular motion as he released it, absorbed in it's motion. He asked me excitedly if I knew what he was "holding onto". I said I didn't, how was he doing it? He was delighted, and again asked if I knew how he did it, and I said with bafflement I didn't, but did he want to tell me? After a while he showed me how he was "holding onto the piece inside".

Here Chad repeated the circular spinning movement of the snake, in which I had held him, but was now doing so himself, by holding onto something internal. This may be understood as a way of symbolising that he is turned inward, communicating internally, with space to think and process (Bick, 1967/1988; Bion, 1962).

In conclusion, this theme has explored Chad's expression of having initially lacked, and of now needing, several specific functions of mothering. His sense of having been deprived of proper maternal care was understood as a reflection of his mother's likely actual physical and emotional unavailability, the profound sense of abandonment that probably stemmed from her failure to protect him from, as well as her direct perpetration of, his abusive treatment, and the likely experience of his trauma as a failure of whatever good maternal object he might have managed to internalise (Garland, 1999). Chad's sense of maternal deprivation was expressed in therapy mainly through the motif of the baby doll, whose experience he sought. The needs he variously expressed were for me as maternal object to 'fix' him, to 'be there', and to 'hold' him. The first was explored through Bick's (1967/1988) concept of the primary skin function by which fragmented parts of the personality, in a state of unintegration, are externally cohered. This was associated with a desire to return to a state of mergence with the maternal body, seen in relation to the phantasy of a common skin (Anzieu, 1989) that Chad perhaps sought to recreate with Natasha, and what was felt to be evidence of an adhesive attachment in therapy. The second of Chad's communicated needs was understood through Bion's (1962) concept of maternal containment, and particularly a state of reverie in which I would be receptive to, and survive, the things he was communicating to me that felt very

vulnerable or bad. Thirdly, Chad's expressed need was understood in relation to Winnicott's (Davis & Wallbridge, 1981) concept of maternal holding, through which the child comes to be internally cohered. The recurrent theme of sticking was seen to reflect both his need for internal cohesion and his attempts to stick himself to the good maternal object that, newly found, he desperately feared losing (and had not yet securely internalised). Some suggestions of this gradual capacity to take in the maternal qualities Chad sought was seen in the motif of the telephone and the toy snake, through which he expressed a sense of being internally cohered and able to hold himself at times.

4.2.2 Theme 2: Intake of goodness (incorporation and introjection)

Throughout the therapy, but in a changing way, Chad demanded food and drink in the sessions, and became furious or distraught when this was denied. In this section, I explore his changing relationship to material provision, and its relationship to psychic introjection.

During the early phase of therapy, Chad asked occasionally if there was coldrink or tea, or food, in the room, but accepted with little complaint when there was not. He did occasionally drink from the jug of water in the room. For example, in the middle of a session (10):

Chad said "there is no food here, is there?", and when I confirmed this he said with resignation, "I knew there wasn't". A little later in the session, while cleaning up the painting material, he asked what it said on the jars in which the paints are kept. These are called First Food, which I read out to him, explaining that it is a "container for baby's food". He looked at the jars with wonder, saying he could see the baby on the lid, and that he knows what babies eat. I asked what this was, and he said "I can't describe but it is very nice". I asked if he has ever had any and he said no.

Although apparently resigned to its absence from the therapy room, Chad seems here to be expressing a tentative craving for the 'first food', that mixture of love and milk, the goodness of which Chad has knowledge but not experience. At that stage when psychic and physical are still entwined, the first food is both the milk – physical nourishment – and the maternal love, care, and understanding (Bion, 1962; Freud, 1905; Klein in Segal,

1973). Here Chad seems to be expressing that he lacked both, so lacked the “goodness” which he knew to be contained in it, lacked a good maternal object (ibid.).

After this, Chad became gradually more demanding of food and drink, and started to experience my lack of provision of this as sadistic withholding. It seems that the emotional provision in the therapy process had at once brought his emotional and physical deprivation into poignant focus, and awakened his ‘appetite’ for the first food denied to him the first time around (Bion, 1967). As physical and psychic remained undifferentiated for Chad (initial inadequate maternal containment layered with subsequent trauma, leading to beta-screen functioning), he sought this in the form of bodily nourishment from material food (ibid.). During the middle of the first year, Chad repeatedly complained of being hungry during the sessions, and at one point (25) said that talking makes him hungry inside. Emotional provision seems to have re-awakened in Chad an early craving that it could not (retrospectively) fulfil – but Chad was initially unable to mourn the historical loss, trying instead to fill what he experienced as physical emptiness and hunger with actual food, which therefore acted as a form of symbolic equation (Segal, 1954/1988).

In the following session (26):

Chad said again that he was hungry, and then asked if there was food here, or tea. I said there was not, but he could have water if he was thirsty. He started to moan and then to shout, telling me I was starving him and that I was jealous of him and that I was a thief that wanted to take all the good things that he liked away from him. He said he never wants to come to see a person like me, and that I am horrid and I always boss him around because I can't understand what it is like to be him, and I never listen to him, I always forget. He said I must apologise to him for all this. I replied that I am sorry that he is feeling like this. He repeated that he wants tea and that I am making him cry. By then he was crying so hard that he was drooling and shaking. Later, in the waiting room he told Natasha that “Aunty Anya made me cry because she wouldn't let me drink tea”.

In responding to Chad's demands for material sustenance with an offer of a material alternative, I missed his call for emotional containment and so did not translate this

craving (beta-elements) into meaningful form (alpha-elements) (Bion, 1962). This seemed to have left him both with the initial craving unsatiated, and with the additional sense of being mis-understood, unheard and forgotten: not held in mind. This is experienced by Chad as sadistic withholding out of envy and greed, stealing what is his right (Klein, 1957/1975).

After this, Chad started bringing his own juice to the sessions, sometimes sharing this with me and at other times not, but continued to ask for food and drink and to be distressed by its absence. He resisted my attempts to reflect on this or to link it to his internal world. The food here felt like a symbolic equation, his need being to replace and so deny what he had missed early in his development, which left him feeling so empty and hungry (Segal, 1954/1988). At the same time, potential symbols of the good object were also reduced to the physical. For example, in a session (30) in which we each made a clay bird to look after for each other over the pending long holiday break, Chad smashed one of the birds and dissolved some of this clay in the water and then tried to drink it up! This seemed to be an attempt to deny the reactivation of loss threatened by the holiday by physically incorporating and taking with him the symbolic object that I was to take symbolic care of. At this point, this psychic process did not seem to hold Chad, so he had to reduce the space of the symbol by collapsing this into the thing-in-itself. Unable to trust that I would bear him in mind, he had to take away the therapy space in his own body.

Yet a shift occurred during the following session (31), which was the final one for 2006, in which Chad began to play symbolically with the juice, using it to celebrate his growth over the course of the year:

Chad arrived in a lively mood, with two juices which he poured for us after playing some sports. Laughing, he called the juice wine. I said are we drinking wine like grown ups? Delightedly, he said yes, and clinked our glasses together, saying "cheers" and looking very pleased with himself.

Here the juice seems to have become a symbol proper, the wine used playfully to signify his grown-upness, while knowing that it was really juice (Segal, 1954/1988).

During the second year, Chad was increasingly able to symbolise his desire for nourishment, which began to feel increasingly satisfied through alpha functioning (Bion, 1962), and the motif of emptiness gradually shifted to that of fullness, and bodily incorporation shifted to psychic internalisation of good (Freud, in Laplanche & Pontalis, 1973). Early in the year (38), Chad muttered as he arrived, “there is tea up there” in the therapy room, and later that session he drew an oven “where you put a kettle on”, making me guess what it was and being delighted when I did so. Here the tea that he knows is in the room takes a psychic form, symbolised in his drawing which re-presents rather than denies the lost original object (Segal, 1954/1988). My ability to ‘read’ and understand his representation was itself a form of nourishment. Later in the year (64), he drew a fridge, and when I ask what is inside it, he said “drawings.” So the symbolisation of physical nourishment now became psychically nourishing, and Chad pictured this relationship by replacing food with drawings, suggesting that psychic introjection may have replaced the need for concrete bodily incorporation (Klein in Segal, 1973). This was associated with a period in which Chad began to tolerate thinking and reflecting, rather than avoiding this through activity or shutting it down actively (Bion, 1962). For example, in a session where Chad tolerated more talk than usual (59):

He seemed to be listening attentively, and continued kicking the ball but in a calmer way, playing with it gently and distractedly. He seemed to be thinking, or reflecting/processing in some way: his energy was not with the activity, but turned inwards. I could feel a kind of charge and presence between us in the room, and I experienced a sense of relief in myself.

In symbolising nourishment, Chad returned to the image of the snake (explored in relation to the soft toy under Theme 1) a number of times, two examples of which will be examined. Earlier in the first year (13):

Chad made what he called a “fat queen” out of clay. He said at first that she was “good”, and then that she was “bad”. I said it must be a bit scary if people suddenly change from good to bad. He then made a snake and said “the snake makes her bad”,

and that people can make other people turn from good to bad by making them “eat stuff” that “changes your brain”.

Towards the end of the second year (61), Chad again made a snake out of play dough, initially *pretending* to eat the play dough:

... saying it is “lekker”, “good” and “healthy”. When I commented that the stuff he used to feel was dirty and had to wash off his body [see Theme 3] he now felt to be good and was *pretending* to take into his body, he listened thoughtfully, and then made a snake out of clay that bites me, “‘cause you’re nice”. When I said, “so you’re taking the goodness into you”, he said “yes I can feel it in my stomach!”

In this second sequence, the play dough had become a symbol proper, representing rather than replacing the goodness which Chad no longer needed to actually eat, but through the symbolic play, came to introject. Bodily incorporation is then the model for psychic introjection, which occurs *through* this symbolic ‘eating’ of me as good object.

In both of the above sequences, the snakes seem related to the toy snake in the game described under Theme 1, which I understood as a physical umbilical link enabling an experience of being held – the snake a form of transitional object, here a symbol of connection and of healing (Winnicott, 1981). The umbilical cord is that through which very early nourishment is conveyed from mother to baby’s body at a time when the two are still *physically* merged. So the snake seemed to represent Chad’s hope that through therapy he can change from bad to good, but in an *internal* way, not just covering good over bad (as will be explored in Theme 3), but *becoming* good inside himself, through re-experiencing, eating in and digesting the good. In the second sequence, the snake is the medium of introjection, the umbilical cord through which maternal goodness is taken into his body. In the first sequence, the reverse took place: rather than conveying goodness from mother to child, the snake fed back badness to the queen as mother-figure, and changed her from good to bad. This seems to reflect Chad’s sense of internal badness and fear of contaminating me with this (to be explored in the following theme), as well as the belief that through physical incorporation psychic change can take place, here from good to bad, but perhaps an expression of hope of the possibility of change from bad to good,

expressed in its inverse. At the same time, the queen's fatness suggests that she was 'full' (see below) with sustenance that she was absorbing and stealing from her child's body, rather than feeding him with it, and this theft turned her from good to bad (Klein, 1957/1975). This seems related to the example discussed above where Chad accuses me of stealing the goodness out of him out of jealousy.

Chad then began *talking* of food that had satisfied and fulfilled him, the talking itself generating these feelings – a link which he tolerated and accepted when I made it in therapy (Bion, 1962) (65):

Chad lay down and told me in great detail, with energy and animation, of a 'lekker, lekker' meal he had, and repeats instructions so I can make it too, saying I must taste this meal. I engaged in this in a lively way, repeating and exclaiming with him how lekker it sounds. I said that he was wanting to share the goodness with me, and that thinking and talking about how lekker it is just about as lekker as eating it! He squirmed on the floor in delight, agreeing, then said that he was 'lus' for it now, and I'm also lus for it, and he wishes he was eating a lekker meal right now. I said that in a funny kind of way we're eating it by talking about it! He said yes, he ate "soooo much, two whole burgers", and that he had to hold his stomach in he was so full (gesturing to show me how very full!).

Over the next few sessions Chad told many stories about being full, for example (67) speaking of a McDonald's meal he had with his best friend where, "I was *so full so full, too full!*"

During the following session (68), he asked me with a sense of urgency if I had tried the meal, and was very angry and upset when I said I had not yet, but that I hear its really important to him. The following session (69), which was our final one, for the first time involved actual food: when I asked Chad how he would like to mark the end of our time together, he said he wanted to have a party with food, and told me exactly what he wanted. We spent a lot of time planning and talking about this in the sessions leading up to it:

Chad was very excited about the food, delighted, repeating that it's just what he wanted, and it's "so nice" he "won't ever be full", and also that he's "going to eat until I'm full", repeating the word "full" with a lot of energy. He stuffed chips into his mouth, moaning with joy, saying he's "such a lucky child". Then he asked if I had eaten "the meal", which I had the night before, and I said (truthfully!) that I had really enjoyed it and I had thought of him all the time. He was delighted, and asked me in detail about each step of the preparation and eating. In the last moments of the therapy, he asked if I was going to take home the left-overs. I asked if he would like to: he replied with joy "yes!"

In the end there was a return to the concrete in Chad's need to leave something of himself in my body, to digest this physically for him, and his need to take something concrete with him (Bion, 1962).

In conclusion, this theme has explored Chad's shifting modes of taking in goodness, from bodily incorporation to psychic introjection (Bion, 1962; Freud, 1905; Klein in Segal, 1973). I have understood his intense craving for physical nourishment both in relation to Chad's experience of actual deprivation, and as an expression of, and need to fill his sense of lacking good enough mothering at a time when food and love were merged (ibid.). This absence of adequate early containment meant that Chad was left with a seemingly insatiable craving for the good breast, that he still experienced in concrete form, as physical and psychic had not been adequately differentiated (and whatever differentiation had been achieved likely reversed to some extent on subsequent traumatisation) (Klein in Segal, 1973, Bion, 1962). It is interesting to reflect that the sustenance that Chad called for most frequently was tea – a warm, sweet, comforting liquid, perhaps the closest he could get to asking for breast milk. As has been seen, during most of the therapy process, Chad needed this actual nourishment, which felt indistinguishable from the absent good object, in a form of symbolic equation used to deny this loss (Segal, 1954/1988). However, he gradually came to symbolise nourishment in various ways, and to feel satisfied by images and words, rather than things in themselves (Bion, 1962). This shift to symbolisation proper was associated with a depressive position capacity to mourn the absence of the good breast (Klein in Segal, 1973). This enabled a shift from incorporation to introjection, and with this a marked

change from expressions of emptiness to fullness: the initially insatiable hunger and narratives of lack, emptiness and craving shifting to those of fullness, bounty and satisfaction.

4.2.3 Theme 3: Sense of self

The third theme to be explored is that of Chad's sense of himself, which is a layered one, expressed in the opposition between his inside and his outside. Inside, the sense of brokenness explored in Theme 1 will here be examined in relation to a sense of profound vulnerability, which is equated with inherent badness. I first examine the ways in which Chad felt this internal badness to be revealed through his physical skin, and through 'mess' on this skin and in the therapy room. I then turn to his consequent attempts to conceal this badness through a defensive identification with goodness and strength, and through controlling and bullying behaviour in therapy and outside it, which I understand as manifestations of a second skin formation. The tension and interplay between these various meanings of the skin will be discussed in relation to Bick's (1967/1988) understanding of the second skin formation resulting from impaired primary skin function, Anzieu's (1989) theory of the Skin Ego, and Kristeva's (1980/2004) concept of abjection.

Chad seems to have experienced the underlying sense of damage within himself, explored in relation to brokenness in Theme 1, as an inherent badness, this badness being associated with weakness and smallness. Beyond the motif of brokenness examined in that theme, Chad rarely expressed directly this internal sense of vulnerability or badness – mostly it manifested through its inverse in his defensive identification with goodness, bigness, strength and dominance. But there were a few occasions when he did communicate this inherent sense of badness in itself, for example, early in the therapy process (4):

Chad made a drawing of a man who he said was "angry", and "powered", adding spontaneously and very adamantly that this man was "good". Next to the man he drew a small boy, clearly himself (he was standing on the staircase we climb to the therapy room, each of the 18 steps he counts each week reflected in the drawing). This "little

boy” standing on the staircase next to the angry and powered man, Chad identified as “bad”.

In Chad’s symbolic play, almost every game involved a battle between “goodies”, who were “big” and “strong”, and always won, and “baddies”, who were “small” and “weak” and “losers”. While Chad’s defensive identification with the goodness=bigness=strength will be explored below, in another rare communication of his underlying sense of badness=smallness=weakness (24):

Chad become intensely absorbed in the manner in which his fist appeared to change size when it was submerged in, and then emerged from, a jug of water. He exclaimed over and over, with incredulity but also a sense of cunning, how “big” and then how “small” he was. Then he turned and said he had a “secret”, that he would tell me only if I promised not to tell anyone (threatening to hurt me if I did): his hand “can be big in the water, but it is really small, but the water makes it look big”.

Through this “trick”, Chad may have been communicating that his defensive mask of bigness, goodness, strength, was in fact an illusion, that beneath this musculature he was really very small and vulnerable. In an inversion of his protective disguise of this underlying state, the deception was sunken beneath the surface while the reality revealed above it. But this truth remains a fiercely controlled secret, and he needed to bully and threaten me in order to guard it – a manifestation of the second skin formation (Bick, 1967/1988) to be explored below.

It is this tension between his underlying sense of smallness, weakness and vulnerability, and his defensive second skin of strength, bigness, and control that seems to have been felt by Chad to have caused the brokenness, the sense of deep damage within him. Returning to the moving play sequence from our first therapy session (2) discussed above, Chad communicated, over the toy telephones, that he had a towel of his own, which had broken, and which I must fix. When I asked what happened to it, he said “*it was a little thing that was trying to be big, but it couldn’t be, so it stretched and got broken*”. The defensive need to split good from bad, to be big when he feels small, seems to split Chad within himself, leaving him in a state of fragmentation or unintegration.

Chad may have been communicating his need for fixing, binding or integration through the image of a second skin, not of rigid strength and control, but of softness, warmth, and flexibility: a towel in which to be wrapped, comforted, held. A towel is an external skin, but a soft, absorbent, malleable one. He may also be communicating that this defensive musculature is not working, it has made him prematurely 'big' but has stunted true growth – so he needs the holding environment or external skin of therapy to provide the necessary supporting structure in which he can begin to heal and grow.

Turning now to the role of Chad's physical skin, I have mentioned his preoccupation with its colour (explored above in relation to its difference from Natasha's), but here I look at the implications of this mis-fit between external and internal 'envelopes' (Anzieu, 1989), which seems to have been experienced by Chad as caused by his own badness, which his skin colour was felt to reflect. This meant that instead of being able to introject the containing functions of the maternal envelope to his own skin, it seems that this skin was felt to betray his dark internal state through its uncohered and porous state (Anzieu, 1989). Chad was preoccupied not only with the difference between his and Natasha's skin, but the darkness of his own. He expressed a belief that people with dark skin are hated by others, his internal sense of badness seeming to articulate with cultural associations of blackness with badness through the historical and enduring implications of skin colour in this country. Early in therapy, Chad was reported by Natasha and his teacher to avoid black people, while in therapy he identified them as being "poor", but deserving "pity" and urged that "we must not hate them". This seemed to be exacerbated by the fact that Chad was teasingly called "black cat peanut butter" by the children at school.

It seems that Chad's physical skin reflected the state of his impaired 'skin ego' (Anzieu, 1989), which failed to protect his inside from the outside world, but instead, in its porousness, its lack of cohesion, revealed what he felt to be his bad, dark interior. And the outside world seems to have reinforced this equation of blackness with badness, and the inscription of the skin in particular as signifier of this (further exploration of this social and contextual 'loop' in the interplay between body and mind, inside and outside, although highly relevant, is beyond the scope of this discussion). It is perhaps

understandable that Chad would wish to avoid black people for fear of what they mirror to him. Yet his expectation is that he will be hated for the badness made manifest through his dark skin, and through his urging that black people should be pitied and not hated, Chad seems to be asking this same treatment for himself.

This association of himself with blackness, and blackness with badness, seems to have been profoundly if inadvertently reinforced by responses to Chad's use of the colour black in drawing and painting, which at the start of therapy was reported by Natasha and his teacher to be excessive. Both were greatly concerned and distressed by Chad's reportedly constant use of black to colour in and to scribble over his drawings, and so forbade him to use this colour. Chad continued to use black despite this prohibition, and was repeatedly punished for doing so, getting demerits at school and being scolding at home. This struggle was consuming so much energy that it was identified as a primary reason for referral to the CGC, and it seemed that all their concern about Chad, as well as their horror at, and fear of, what had happened to him, were concentrated in this issue. This use of black coincided with Chad's "bad behaviour" discussed above, and can be understood as an equivalent expression of the darkness, disturbance and real badness that he felt to be inside him, which he seemed to be attempting to symbolise and express in his drawings. But as the internal meaning of his dark skin seems to have been reinforced by external associations of blackness with badness, so too the banning of his use of black reinforced his sense that this thing with which he identified, that was him, his own inside and his skin, was in fact bad, deserving of punishment. Instead of feeling that this expression of his distress could be received and contained by the adults around him, Chad was given the message that the pain and darkness he contained was unbearable to them (Bion, 1962).

I understand that in the post-traumatic and vicariously traumatised state that Chad and those around him were in, this symbol of his traumatic experiences was felt to be traumatic in itself (Garland, 1999), and therefore evoked a level of horror and concern proportionate to a major trauma. This seemed to entail a collapsing of what was perhaps a 'symbol proper' for Chad, into a 'symbolic equation' (Segal, 1954/1988) in which his drawings were felt to be indistinguishable from his actual experiences. This may have

made the adults around him feel that in preventing him from using black, they could retrospectively protect him from the terrible things that had happened to him. However, these responses seem inadvertently to have reinforced Chad's sense of internal badness, his attempts to express what he felt to be inside him being met with the message that this was itself bad, so much so that it had to be banned and punished. This was made painfully clear when I met with him and Natasha to contract for two years of therapy: on hearing that this was going to be the case, Chad turned to Natasha and said very urgently, "but she doesn't know the secret". When we asked what secret this was, he said "that I'm not supposed to use black". So it seems that for Chad too his use of black had become indistinguishable from the badness he felt to be inside him, both perhaps being equated with the badness he had experienced. This cumulative badness felt bad enough that it should prevent him from coming to therapy. And when I then told him that in this room he would be allowed to use whatever colour he wanted to, and that this was his space to do and play and draw and be as he liked, as he was, as he felt, he was completely incredulous. A lot of psycho-education work was done with Natasha and his teacher around understanding the meaning of Chad's use of blackness as an expression of his trauma and a sign that he was feeling safe enough to begin to process this.

In therapy, Chad was at first very tentative with his use of black, slowly testing whether this would indeed be allowed. Early on he made a portrait of himself filled with a light shading of black, but apart from this did not use black until one session (8) during a time when he became fascinated with the paints themselves rather than their application, and was particularly engrossed with squeezing out huge *amounts* of paint, exclaiming with wonder again and again at "how much" he was using. This seemed a reflection of his material deprivation and the fact that he had not had a lot of anything that was delightful to him. In this session:

Chad decided to paint the back cover of his book, pointing out a few times that this is what it was. He mixed many colours together, and then commented tentatively that "they are becoming like black". Seeing that this was allowed, he later asked (for the first time) for the black paint. With a sense of urgency and excitement, he then started filling the jar of red paint with this blackness. I felt very uncomfortable with this, and for the first time

really understood the distress Natasha and Chad's teacher experienced watching this child 'consume' colour with blackness. Out of this distress, I suggested that we divide the red into two jars, and that he could do whatever he wanted with the one half, but that we 'save' the other half. Chad proceeded to fill both jars of red paint with black, turning it all black. I sat watching, feeling really wrenched.

Here Chad seemed to be testing my tolerance of the black that was previously banned for him (the back of his book was perhaps associated with licence to express what would not normally be seen). In thus testing the truth of my statement that he could bring and be whatever he wanted in this room, Chad seemed at the same time to be testing whether I would allow and be able to bear the badness that had become associated with blackness. And my immediate response was to feel something of the unbearableness of this, and to react out of this in a way that repeated in part the prohibition of the other adults. Chad discounted this, and only then was I able to be with the feeling that this blackness evoked in me, and so to allow and begin to bear this (Bion, 1962).

A related consequence of what can be understood as a porous or uncohered skin ego, manifesting in Chad's sense of a physical skin that exposed rather than protected his vulnerable inside, was his concern about contamination. This experience of a skin functioning in reverse, opening out the inside rather than holding out the outside, a skin which is therefore too permeable, may be associated with Chad's immense anxiety about contamination. This included what I understood to be a fear that he would contaminate others by his badness, which will be explored in the following section, and that he would be contaminated by the outside world. The latter manifested in Chad's anxieties about what he called "mess" or "dirt". It seemed that in external filth, Chad had found a further external representation (in addition to badness and brokenness) of what he felt himself to be internally made up of. The three are understood to be linked, dirt being that which is out of place and so threatening of order and boundaries, and in this sense abject (Kristeva, 1989). (The relationship of this to faeces and farting will be discussed in the following section).

Turning to the manifestations of this during therapy, Chad would become extraordinarily distraught when his hands became “messy” or “dirty” with paint or with clay, and he would need to rush to the bathroom in a state of urgency, to wash these off (this meant that during the early stages of therapy he would often decide excitedly to play with the clay, but as soon as he had taken some in his hands he would look at them in horror, and immediately need to clean them). Before I understood the seriousness of this need for Chad, I tried to restrict his ‘breaking’ of the session with trips to the toilet for cleaning (feeling that this was avoidant). On one such occasion (19):

We had just been down to the toilet to clean his hands after he broke a drinking glass with the soccer ball, when Chad took out the clay and then immediately wanted to go wash his hands. I said he could do so with the water in the room, and that we only go out of this room when he needs the toilet or when there is an “emergency” like with the broken glass (which had gotten into his hand). He looked at me with an expression of panic and said “the mess is very serious”, then started shouting and crying that he needs to go right now because he “can’t have messy hands”. I said I know that the mess “feels like an emergency” for him, and that he can clean his hands with the water from the jug. He does this, but again becomes distressed at the “dirty” water, which he wants to go clean, repeating with rising panic “it can’t be messy”. I said maybe we can make a deal, that he can choose one time to go out the room each session, but only once and for very short (he had previously tried to stay out of the room on the way to and from the toilet).

This stuff on Chad’s hands seems to have been felt to be not a symbol proper but a symbolic equation (Segal, 1954/1988), an actual manifestation of the messy yucky, gooey stuff inside him, which his skin could not contain, and which was therefore leaking out onto this skin. This felt like a profound anxiety, a real emergency for him, that his skin would not hold and conceal but *become* his insides, that all differentiation between inside and outside would collapse, and that this internal badness would be exposed to the world. On a few occasions, he said with panic that Natasha and her husband “must not see me like this”, and when I tried to explore this he would make reference to punishment. So it seems that, like the blackness of his skin, the “mess” on his hands threatened to reveal the badness inside him, which those around him could not bear, but would instead punish.

Inversely, this seems to have translated into anxiety that the muck of the external world would penetrate into his porous skin, filling him with filth.

Once his actual hands were clean, Chad would often develop elaborate cleaning activities to remove the traces of clay or paint or even spilt water in the therapy room. These did not have the same feeling of panic to them, but rather of playful relief. He would always include me in these activities, giving me precise instructions what to do, but the atmosphere between us was amiable and often lively, rather than controlling or punitive. This extended at times to the cleaning of existing aspects of the room, which seemed to be in response not to the presence of material 'yuckiness', but to emotional stuff that felt bad and had to be cleaned away, both because of the discomfort within him, and the need to hide evidence of this internal badness to others. For example, during one session (26):

He told me he had turned 8 on Friday, and I asked what it felt like to be 8. He started speaking about how he could "hit the bigger boys now" because he was big. When I tried to ask him about this he interrupted and said "we must go clean the windows". He gave me strict instructions as to how we should do so, with bits of paper dipped into the jug of water and then proceeding to clean each part of the windows. When I wondered why we were cleaning the windows now, Chad said so that the room will be "nice and clean and special" for other people, and then commented that Natasha was waiting for him downstairs. I said that a little while ago we had spoken about messy feelings and how cleaning can also make you feel like you are cleaning up the messy things inside. He said yes, that is right, "because you can control if you feel things, like anger, you can decide to not be angry".

Here it seems that not only did Chad try to 'clean away' his admission of what he knew was "bad behaviour" (his desire to fight the children), but to cover over this exposure of 'badness' with a façade of 'goodness', making the room nice for others (his association being the nearness of Natasha). Yet he permitted and then contributed to my linking of activity to feelings, articulating his desire to control and so wipe away his anger. Similarly, in the session (24) to which I had referred in the above sequence, this linking of Chad's need to clean up mess with his attempts not to feel "yucky feelings", seemed in

itself to enable him to expose, now through talking about rather than acting out, both some of this 'bad' behaviour, and the difficult feeling that lay behind it:

After splashing painty water out the jug, Chad said he wanted to clean up the mess, and then that, "that is why I made the mess, to clean it up". I said maybe if we clean up the mess around us it makes us feel like we're clean inside, and I wonder if we can also have messy feelings that we want to clean up or make go away? He went on to talk about "fighting with the children" when he is "very angry", and about being punished for this.

Gradually, over the course of therapy, Chad became able to tolerate clay and paint on his hands, the first time being in the pivotal session (61) discussed in Theme 2 above, when he said that the clay was "lekker", "good" and "healthy", and he did not need to clean it off his hands! When I then commented that the stuff he used to feel was dirty and had to wash off his body he now felt to be good and was pretending to take into his body, Chad made a snake out of play dough and used this to 'eat' me into him because I was "nice", later saying that he felt full of goodness. It seems that this change from symbolic equation (in which the clay was equated with his insides) to symbolisation proper (in which the material of the external world, now felt to be external to him, could be used to represent these insides) was associated with his introjection of the good maternal object, which could itself be symbolised in this sequence (Segal, 1954/1988). This suggests that his shift from feeling that the clay was an *actual* manifestation of his all-bad insides, to a sense that it was external to him and could thus be used with some distance to symbolise, without collapsing into, his internal world, coincided with Chad's experience of some goodness within him.

In-between the experience of the materials of the therapy room as either bad or good, either entirely of him or entirely external to him, there were times when Chad seemed to be in a state of simultaneous wonder and horror at this 'mess', a kind of incredulous delight tinged with repulsion, and a sense of disbelief at the licence to 'indulge' in it. I understand the mess at these times to be abject in Kristeva's (1980/2004) sense: both of him and not of him, and his hovering between disgust and a desire to be rid of it, and a particular kind of longing to incorporate and 'merge' with it. Here the abject mess

seemed not only associated with his own interior, but with his ambivalence towards the maternal body (Kristeva, 1980/2004). For example, in an early session explored above (8), during which Chad used black to paint the back cover of his book,

Chad commented with a mixture of concern and tentative glee that his “dirty” hands had marked his book, when I said that he could actually use his fingers to paint with if he wanted to, he did so with abandon and revelry, smearing all the paint, all the colours onto the back cover of his book and exclaiming with delight at the huge mess he was making! A moment later he looked at what he had made with a kind of disgust, and said he must go wash his hands.

Later, on a number of occasions Chad looked with dismay at what he called the “mess” on the back of his book, asking “*who did this, who made this mess?*” It seems that this specific abject space of horrified delight in the stuff that for this time hovers between being and symbolising what is inside him, feels foreign to Chad when he is outside of it (Kristeva, 1980/2004).

In the light of the erosion of distinction between physical and psychic that is understood to have occurred through the trauma Chad experienced, as well as the lack of early maternal containment that should have enabled their differentiation, Chad’s actual skin seems to have become particularly invested as a manifestation of his sense of self. In an inversion of the process of anaclysis by which the psychic structures are derived from the physical (Freud, 1923), here it seems that Chad’s physical skin was a concretised form of his psychic self (Anzieu, 1989). In Bick’s (1967/1988) terms, it is understood that the absence of an adequate primary skin function disallowed Chad’s internalisation of this experience of being externally cohered to his own skin, leaving him instead in a state of unintegration, which manifested in his experience of his physical skin as uncohered and unable to hold him in. Using Anzieu’s (1989) language, in the absence of the experience of a containing external envelop meeting his own skin to create a phantasy of common skin, which could then be internalised to form his own Skin Ego, Chad’s Skin Ego seems to be porous and leaky, and his physical skin, as a reflection of this, to be permeable both to his inside and to the external world. Bick and Anzieu’s theorising converges in their

understanding that it is under such circumstances that the defensive second skin is formed as a rigid, muscular mask to this fragile, pierced inside. It is to the various manifestations of this second skin formation to which I now turn.

As mentioned, almost all of Chad's symbolic play involved a battle between "goodies", who were "big" and "strong", and always won, and "baddies", who were "small" and "weak" and "losers". While Chad would always identify himself with the goodies, there was a confusing tendency for the goodies and the baddies to inexplicably reverse roles. This seemed to reflect a tension between Chad's defensive identification with the good and his internal sense of badness. Despite this interchangeability between good and bad, these opposing positions initially remained rigidly split, suggestive of paranoid-schizoid functioning; however, towards the end of the therapy process, there was some indication of their integration with Chad's move towards depressive position functioning (Klein in Segal, 1973). This need to mask an underlying sense of weakness, badness and vulnerability with an external display of power and strength manifested markedly through the activity of sport – which occupied a great deal of therapeutic time! Throughout these games Chad would make sure he won, changing the rules when I threatened to score or to win, and mocking me for losing, designating a "loser's chair" on which I must sit. Later in the therapy, he began gradually to tolerate losing in sport, and to play fairly.

This dynamic was played out further in Chad's extreme attempts to control my every action, my talking, and even my thinking. This was initially expressed through a play character called "the boss", whose voice and demeanour Chad came to adopt as his own. Through this, Chad aggressively and threateningly ordered what I must do, how to be, and shut down my questioning and my thinking (to be examined further in the following section). This rigid control seemed to serve the purpose of restricting my access to his 'bad' inside, which questions and talk and interpretation threatened to expose, but ironically the very form of this control came to reveal this: Chad experienced his own bullying as "bad behaviour", and was very anxious that I would tell Natasha that he had been "naughty", and that he would then be punished. Unable to bear or own this "badness", Chad then projected 'the boss' onto me, experiencing and accusing me of sadistically controlling him. This was particularly the case when I resisted his attempts at

complete control of me - he then become distraught, a 'victim', and I the perpetrator. For example (23),

Chad assigned us each an animal, and showed me exactly how I must manipulate mine in a play fight between them. As was usually the case, I inevitably got this wrong, and Chad became increasingly angry and upset, shouting that I "don't know how to do it". I began to say that I realise it feels like I never get things right for him, but I wonder if he knows what it feels like to be shouted at? He became furious, cutting into my talk and saying with a threatening, almost sinister-feeling voice "remember what I said? Remember the rules? NO TALKING!" I said I hear the talking is feeling too much for him. He then went into an almost incoherent frenzy of screaming that I must not speak, that I must remember the rules, that I just make up the rules. At one point he pushed the table over towards me and says he would "hit" me if I don't listen to him. He then threw all the toys onto the floor. He closed the curtains, and told me not to look at him, and then to close my eyes. I did so for a moment, and felt terrified, hearing him banging things around in the room. I decided to open my eyes and said I won't close my eyes and I won't stop thinking but I will try hear what he needs me to. He shouted and shouted again about the rules, and who made them. I said it's very scary not to know who made the rules and why they made them. He then seemed to kind of collapse into himself and began to weep wrenchingly. He said in a timid, broken child's voice, "don't be scared of me". I felt terrified and overwhelmed. He sat weeping and whimpering. I went up to him and tried to settle him, offering him a tissue and suggesting he sit on the small chair for a little bit. He did so, still crying, and gradually became calmer.

At such times, I felt caught in an intractable situation. Either I allowed Chad to 'bully' me, and felt shut down and persecuted, or, I attempted to interpret what he was doing to curb this enactment. But such interpretation gave back to him his disowned and split off experience of victimhood, which swung our positions so that I became perpetrator, violating him now with words. These interchangeable but always opposing positions felt a form of traumatic re-enactment, a dialectic of dominance and submission which left me feeling vicariously traumatised (Herman, 1997). Through his bullying and through projective identification, I was experiencing something of the complete helplessness,

persecution and terror to which he must have been subjected (Bion, 1967). Yet in becoming overwhelmed by these feelings I was no longer able to contain them for him, and so repeated his experience of impaired maternal containment. Chad's splitting of good and bad therefore occurred both intrapsychically and interpersonally, both of which manifested in his intolerance of any attempt to bring together the experiences of victimhood and perpetration (Klein in Segal, 1973). In adopting the role of powerful perpetrator, Chad distanced himself from the vulnerable and bad-feeling parts of himself. In casting me as victim, he expressed at the same time his anger and contempt for, as well as fear and shame of, these projected parts of himself. Attempts to bring these together reversed these roles.

This bullying behaviour extended beyond the therapy room, Chad's aggression towards smaller children being his most serious presenting symptom. He similarly seemed to be projecting his own experience of being a victim onto others, and assuming the role of aggressor. This made up one aspect of Chad's more general behavioral acting out, which he called his "bad behaviour". This behaviour emerged at school, at home and in therapy only when he felt safe enough to express this internal sense of badness - initially he was very compliant and 'good' in all these contexts. Yet his fear that revealing and communicating his internal state of 'badness' and disturbance would be intolerable for those around him, and lead to punishment or abandonment, was almost confirmed in reality: his discipline problems reached such an extreme that the school threatened to expel him and Natasha threatened to return Chad to his mother's house. A lot of psycho-education and supportive work was done with Natasha and the school, through which we came to see Chad's behaviour as a healthy sign that he was beginning to process the trauma that he had until now not been safe enough to metabolise, and for which these three environments were providing the necessary external containment.

In conclusion, this theme has examined the implications of Chad's experience of impaired primary skin function and resulting state of unintegration (explored in Theme 1) for his layered self-experience (Bick, 1967/1988). This was understood in terms of a tension between an inherent sense of badness (associated with vulnerability and the motif of brokenness explored in relation to unintegration in Theme 1), and his defensive

attempts to mask this through a second skin of goodness and dominance (ibid.). Yet Chad's physical skin was found to function in opposition to this psychic second skin, exposing rather than masking his internal world, and in this way manifesting his ill-formed, porous Skin Ego (Anzieu). It is this state of fragility and lack of cohesion that was understood to further fuel his defensive need to mask and control access to his insides. The changing meaning of 'mess' was explored in relation to this fear that his intact skin would not hold out his insides, or the world (Kristeva, 1980/2004). While it has not been explicitly explored in this discussion, this motif of rupture is understood not only in terms of the impaired psychic cohesion stemming from this 'developmental' trauma, but in relation too to the actual breaking and crossing of his body's boundary through the physical and sexual abuse to which Chad was subjected, and the psychic rupture to the internal protective shield that these 'external' traumas would constitute (Freud, 1920).

4.2.4 Theme 4: Evacuation of badness (expulsion and projection)

Having examined Chad's underlying sense of badness and his (more and less 'successful') attempts to mask this through a second skin formation, I turn now to a discussion of the ways in which he attempted to *rid* himself of this internal badness. This occurred through the related processes of bodily evacuation and psychic projection.

Turning firstly to the role of actual defecation within the therapy process, Chad would frequently break the sessions - initially almost every session - with an urgent need for the toilet, usually to defecate (the times when he would urinate seemed to be a more deliberate and conscious avoidance of material as opposed to urgent unconscious evacuation). This occurred in moments when his anxiety was highest, when I was in some way challenging him to reflect internally, to acknowledge his inside and use his alpha function, and so attempt myself to gain some access into his internal world (Bion, 1962). Questions or talk or interpretations that challenged him to look inside, to be inside, to use and experience an internal reflective space, were profoundly threatening for Chad. This could be as simple as a question, any question, a linking of behaviour to feeling, a reflection or 'mild' interpretation, linking perhaps a story he has told me to a general theme, or talk itself, which required Chad to process, to psychically digest what he or I

was saying (ibid.). In response, Chad would urgently rush to the toilet with a very upset stomach, and often bad diarrhoea (which I could hear and smell from the door where he asked me to wait for him, often for up to ten to fifteen minutes). As he rushed down to the toilet, Chad's whole body seemed to flop or dissolve, becoming jelly-like and wobbly. Such diarrhoea was not reported to be a problem for Chad at home or at school.

The absence of an internalised good maternal object or internal containment, seemed to mean that Chad couldn't *hold* anything inside him, everything just poured out of him - diarrhoea reflecting an inability to hold the nourishing part of food in, absorb it, but rather fragmenting this and expelling it as indistinguishable from waste (Bion, 1962). It seems that to hold something in mind was too threatening for Chad, forcing him to know what was too painful, so this link was attacked and splintered, and the thought or feeling concretised and then 'liquidised' into the mushy yucky insides that filled and rushed out of him. This process can be understood as a form of anti-anaclysis, a reversal of the mind's differentiation from the body, in which they collapsed back into indistinction, and alpha elements, instead of being linked to create meaning, became fragmented and turned back into disparate beta-elements (Bion, 1962). This may have meant that Chad's body came to mirror the 'collapsed' state of his mind, or rather his collapsed-together body-mind could not hold itself up, could not hold anything in, neither thought or faeces, which collapsed into one another and poured out together. In this way, physical in-digestion perhaps defended against, replaced, and got rid of, psychic metabolisation.

This was associated with the loss of the good object along with the riddance of bad. In a session at the start of the second year (36), after allowing me to score in sport for the first time and then telling me that the ball mustn't go out the window because "it is very important to me":

He talked in great detail about "water poeps" that he had made recently after eating too much sweet melon, which he loves. He says that these "poeps just kept coming out", and remained in the toilet even when he flushed it. He says he was "very worried that the toilet wouldn't come clean". When I said it seemed like he was worried there was bad

stuff inside him that would come out and not be cleaned away, he said yes he was worried about "the mess" but that it was "healthy" that it came out.

The sweet good food that he loved came straight out of him, could not be integrated, held there, so was expelled and turned bad. But it could not be gotten rid of, and instead stayed there for him to see. This kind of getting out is felt to be healthy. Chad was now bringing what he saw and didn't flush away, what he held onto, and bringing it to me in words (Bion, 1962). This seemed to be a test of whether I could tolerate, could connect with, the yucky stuff that was inside him, that makes him up. And if he 'gets it out' in this way, seeing it, in therapy, will this be healthy? Later in the session he spoke about being very "worried" about starting Grade 2 the next day, calling this a "secret" as he was supposed to be looking forward to it. He was now able to share *verbally* this 'bad thing' inside him, which he experienced as a feeling (ibid.).

While this physical evacuation is understood as a means of emptying out his inside for fear of exposure of bad, the physical evidence of this, particularly in the form of smell, was deeply threatening for Chad. He therefore used the air freshener toilet spray to try and disguise this smell, at times spraying this all over his body, and becoming very distressed when I tried to set a limit on this, for example (43) crying out "but its stinky". He also initiated an elaborate ritual of cleaning his hands after defecating, in which he called me into the bathroom and asked me to squeeze soap onto them and help him dry them with the towel. While Chad needed privacy while he was in the toilet cubicle so as to hide the evidence of his bad stinky insides coming out (on a few occasions I was concerned about him and poked my head around the bathroom door to ask if he was ok, and he shouted that I must stay out), he needed me to witness his cleansing. Chad's digestive disturbances and his shame in relation to them are also understood in relation to his history of anal sexual abuse, and in his drawings and games 'bottoms' were often identified as being naughty and embarrassing.

Because of this collapse of distinction between physical and psychical, talk, questions and reflections not only threatened to expose Chad's bad insides, but may also have been experienced by him as concrete intrusions (Bion, 1962; Segal, 1954/1988).

Interpretations in particular seemed to be experienced as violations through which I was gaining access to, or read, his mind. Thus words were felt to penetrate and wound him in a form of repetition of his physical and sexual abuse. As a means of defending himself against this vulnerability and violation, Chad projected these feelings, associated with the role of victim, onto me, adopting that of aggressor himself. He frequently threatened me physically when I asked him a question. For instance (11):

Chad threatened to hit me in the stomach with the ball if I ask any more questions, saying "you mustn't ask someone a lot of questions. They don't like it because they feel bad". I asked if they feel "they are bad" if you ask them questions. He said no, they feel angry.

In this way, Chad seemed to have turned his sense of badness into anger and rather than have his internal world exposed through questions, Chad both shut down the questioning and disavowed this internal world. Around the same time (10), when I made reference to this internal world by linking behaviour to a feeling, he said "*there is nothing inside*". I had been asking Chad questions which, when he resisted them, I explained I was asking in order "to try and understand what's going on inside you", giving him the example that sometimes when he kicked the ball very hard or pulled a particular face I realised that he must be feeling angry. This may have been deeply threatening, both because it challenged him to experience and know this inside which was felt to be bad, and because this would be seen and known by me. The denouncing of his psychic insides enabled their collapse into physical insides which could be expelled through defecation.

This disavowal of his internal world seems to have left Chad stripped of curiosity, of the capacity to think and learn, in a state of – K, where all linking, thinking, talking is threatening (Bion, 1967). It left him not only with "nothing inside", but with an 'empty head'. Around the same time (9), Chad told me that the children at school tease him by calling him 'dikkop', which is associated with being 'thick' or 'stupid'. In response, he told me that he "forgets what they say". So the pain of an empty head reflected was dealt with by further emptying it. When I wondered how it must have felt to be teased like that, Chad says, "*there is no feelings 'cause sticks and stones can break your bones but words can never harm you*". Yet he goes on to say that he hit a "small boy" at school that day.

For Chad, words are things, and can do harm, can threaten to break him, so he responds by breaking them up and by breaking up those who threaten him or those onto whom he can project his vulnerability. Thus words are dealt with physically, splintered and expelled through the body, shutting down and beating up, and by filling the space of thought with action. As has been discussed, words hurt Chad in therapy too, interpretations feeling like concrete invasions. Chad's constant need for activity (mainly in the form of sport), seemed to be a means of avoiding and shutting down this pain of mental activity, and with this any curiosity and understanding, as well as a form of direct discharge of the split-up beta elements that were the product of this process of reversal of alpha functioning (Bion, 1962).

A further form of attacking and splintering words, which brought together various of these mechanisms, was what we came to call "fart language". This occurred over a number of sessions at the beginning of the second year of therapy, when Chad would respond to me or shut me down by making farting sounds with his mouth, often loudly and repeatedly, right into my face. This occurred at times when he was threatened by having to hold onto a position of vulnerability, for instance (41):

He told me how he had laughed at a "little boy" who he saw in his underwear, and I wondered out loud how that little boy felt. Chad responded by saying very anxiously, "not sad", and then making his farting noises. When I wondered again what he was trying to tell me through these noises, and suggested I would understand better in words, he became very angry and punitive, and then rushed off to the toilet where he used a great deal of spray.

So it seems that when he was challenged to be in touch with his own small/weak/bad-feeling state, Chad attacked the words that threatened to link him to this, reducing language to flatus (Bion, 1962), emptying it of meaning and expelling it not through his anus but through his mouth. This created another form of anti-digestion in which the mouth was turned into a kind of anus, scrambling and excreting rather than forming and containing words. This gave rise to a form of 'verbal diarrhoea' in which language became discarded waste which blocked, rather than enabled, communication.

But farts held other, shifting, functions over the course of therapy. During the early stages, Chad would occasionally ask me whether my nose was blocked, and as it so happened it always was! When I asked why, he would always answer something like “good, then you won’t smell if I made a stinky fart” (11). This seemed an expression of his anxiety that I would find out about and come to experience his stinky, bad inside, and not be able to bear it – might perhaps be disgusted by it. When I asked what it means if someone is stinky, he said (12) “they can’t help it”. It also seems that he was afraid of contaminating my body with his (Kristeva, 1980/2004). A number of times, Chad expressed his sense that my body was ‘pure’ and ‘healthy’, while his was stinky and contaminated. For example (53), when I followed him in taking off his shoes and emptying the “dirt” from them into the bin (in an attempt to show that I, too, had dirty shoes, and that it was okay to contain and express this), he said that my feet are “clean” and his “dirty”. In another example (16) he said that he must drink water “to be healthy” but I don’t have to “‘cause you’re healthy”. This anxiety about contaminating other’s purity was also expressed in Chad’s fascination with the idea of contagion. For example, around this time (15):

Chad spoke with great energy of a little girl who had chicken pox at school, and the ways in which one could and could not catch this disease, but particularly how one could “pass on the germs” without knowing it. He said that “if you have had the sickness it’s as if you’re invisible”.

Chad may have been afraid not only of the effects of the visible evidence of his ‘stinky’ insides in the form of faeces (and his skin which is felt to reveal these), but with unseen signs of these, such as farts. These might infect others unknowingly, and so overwhelm their bodies as his mother might have been felt to be overwhelmed by projected beta elements (Bion, 1962).

Yet speaking about it seemed to shift something for Chad. During this discussion about illness (15):

Chad made a loud fart, and when he asked as usual if my nose was blocked I told him for the first time (as this was honestly the case), rather tentatively, that today I could smell a

bit, adding that maybe he's worried that if I find out he's stinky I won't want to be near him. He said no, he wanted me to smell his stinky fart, "'cause then you'll know how it feels!" I said that if I can smell his stinky fart then I will understand what it's like to be him. He said yes. Later that session, he went on to speak more about the content of his past, and for the first time in ages he did not go to the toilet.

In the period following this session, Chad repeatedly asked me if I could smell his "stinky farts", and continued to be delighted every time, repeatedly saying that it is "the first time" I have smelled him and that now I "know how it feels" (17). It seemed that for the 'first time' Chad was allowing himself to be known, not through the defensive second skin of compliant goodness or controlling badness (Bick, 1967/1988), but as he felt himself to be. This knowledge was on the one hand very concrete: in physically taking into my body his actual stink, I would experience what it is like to have a stinky inside. At the same time, Chad was possibly asking me not only to *ingest* his stinkiness, but to *digest* these expelled beta-elements such that they could be transformed into alpha elements (Bion, 1962). This would enable me to make meaning of his experience of internal stinkiness and come to *know* not just his body but his self. No longer afraid of contaminating my body with his stink, he now trusted that this was bearable for me, that I could in fact contain this for him. In this way Chad was allowing me to resume the function of reverie, which for him was modelled on the physical intake and processing (*ibid.*). This was associated with licence to bring bad/rude/forbidden stuff, for example in one session (21) singing a "rude" song, repeatedly saying "ass hole", and then telling me about a music video in which people are dancing about, and "you can see their bums, shaking about". He began to tolerate questions, talking and thinking a little more, and began to talk himself about some of the content of his traumatic past.

Over the course of therapy, this theme of faeces and farting gradually changed from concrete to symbolised form, starting to appear in play and drawings and in Chad's growing capacity to talk about his 'yucky' feelings. Associated with this was a gradual ability to hold within him, rather than splitting apart, states of goodness and badness (Klein in Segal, 1973). For example, in a play sequence with the toy animals (51):

Chad explained that the two lions were brothers, and he kept saying that one was good and the other bad, and then these reversed and got increasingly interchangeable. Then he continued playing with only one of the lions. A monkey came to "help" this lion, offering him a chocolate, which Chad said was his "favourite food". After making the lion 'eat' the chocolate, Chad said quite lightly that it was "actually popo". Then more animals arrived and they got into a fight and when this lion's "stomach got kicked in" Chad exclaimed that "all the blood and popo comes out!" I said that both the good stuff and the bad stuff are together in one animal.

It seems that the two lion brothers, initially split between good and bad, were integrated into one, which then contained both good and bad. The 'favourite food', given out of helpfulness, seems to have been 'digested' by the lion, turning it to faeces. This 'popo' was not immediately evacuated, but was held inside the lion's body along with it's blood, the stuff of life. While the exposure of this inside still felt violently painful, it was perhaps tolerable because what was revealed was not only badness. Around this time, Chad started going to the toilet less frequently, and when he did, would use the toilet spray to a lesser extent, suggesting a lowering of the need to disguise evidence of his stinky insides. He also began to tolerate making mistakes and losing games, and showed a decreased need to control me. A more reciprocal relationship became possible. He was able to express difficult feelings more directly, in words rather than bodily. For example, in the first of these sessions in which he did not go to the toilet (58):

Chad says in anger, "I'm not your baby and I'm not your slave! I'm here 'cause I have a problem, and it hasn't gone away - I get angry!"

His problem had not disappeared by being flushed out of his body and flushed down the toilet, but was now being owned and faced and expressed with words and real feeling, directly to me.

Turning now from the motif of bodily evacuation to that of psychic projection in this theme of the riddance of badness, I return to the dialectic, explored in part above, through which Chad shut down talking, questioning and thinking by 'bullying' me, adopting the role of aggressor and projecting that of victim onto me. This occurred in many sessions,

particularly during the second half of the first year, in which he would kick things and throw toys around, would threaten to hurt me, and would above all shout and scream at me, telling me stop to talking, stop looking at him, to close my eyes and block my ears, and at times to actually “stop having thoughts in your head”. I would feel terrified, terribly shut down, and would struggle desperately to resist this, to maintain the function of reverie (Bion, 1962). Often I felt unable to do so, felt overwhelmed and quite unable to think. Through his bullying and through projective identification, Chad seemed to be communicating and evoking in me an experience of extreme helplessness which must have been his, particularly I felt in relation to the sadistic forms of punishment to which he was subjected, as well as earlier experiences of nameless dread when his overwhelming fears were not contained by his mother. My overwhelmed response to this seems to have constituted a repetition of this failure of containment, and perhaps confirmed for Chad a deep fear that his feelings were too much for the adults around him, and couldn't be digested and made manageable by them, but were rather returned further stripped of meaning (Bion, 1962). This was expressed by Chad when he cried out once in the middle of such an attack that I “can't handle” him (21). Around the same time (23), in an example mentioned above, again in the midst of a barrage of shouting and screaming at me, Chad cried out poignantly, “don't be scared of me”.

Here Chad seemed to be calling for me *not* to be subjected to this state of thought-less terror, to resist his shutting down of my containing capacities (Bion, 1962). However, when I was more able to hold onto these, to receive his violent communication but to keep thinking and find some space inside me within which to hold this, this too became terrifying for him, as it held the risk of being known that he had originally attacked. This left us in a vicious cycle whereby the alpha functioning that he needed to curb his enactment further fuelled it: he began by attacking the links that might lead to understanding, but the devastation that this fragmentation left us with, the splintered beta-elements, required alpha functioning to be cohered and contained (ibid.). One of the ways in which I would resist being completely shut down by Chad in these interactions was to speak to the experience of the victim (for example, saying that it is very scary to be shouted at like that, or it makes me feel sore inside when I can never get things right), and so resist being completely overwhelmed by it. But this challenged Chad to hear and

hold onto the experience of victim while enacting that of aggressor, which he had defensively split from each other (Klein in Segal, 1973). He would then break down, and weep distraughtly, collapsed back into the role of victim, my words wounding him. He would cry out that I was doing something very terrible to him, was making him cry, and I would again feel like an abuser. There seemed no easy way out of this dialectic, only the challenge to continue feeling and surviving what he needed me to bear for him, as well as to keep thinking and making meaning of this – despite the fact that the two processes felt directly contradictory so much of the time.

In conclusion, this theme has explored Chad's attempts to get rid of badness through the related processes of bodily evacuation and psychic projection (Freud in Laplanche & Pontalis, 1973; Klein in Segal, 1973). These have been found to entail a reversal from alpha to beta functioning in which psychic products are subjected to physical discarding through defecation and farting, alongside the psychological projection of the undesirable roles of victim and 'baddie' (Bion, 1962). I have identified the shifting meaning of these forms of elimination through the course of therapy: in relation to Chad's anxiety about exposure of his bad inside, which is therefore 'emptied out'; as a form of direct discharge of splintered beta-elements; as a means of avoiding alpha functioning in the form of talking and thinking by actually breaking the session and by reducing language to flatus; as well as a gradual desire to be known and understood, and a communication of what is inside through bodily waste. As a result of this in-digestion, in which all goodness and meaning was attacked, stripped away and evacuated along with the badness felt to be inside him, rather than 'absorbed' or integrated, Chad seemed to have been left emptied out, denuded not only of the badness he sought to expel but of good internal objects. (It is this emptiness that Chad attempted to fill by the physical nourishment referred to in Theme 2). Words and questions were explored as having exposed his bad insides, leading to concrete evacuation, and as concrete intrusions leading to psychic projection. Farts were understood as a means of emptying meaning, as threatening exposure of and contamination from the bad inside, and eventually as a communication of his internal badness.

4.3 Conclusion

This analysis of the case material has identified four inter-related themes which have been examined through the lens of the reviewed psychoanalytic literature on the role of the body in conditions of containment and traumatisation. The first two themes examined the absence of the good object: firstly in relation to Chad's expression of having initially lacked, and now needing, maternal care which once newly experienced, he fears losing, before internalising a maternal object for himself (Anzieu, 1989; Bick, 1967/1988; Bion, 1962; Winnicott in Davis & Wallbridge, 1981); secondly in relation to Chad's seemingly insatiable desire for material nourishment during therapy, and the interplay between bodily incorporation and psychic introjection (Bion, 1962; Freud in Laplanche & Pontalis, 1973; Klein in Segal, 1973). Tracked across both these themes was Chad's gradual shift from attempts to replace his losses through symbolic equation, and so deny the absence of the lost good object (associated with paranoid-schizoid functioning), to his symbolisation of this absence (associated with the depressive position capacity for integration) (Segal, 1954/1988). The second two themes related to the presence of the bad object: the third theme in terms of Chad's experience of his physical skin as revealing the badness he felt to be inside him, and his attempts to mask this through a defensive 'second skin' (Anzieu, 1989; Bick, 1967/1988; Kristeva, 1980/2004); the fourth theme relating to Chad's concrete expulsion and psychic projection of this bad inside, through faeces and farting on the one hand and re-enactment and projective identification on the other (Bion, 1962; Freud in Laplanche & Pontalis, 1973; Klein in Segal, 1973). Traced across these latter two themes was Chad's gradual shift from evacuation to communication, from terror of and attacks on knowing, to a tentative desire to be known.

In the following chapter, I draw together these four themes to summarise the findings of this analysis in the light of the literature reviewed in Chapter 2, as well as evaluating that literature in relation to these findings. I then discuss limitations to this study, and, finally, provide recommendations for future research and practice.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

In this study, I have drawn together previously disparate threads of psychoanalytic thinking on the role of the body in trauma and containment to make sense of the whole of what often felt like a disjointed and bewildering therapeutic process with a multiply traumatised child. In this way, the theoretical lens has performed a containing and integrative function. While this process was very useful for me as a trainee therapist, and I feel in some way retrospectively meaningful for Chad, the more broadly useful finding of this study is considered to be the robustness of the theoretical lens in accounting for a wide range of what previously felt like confusing and dispersed case material. In this sense, the case analysis has served to illustrate and to demonstrate the utility and explanatory power of this theoretical framework, rather than to add something new to this. The usefulness of this literary lens was found to lie in its bringing together of a number of disparate, although conceptually related, theories spanning the last hundred years and more of psychoanalytic thinking. While Bion's model formed the core of the analysis, the integration of the work of other theorists to create a broader framework was found to enable a more nuanced and cohered reading of the case material as a whole, indicating the robustness of this lens in making meaning of therapeutic work with a multiply traumatised child. In this chapter, I summarise these findings by reviewing the relationships between, and roles of, the different theories in analysing aspects of the case material. I then identify the limitations of this study. Finally, recommendations are made for future research and clinical practice.

5.1 Summary of findings

Bion's thinking formed the basis of this analysis, into which the work of the other theorists was integrated. His conception of containment and the consequences when this goes wrong ('developmental' trauma) or is later eroded ('external' trauma), in terms of the interplay between physical and mental alimantation, brings together the components of the central question of the role of the body in the reciprocal conditions of containment and traumatisation. Central to the analysis then was Bion's (1962) model of mentalisation

as an adaptation and abstraction of metabolisation, which therefore provides both the actual developmental bodily basis, and a metaphor with rich explanatory power, for psychic processing. In this process, raw sensory and somatic experiences, or beta-elements, are 'digested' through the alpha function to create alpha elements that are of meaningful mental form, and which can be linked together to enable thinking and dreaming, creating a protective alpha screen. Bion understood that before the infant has his own alpha function, he digests his experiences through his mother's mental alimentary system. This is the process of maternal containment, through which the mother receives, bears, emotionally thinks about, and so makes meaning of, her infant's intense and overwhelming feelings and fears. These she returns to him modified through this process, in a mental form. The infant can then re-introject both his initial fears made more manageable, and the containing function itself, which forms the basis for the development of his own alpha function, or internal containment.

I now examine the specific aspects of this theory that were found to be useful in interpreting case material from each of the four themes of the analysis. Into this will be woven the work of the other theorists, and their links as well as additions to Bion's thinking will be summarised. I will begin by discussing Theme 1 (Chad's relationship to the maternal object) and Theme 3 (Chad's sense of self), which together focussed on the relationship between mother and child, explored through the central motif of skin. I then discuss Theme 2 (intake of goodness) and Theme 4 (riddance of badness), which together focussed on the relationship between body and mind, explored through the central motif of digestion. In the first pair of themes, the work of Bick, Anzieu and Winnicott was added to that of Bion. In the second pair, the work of Freud and Klein provided a background to Bion's concepts. Across all four, Segal and Kristeva's thinking was included in specific places.

The first and third themes were analysed through Bion's (1962) concept of containment, and specifically the state of maternal reverie. In the first theme, aspects of Chad's behaviour and play were interpreted as expressions of the initial absence of, and now need for, maternal containment. His various play sequences with the baby doll were understood as communication of the pain of having lacked maternal love and

understanding, and his tentative curiosity about, and desire to experience, this. His repeated requests for me to 'be there' and in so doing, repair what felt to be broken within him, were understood as calls for maternal reverie, to receive and bear and survive, as well as make meaning of, his painful, bad-feeling experiences and anxieties. The devastating consequences when he felt I was not there, particularly after breaks in therapy when he feared I had not held him in mind (expressed in relation to the physical containment of the therapy room) were understood to perpetuate this failure as I tried to reassure and 'take away', rather than receive, bear and so contain them. This was felt to confirm his early experience that his feelings were unbearable to others, and so unknowable in himself. This seemed to have left him in a state of 'nameless dread', out of which he expressed his anxiety that I could not handle him and was afraid of him.

Within this first theme, various theories were used in conjunction with Bion's concept of maternal containment to enable a broader reading of the various implications of impaired maternal skin functions as expressed by Chad through the motif of brokenness and fixing. The brokenness was understood as a reflection of a porous and unintact Skin Ego (Anzieu, 1989), and what Bick (1967/1988) understood as a state of unintegration resulting from the failure of the primary skin function, through which an infant would initially feel passively held together. His sticking activities were read in relation to Chad's consequent attempts to cohere himself internally, as well as to fix himself to me in what Bick called an adhesive attachment, fearing further loss of this newly found maternal object before he had securely internalised his own. This was simultaneous interpreted as an attempt to recreate what Anzieu (1989) identifies as a phantasy of common skin which Chad had apparently sought with Natasha too. Winnicott's concept of maternal holding and the interplay between separation and connection across the potential space were used to understand Chad's play sequences with the 'umbilical' toy snake as transitional object.

The third theme explored the consequences of these impaired maternal functions for Chad's sense of himself. Here Bion's understanding that disruptions to the container-contained leave the child with a sense of damage within themselves was understood as the basis for Chad's profound sense of inherent badness. The defensive structure he

developed to disguise this was understood through Bick's (1967/1988) concept of a defensive second skin, here manifesting in Chad's identification with goodness and strength, and controlling and bullying behaviour. This musculature was understood to mask the state of fragility and lack of cohesion identified in the first theme as a state of unintegration (Bick, 1967/1988) and of a porous, uncohered Skin Ego (Anzieu, 1989). Chad's profound anxieties about his physical skin and associated use of the colour black were made sense of through the understanding that his bodily skin reflected the fragility of his Skin Ego, exposing rather than protecting his bad and broken-feeling insides - which he attempted to hide through his defensive second skin. Segal's distinction between symbolic equation and symbolisation proper and Kristeva's concept of abjection, were drawn on in interpreting Chad's changing relationship to the materials in the therapy room. These were initially experienced as a failure of his skin to hold in his gooey yucky insides, with which the materials were equated, but gradually came to be used to represent this internal world.

I now turn to the role of theory in interpreting case material in the second and fourth themes of the analysis, which focussed on the relationship between body and mind, explored through the central motif of digestion: Theme 2 in relation to food and the intake of goodness, and Theme 3 in relation to faeces and the riddance of badness. In these two themes, Bion's theories were used against the backdrop of Freud and Klein's, and so their role in reading the case material will therefore be summarised first, as well as mentioning those of Segal and Kristeva. The analysis of the relationship between processes of bodily incorporation/expulsion and psychic internalisation/projection was based on Freud's theory of the anaclitic relationship between psyche and soma, the body providing the basis for the development of the ego, and the differentiation between them being a developmental achievement which collapses under trauma. Thus Chad's seeking of emotional nourishment through material means was understood as a reflection of his fixation in and regression to the oral stage of libidinal development, in which Freud understood milk and love to be initially entwined. His gradual capacity for psychic introjection could then develop out of this initial need for bodily incorporation. Similarly, Chad's attempts to rid himself of unbearable feelings by concrete evacuation was understood in relation to Freud's concept of the anal stage of libidinal development, in

which he sought to reject through bodily means what he could not recognise in himself. This was associated with controlling behaviour and the psychic projection of unwanted parts of himself. This reverting of the mind back to its bodily basis was understood as the reversal of the anaclitic relationship between them. Layered upon this was Klein's model of the role of the maternal body in these processes, from which goodness is eaten, and into which badness is expelled. In addition, Segal's distinction between symbolic equation and symbolisation proper was used to interpret the shifting meaning of food, which Chad initially required concretely to replace and so deny the absent good object, but which he gradually came to use symbolically to represent his psychic internalisation of this. Kristeva's concept of abjection was drawn on in understanding Chad's fears of contamination and contaminating.

Like Freud and Klein, Bion understood that body and mind, milk and love, are initially indistinguishable, and are introjected as such, concretely, in the form of the good breast. Bion understood the differentiation between physical and psychic to occur when, under conditions of manageable frustration, the absence of the good breast is made bearable by the evolution of a thought to fill the gap of the absent thing. In this way, the thought of the good breast is able to satisfy the infant in the absence of the physical satisfaction provided by the real milk. Without this capacity, the absent good breast is experienced as the presence of a bad breast, which must be concretely evacuated through defecation. And when frustration is not manageable by thought, either because of the disruption of this function in the infant or the fact that the frustration is too great to be tolerated in this way, the psyche would become filled with concrete bad objects (absent good objects), or beta-elements, instead of thoughts. These are fit only for evacuation, through direct discharge, acting out or excessive projective identification that erodes rather than enables communication. These beta-elements accumulate to form a rigid yet chaotic beta-screen in which thinking is attacked as it threatens to link together understanding which, in the absence of an apparatus for psychic digestion, is too painful to bear, and so is split up and broken to pieces.

The case material in Themes 2 and 4 was interpreted through Bion's understanding that under such circumstances, the psychical will collapse back into the physical, such that

emotional sustenance will be sought through bodily or material gratification, and emotional pain will be evacuated through bodily or direct discharge. Thus Chad's initial insatiable craving for food and drink were understood as expressions of the absence of an internalised maternal object, and therefore of a desperate need to fill himself with concrete goodness from the outside world. This was understood to articulate with the actual material deprivation he had suffered. Chad's defecation was understood as a means of ridding himself of unwanted thoughts that he had reduced to faeces, his diarrhoea reflecting this failure to assimilate goodness, the denuding of meaning. This left Chad in a situation where the love and understanding he so badly needed could not be provided through the food and drink (beta elements) by which he sought them, while the emotional provision of the therapy, particularly my moves towards understanding him (alpha functions), were deeply threatening and so were reduced to faeces (beta elements) and expelled as such. Yet gradually Chad did start to tolerate and seek out knowing, communicating his previously disavowed internal world, initially in the bodily form of farting, and then more psychically directly through verbal expression of his feelings. This was associated with a shift from a narrative of emptiness and craving to that of fullness and satisfaction that was understood to reflect Chad's gradual psychic introjection of the good containing object.

In conclusion, the findings of this study illustrate the potential usefulness and robustness of this integrated theoretical frame in making meaning of a large amount of complex and potentially confusing therapeutic material in a case of child maltreatment. Drawing together and applying these various psychoanalytic understandings of the role of the body in the reciprocal conditions of containment and traumatisation has helped me to understand and explain, and so to digest and contain, therapeutic processes and dynamics that at the time often felt incomprehensible and overwhelming. I therefore feel that this body of literature might similarly be useful for others working with multiply traumatised children, both those working within a psychoanalytic frame, and outside of this. I return to this in my recommendations, but firstly discuss limitations of this study.

5.2 Limitations of the study

I now discuss a number of limitations to this study, which pertain to its generalisability, validity and objectivity, the use of a particular theoretical frame and the associated selection of specific data to analyse, the socio-political context of this study, and finally the form of this written dissertation in relation to the subject matter.

While the findings of this case study are generalisable to theory (Yin, 2003) as noted in Chapter 3, the $N = 1$ design limits generalisability to other such cases. This means that inferences drawn about psychotherapeutic work with child trauma survivors cannot stand alone, but will only be meaningful in conjunction with other such case studies (Fishman, 2005). The dearth of these further limits the utility of this research in this regard.

The validity of this psychoanalytic case study is limited in its reliance on relatively subjective, although theoretically and clinically informed, judgement of “coherence of argument, comprehensiveness of explanation, consistency with accepted psychological knowledge, and the aesthetic beauty of the analysis in disclosing previously hidden patterns in the material being investigated” (Attwood & Stolorow, 1993 p.29). While my subjective experience in my joint roles as therapist and researcher has been utilised as a source of information in this study, this limits the objectivity of the findings. Moreover, in drawing on my counter-transference experiences in analysing the case material, distinction between what arises as a response to the client’s internal world, and what reflects my own, is inevitably blurred.

The adoption of this particular theoretical frame of psychoanalytic understandings of the role of the body in processes of containment and traumatisation, necessarily omits other readings of the case material, which may complement or contradict the current one. Similarly, the synthesis of disparate theories reviewed into a unified lens through which the data have been analysed does not account for discrepancies or contradictions between these. And correspondingly, selection of data for analysis has been made on the basis of what resonates with this unified theoretical frame, which means leaving out a great deal of additional case material that may have produced alternative meanings, or introduced dissonances into the findings. This emphasis on integration in the literature review and

analysis is perhaps appropriate in relation to the central theme of containment, but excludes the disruption to this cohesion that might be associated with the workings of trauma.

This study is also limited by its focus on interpersonal and intrapsychic traumas and processes without situating these in the wider socio-economic and political context. This meant that the impact of the environment of poverty and marginalisation into which Chad was born was not accounted for in understanding the 'developmental' or 'external' traumas to which he was subjected. Omitted therefore was a discussion of the interactions between the personal psychological, and cultural and contextual, meanings of many of the concepts discussed, such as Chad's skin colour, his relationship to food and to defecation, and his need to control and bully.

Finally, I am left with some sense of contradiction in writing with words about inherently non-verbal, pre-verbal, even anti-verbal processes of messy materiality and bodily experience. While the process of making meaning from the raw data has felt analogous to the process of containment by which sensory and somatic beta-elements are transformed into mental alpha-elements, the final form of this dissertation clearly privileges the latter. The very act of writing necessarily coheres and makes sense of disparate, nonsensical, crude or concrete things that would themselves undercut language and meaning, but cannot be captured by it. States of not knowing cannot be written about without making them known. This is of course not a solvable dilemma, but one that feels important to acknowledge and 'be with'.

5.3 Recommendations

The findings of this study, while limited in their representivity, indicate some tentative recommendations for theory and practice.

With regard to theory, while this study provided a review of the many disparate references to the role of the body in containment and traumatisation in psychoanalytic thinking, these were integrated only implicitly through their application as a unified frame through which the case material was analysed. In the light of the usefulness of this theoretical lens in making meaning of this therapeutic process, it is felt that further work

is called for in drawing this 'body' of literature (so to speak!) together more explicitly, and in so doing clarifying its utility as an integrated model, as well as identifying points of divergence within it. Similarly, while this study made implicit links between the reviewed literature on early development and the therapeutic process, it is felt that a review and formulation of the implications of psychoanalytic understandings of the relationship between body and mind for psychoanalytic therapy with child trauma survivors would be very useful. Relatedly, while this study acknowledged the layered implications of what was denoted 'developmental' and 'external' trauma, the analysis privileged the former in focusing on the role of maternal containment in the therapy process. A more detailed exploration of the interplay between the bodily meanings and metaphors explored in relation to containment, and the actual bodily violations or omissions, with their psychological sequelae, involved in the different forms of child maltreatment, could build on the ideas explored in this study. This would involve a more in-depth linking of the 'external' traumas of abuse and neglect to the concrete and material, as well as metaphoric and psychic, meanings of bodily intake and expulsion, of digestion, and of the skin as a piercable boundary of the body and self, which were here explored primarily in relation to the 'developmental' trauma of inadequate containment. To this could be usefully added an exploration of the interactions between these intrapsychic and interpersonal processes with the social processes of marginalisation and the marking of bodies, and the weighty meanings of skins in this country.

Recommendations for clinical practice are made in the light of the recognition, as outlined in the Introduction to this dissertation, that child maltreatment constitutes a crisis in South Africa. For most of the multiply traumatised children who present to mental health services in this country, long-term psychoanalytic therapy is not a possibility (both because of lack of resources and because this may not be the most suitable treatment option). However, it is felt that the theoretical frame that really helped me to make meaning of what at the time often felt like incomprehensible and overwhelming therapeutic material, could be usefully applied in other forms of child interventions. In particular, I feel that the motifs of skin and of digestion could provide a useful metaphor to assist care workers and counselors in making sense of the presentations and behavior of traumatised children they work with, as well as the feelings and responses this elicits

within them. This would involve an accessible explanation of psychoanalytic understandings of the actual bodily processes, as well as the symbolic and psychological meanings, of skin and of digestion in this work. The potential value and explanatory power of such a model is felt to lie in its capacity to capture complex psychological processes in a concrete way, which would therefore make psychoanalytic theory accessible to a wider range of mental health workers across different settings. The language of taking food into, and expelling faeces out of, the body, and the role of the skin as boundary, could then help make sense both of actual material phenomena in therapy, and be used as metaphors for the powerful psychic processes and dynamics likely to be experienced in working with multiply traumatised children. And this understanding might, as it did for me, help careworkers and counselors digest and integrate, and so contain, what may often feel like fragmented and bewildering therapeutic material. However, these recommendations remain tentative, as additional case studies of therapeutic work with children who have been multiply maltreated are needed to further explore the ideas presented here.

5.4 Conclusion

In conclusion, this study has found the integrated body of psychoanalytic literature on the relationship between psyche and soma under conditions of containment and traumatisation to be a useful and robust frame through which to make meaning of what had been a confusing and disjointed corpus of case material from a long-term therapy process with a multiply maltreated child. While bearing in mind the various identified limitations to this study, these findings tentatively indicate further areas of theoretical exploration and practical application.

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APPENDIX: CONSENT FORM

Department of Psychology

University of Cape Town

MA (Clinical Psychology) Research Project

CONSENT FORM

I, _____, understand that Anya Subotzky intends to write her master's research project on her therapy process with my nephew _____.

I have been informed that the aim of this study is to examine the use of such a therapy process with children who have a history of traumatic experiences in South Africa.

I am aware that _____ identity will be protected, and that all identifying details will be changed in the research report.

I also understand that this project will not entail any other procedure apart from the existing therapy process, which began in April 2006 and is due to continue until December 2007.

In my capacity as primary caretaker for my nephew, _____, I give consent for this study to take place. I am aware that I may withdraw this consent at any stage should this become necessary.

Signed:

Date: