that she had brought about much of the desolation and damage in her life was the cause of intense shame and guilt which was hard for her to bear.

This patient demonstrated the continuing importance of a trauma as a preoccupation in the inner world. She could not easily be understood without reference to it. Her character and symptomatology were structured by the experience and the stage of development at which it occurred. She was similar to one of the children studied by Bowlby (1944) traumatised and hurt by the experience of sudden and inappropriate separation. As a consequence, she turned away from the earlier good experience of her mother, making it impossible for her to achieve an integrated picture in which both good and bad could exist.

Her awareness and overwhelming bitterness about the loss led to a failure to form stable relationships, except for those which involved perverse elements. She used the sense of grievance at an unconscious level to justify retaliation and sadism. This gave rise to omnipotent excitement invested in destructive narcissism which was used as an antidote against depression and against an overwhelming sense of guilt about the damage she had done. The tasks of the treatment were first to deal with the perverse excitement and sadism and then the primitive guilt which prevented the patient forming links with helpful objects. As far as the effects of the trauma were concerned, it was necessary to acknowledge the real wound she had suffered with her mother, while engaging her in the task of grieving so that, ultimately, she could move away from her grievance. This also meant standing firm against the regressive wish to use the grievance to hold the past responsible for all her difficulties and to justify the destructiveness of revenge.

11

External Injury and the Internal World

David Bell

Introduction

This paper is concerned with the relationship between external adverse, or traumatic, events and the internal world. Psychoanalysis is particularly well placed to study this relationship, as each patient brings the events of everyday life and shows how they are internally experienced. Each patient brings his own central anxiety situations, and lives them out in the treatment, thereby demonstrating his attempts to master or evade certain types of anxiety or psychic pain. In this process he shows what sort of object relations dominate his internal world and also how they are perpetuated and realised in his lived life.

The word 'trauma' is used in many ways – to indicate a single event, or an accumulation of events, or the subjective experience of this event (the reaction to it), or the sequelae of the event. The more we know of a patient, the more complex becomes our understanding of any particular trauma, as we come to understand the context and the state of the patient's inner world at the time of the trauma. For the purposes of this paper, I prefer to use the term 'traumatic situations', by which I mean the breaking through (often described as a breakdown) of unmanageable anxiety or mental pain; a breakthrough which is brought about by a combination of internal and external factors.

Some external events, apparently almost trivial, will overwhelm a particular individual because of their particular meaning. Other events – loss, major life changes including successes (a potent source of trauma in some people) – are generally accepted as traumatic, though their particular effect on any individual will depend on the prevailing anxieties and defences at the time. There are some patients for whom almost any event which involves emotional contact with another human being evokes the most primitive catastrophic terrors.

The events that we as analysts are able to understand with most clarity and certainty are those events that happen within the treatment setting – for example, reactions to starting, the way the patient deals with interpretations, reactions to breaks in the treatment.

Here is a brief example:

Mr A arrives late for his first session. He is clearly anxious and talks in a hurried way offering dreams, bits of history and so on. The atmosphere of the session is such that the analyst feels that the patient is not offering this material for the mutual work of understanding, but in a more desperate way – the patient hints at some claustrophobic terror and worries whether he will be able to stay for the whole session.

In one of the dreams there is a huge dog in his kitchen. It is so big that he can hardly move round it. In order to keep the dog away he throws it bits of food to keep it occupied. One can immediately see how this patient's experience of starting his analysis is represented internally. It gives expression to a primitive infantile anxiety situation that is realised in the external world. A huge persecutory figure has moved into the kitchen of his mind, threatening him – the figure is placated by giving it something to do: dealing with bits of history, or dreams. He revealed in the analysis over and over again a powerfully intrusive internal figure that had constantly to be placated in order that he may be allowed to keep the odd morsel for himself.

Theoretical Considerations

I will turn now to the understanding of this relation 'internal-external'. These categories are often placed in opposition to each other. However from a psychoanalytical point of view we are more interested in the relation between them: how, in the interplay of projection and introjection, external experiences are represented, internalised and dealt with.

In *The Interpretation of Dreams*, Freud (1900) showed how the mind makes use of everyday perceptions in order to give representation to certain internal situations that are pressing forward into awareness. The unconscious mind is constantly scanning the external world in a very active way, seeking out events and situations which can be used to represent these internal situations. The dream is like a window into this continuous process. The unconscious is therefore making use of perceptions of the external world *for its own purposes*. These representations manage to both express and hide these inner situations – or become objects of projection. The analyst examines the material the patient

brings to analysis from this perspective: it is less a question of whether an event has had an effect but more of what it has come to be used for. The capacity to make use of the external perceptions to represent inner concerns provides one mechanism for 'binding' anxiety.

The ego is constantly striving to preserve its integrity, so that it is not 'overwhelmed' by stimulation from either external or internal sources. Events which are sudden, for which there can be no preparedness, may lead to disorganisation of the ego. This is felt as annihilation, falling to bits. The mind defends itself from such events by what Freud described as a 'stimulus barrier' or 'shield'. Traumatic events, which are those that break through this barrier, derive their pathogenic effect for a multitude of reasons – varying from their suddenness and violence (like accidents), to the type 'which owes its importance merely to its intervention at a point in the psychical organisation already characterised by its own specific points of weakness' (Laplanche and Pontalis,1973). Freud stressed the internal factor in these events. Even in those episodes of trauma in childhood, the traumatic effect is maintained in adulthood through the memories, and the fantasies that they activate in the mind of the individual.

The eventual outcome of a traumatic breach in the shield is the construction of a defence. I shall later describe two very different types of such a defence. Some patients for whom the threat of overwhelming anxiety is ever-present, for whom there have been fundamental problems in the building up of an adequate protective system, are forced to live a life in which they endeavour to do the impossible: to be prepared for anything and thus able to do practically nothing. The analytic situation is particularly terrifying for these patients, because it threatens the known with the unknown.

Freud was hampered in his early thinking about trauma by his lack of an adequate conceptualisation of a living internal world. This did not acquire a proper theoretical underpinning until he wrote *Mourning and Melancholia)* (1915b) which gives a model of how external figures are internalised. Later, in the *Ego and the Id* (1923), he stated that the 'ego is the graveyard of abandoned object cathexes' . In other words we see how external objects, combined with fantasies projected onto them are installed within the ego. Freud (1930) had recognised that the archaic, cruel character of the superego could not be accounted for purely by the reality of the parental figures but must acquire its character from the destructiveness projected onto it.

The main contribution to our understanding of the internal world, however, comes from Melanie Klein. She maintained that from the

beginning of life there is a rudimentary ego that alternates between states of relative cohesion and states of unintegration and disintegration. She emphasised the constant interplay of projection and introjection in the building up of an internal world of objects to which the ego relates and which are also experienced as relating to each other (e.g. an internal parental couple).

She described two fundamentally different states of the internal world, which entail two different orientations to internal and external reality. In the *paranoid schizoid position*, experiences are widely split: the destructive impulses are directed towards an object felt to be bad whilst the loving impulses are directed toward the good object which is protected, through idealisation, from this destructiveness. The infant, in projecting his violent and destructive impulses, feels threatened by violent and persecuting objects. In this paranoid world, the ego has to disown aspects of itself – or of certain internal situations – and locate them in objects separate from the ego. Certain aspects of psychic reality are thus disowned. The developmental task is the building up of a secure enough internal 'good' object for integration to occur. Integration leads to the capacity to see the damage done to the loved objects and, if the guilt can be borne, the wish to make good the damage done through reparation. These are some of the elements of the depressive position. The move towards the depressive position entails a fundamental change in the orientation to reality, both internal and external. These are distinguished as the projections are withdrawn – the objects cease to be identified purely with aspects of the self, and so their own attributes can be perceived.

This gives us a model of the function of the external world. The infant, who has in his mind, destroyed his mother out of frustration and hatred of frustration, will be internally strengthened by the appearance of an undamaged mother externally. In other words, one function of external reality is to disprove the horrors of the internal world through supporting the internalisation of undamaged and unpersecuting figures.

Adverse experiences diminish trust and confirm anxieties about inner annihilation and persecution. Severe mental illness in one parent, particularly in the mother, is likely to deprive the child of having an external reality which can disconfirm his worst terrors – for example, the annihilation of the world including himself. In situations where external reality confirms inner terrors the result is a grave difficulty in distinguishing between them.

Klein suggests that the extent to which external reality is able to disprove anxieties could be taken as one criterion of normality. The

final point I want to make here is to emphasise the difficulty, even the horror, of facing guilt and ordinary human sadness, and yet how the inability to manage this leads to an inhibited and joyless life: the inability to suffer pain means the inability to 'suffer' joy.

Some patients live out their life just on the edge of experiencing depressive pain. They have been unable to face the reality of damaged objects and are always on the run from a terror of being trapped in situations in which they feel faced with the recriminations of these objects. This situation is particularly common in survivors, where they have had the mental equipment to make something of their lives and yet feel constantly threatened by guilt of a particularly unbearable and persecuting kind. Such patients often greet success in their lives as a very mixed blessing and progress in their analysis is constantly impeded. It is as if the patient is saying 'If I get well I have done it at the expense of my loved objects who are in a terrible state. I fear they can never be repaired and I can't stand the pain of their suffering. I can protect myself by being ill'. By being ill the patient also avoids guilt, through identification with his damaged objects.

Clinical Illustrations

This first illustration is a brief piece of clinical material from a patient whose treatment I followed.

Ms B is a woman in her thirties. Her mother was chronically mentally ill and her father died when she was in her adolescence. The family were described as being very impoverished. The patient went to school the day the father died, a matter about which she felt intensely guilty. Her sister committed suicide when the patient was in her early twenties, leaving a note which the patient read, though then hid, protecting her mother from its contents. The patient ensured that she got her schooling and complained to her teacher that she could not study because of the noise at home, enlisting the teacher's support for a temporary move so that she could get through her exams. She went on to become a teacher, teaching very impoverished and deprived children. She has however been unable to have much real pleasure and satisfaction from her achievements, which include a very supportive relationship with her husband. Her life has a driven quality.

There is much to support the idea that this patient's determination to get away from the impoverished and deprived family was an expression of her wish to live and not be dragged down, but also such a situation would be likely to support a very omnipotent view of herself

in which the helpless and impoverished parents are unconsciously triumphed over.

The patient arrived for a session after she had taken a week's holiday. She looked terrible. She had a terrible time. She kept having the figure of a child in her mind, a child whom she teaches. The child was saying to her, 'You didn't listen to me reading'. She felt intensely persecuted and kept frantically busy to blot out this image. Every time she stopped it reappeared. She commented that she didn't have her record with her so that she could check whether she did or did not listen to the child. She also said that she knew 'that it was something in my mind'. This brief bit of material gives, I think, quite a vivid picture of the state of mind from which this patient has been on the run for much of her life.

In her job she struggles in a desperate way to repair all her damaged objects – the deprived and impoverished children. She does recognise the damaged objects in her internal world, but they have to be omnipotently repaired, as she cannot allow herself to face the reality of any irreparably damaged objects. Such objects would face her with situations which support her inner state of persecution, threatening her with retribution – 'look what you have done to me'. Klein (1940) stated that 'the death of a sibling, however shattering for other reasons, is to some extent a victory and gives rise to triumph and therefore all the more to guilt'. Death by suicide is particularly devastating as it gives reality to fantasies of the object's giving in to the death wishes directed against it and enacting them. A further point here is the mother's vulnerability. One gets a picture of an internal mother who would not be able to support her child in facing the guilt of the sister's suicide. She (the mother) is protected from any accusations (the letter), and although this may have been an accurate perception by the patient it again supports her omnipotence. The rather banal external event, the possibility of a minor failure in her work, has because of this patient's particular circumstances, lodged itself in her mind as a persecuting object whose recriminations she cannot escape though she attempts this by her driven activity. I think this situation also represents a type of 'intrapsychic claustrophobia': she feels trapped with damaged objects who persecute and blame.

There remains the question of why this situation came to light now. One possibility is that the holiday was not experienced as a separation from a therapist whom she needed. Her history makes it likely that she would experience herself as turning away from a vulnerable internal mother projected into the therapist, who is then experienced as needing her, fuelling her sense of superiority and triumph over the object who

complains that she never listened to her. What I am emphasising here is how the patient repeats in the transference her central anxiety situation – she triumphs over a vulnerable object – which then lodges itself in her mind persecuting her with recriminations.

However, this patient is able to say that she knows that 'it is in her mind' and she is also expressing her acknowledgement of her need for the therapist (the book that she did not have with her that could help her distinguish reality from fantasy).

This patient has then already managed some quite fundamental achievements. She shows an ability to distinguish internal and external, to acknowledge a helpful mother therapist who can help her think about her experience. There are patients, however, who have not acquired this level of development, and are dealing with unmanageable anxieties of a psychotic nature.

Freud's model of anxiety bound by representation through symbolic function – in dreams, sublimations and neurotic symptoms – assumes the presence of a mental apparatus which can perform this function. Klein (1952) demonstrated that the early psychotic anxieties of infancy – feelings of annihilation and fragmentation – have to be dealt with in order for these symbolic functions to develop. She stated, 'The infantile anxiety situations can be regarded as a combination of processes by which anxieties of a psychotic nature are bound, worked through and modified'.

Bion (1962) has considerably deepened our understanding of this highly condensed phrase, 'bound, worked through and modified'. His work with psychotic patients led him to understand what this involves through observing the results of its failure, which he termed observing the remains of 'a psychological catastrophe' (Bion, 1967b).

Bion described how the mother, by taking in and containing the catastrophic anxiety projected into her, transforms it through thinking and thus makes it available to the infant in modified form. The infant acquires the capacity to internalise an object that performs this function – to think about experience and, through thinking, both experience the experience and contain it. He called this function alpha function.

It is this function that binds the psychotic anxieties and, I am suggesting, forms the basis of Freud's protective shield (1920). Bion described ways in which this function can fail. If the mother cannot contain the anxiety but reprojects it, it returns not attenuated, but magnified: it becomes what Bion called 'nameless dread'. The individual then feels constantly on the verge of a catastrophe and defends himself through further violent projection and cutting himself off from

experience. I will now present material from a patient who faces this type of catastrophic situation, a patient in whom the failure to acquire an internal object that can contain and think about experience, leaves her on the edge of psychotic fragmentation.

As opposed to Ms B, Ms C, a married Asian woman in her early 40s, has followed a path in which, rather than desperately trying to repair her damaged objects, she denies their existence, and lives out an identification with a triumphant and contemptuous object which pours scorn and contempt on any ordinary human vulnerability, especially if evidenced in herself. She frequently uses words like 'wet', 'whingeing'. Miss B, we could see, lived in a world close to depressive anxieties which were constantly evaded. Miss C's internal world, however, is of a much more paranoid nature. She dreams of being pursued, trapped by insanely violent men.

Since a very early age Ms C has been on a campaign to prove that she is the one on top, usurping the position of her numerous siblings. Any overt display of emotion was felt to be a contemptible loss of control. For example when she received her 'A' level results, she took the envelope up to her room, opened it and came downstairs wearing an expression which did not reveal to her parents, anxiously waiting at the bottom of the stairs, whether she had passed or failed. In this way she triumphed internally over any ordinary emotional reaction, projected it and controlled it in the external parents. As far as I can gather, this represents a particular view of the mother inside her, a rather narrowed one, in which she believes she can only gain mother's love through disowning all vulnerability in herself. In her inner world she was engaged in a collusion with her mother, denigrating the weak and contemptible father. This internal scenario received much support from her external circumstances. Simultaneously, as I will show, she was locked in a battle with this internal father, a battle lived out in the transference, and as I will show, of an intensely sado-masochistic nature. She did well educationally because of her high degree of intelligence but this also supported her omnipotence. She read Sociology at university and during these years she was a member of a gang of young women who had very promiscuous relationships with men. The men were cruelly teased, picked up and then dropped the moment they displayed ordinary human dependence and vulnerability. Her own hated vulnerability and dependence was thus projected into these men representing the father, where it was controlled, mocked and ejected. This way of behaving supported her view of herself as in a superior

position alongside mother, looking down on the despised father who has nothing.

This way of living served her needs for some time, though her life offered little in terms of genuine fulfilment and she was never without the threat of catastrophic anxiety. This anxiety came to the fore when her father died after a long and debilitating illness when she was in her late 30s (her mother had died many years before). She said in a rather chilling way, 'I just wanted him to pack his bags and get on with it'. She here shows how she has an internal mother who colludes with her, rather than a figure which can give her support in facing and containing life and death issues. She more recently described how she would get very caught up in excited intellectual arguments with father in which she would try to tie him up in knots. However, when he was so weakened by illness that he couldn't compete, she lost interest. My aim is to convey the chilling, cruel quality of the objects in her inner world. Any display of her own vulnerability is subject to the same chilling cruelty and dismissal.

The death of her father and the delayed effect of the death of her mother resulted in the collapse of her defensive organisation and she was assailed by psycho-somatic symptoms accompanied by the terror of death. She had palpitations and felt her heart would stop at any moment. Desperately she consulted doctors but could never be reassured. She gave up work completely.

Here we see the devastating internal catastrophe with its helpless vulnerability, horrifyingly violent internal persecution further compounded by her own hatred of this state. The death of the parents is not experienced and mourned as the grievous loss that it is, but instead, the parental figures, previously kept far apart, are now set up together inside her combined not in love of each other, but in hatred of her. In phantasy they subject her to a horrifying persecution, murdering her from within, forcing her into the infantile catastrophic state of mind she has previously evaded and projected. Her feeling that she is dying also represents her identification with the dead and dying parents. Like the father in her mind, she is left with no one to support her and help her bear the pain and terror.

The analysis has been characterised by her attempts to regain her original defensive structure. As with many patients of this type, although manifestly they approach the analyst for understanding, there is a deeper aim which is to seek the analyst's help to restore the original defensive structure – and one can see why. The fact that the analysis by its nature is felt to threaten this arrangement, means that the analyst is

dreaded. The vulnerability of this patient to the ordinary adverse circumstances of life – having to cope with the real frustration of not possessing the analyst/mother, having to cope with the pain of awareness of separateness with the consequent envy and jealousy – could be dealt with in the only way available to her, namely to identify again with the superior contemptuous object (mother) projecting all vulnerability into the analyst (father). In this process she tears the analytic understanding to bits. This manoeuvre, however, means that she is left, not with internal figures united in love but with retaliating persecuting figures who unite together to force the dreaded dependent feelings into her. During breaks she frequently dreams of being trapped with violent murderous figures.

Early in the analysis she gave accounts of her symptoms, which sounded quite terrifying. These accounts were punctuated by her saying in sarcastic and superior tones, 'how peculiar', 'how odd'. It seemed to me that she was trying to draw me into a collusion with the superior maternal figure, as if the only way she and I could be on friendly terms by my joining her in mocking her 'peculiar' symptoms. At the start of the analysis, she always arrived a bit late for her sessions. She could not bear the idea of sitting in the waiting room and then following me along the corridor 'as your obedient lapdog', as she put it. She desperately tried to maintain that she didn't need me, attempting to make me the one who had to wait, projecting all the hated frustration and dependence into me.

She brought the following dream:

> She was being pursued by football hooligans. She comes up against a wall. She looks down and there is a small whining dog at her heels. She picks up the dog, puts it in a plastic bag and lobs it over the wall.

From earlier evidence of the way she treated attempts at understanding, this dream seemed to represent a picture of her analyst who is whining at her ankles trying to get her attention. At another level it also represents part of herself – her hated vulnerability – projected into the analyst where it is mocked, controlled and violently attacked.

Though behaving with apparent superior contempt for me in the session she would occasionally hand me letters just as she was leaving. These were letters written in the middle of the night containing long accounts of her horrifying anxiety and fear of dying. It was as if a vulnerable aspect of herself could only be allowed contact with me if it occurred, so to speak, as a secret message slipped under the door. In this

way 'they', the cold mocking figures in her internal world, would know nothing about it.

As one might predict, the patient was much affected by breaks in the analysis. Having murdered the analytic understanding – the analyst's whining – she was left alone with no internal figure to support her against the internal retaliating figures. She felt she was dying, and had attacks of catastrophic anxiety. She, however, experienced interpretations concerning these fears as my attempts to force the hated weakness into her, so that I could be triumphant. She believed that analysts chose their profession to avail themselves of the opportunity of surrounding themselves with weak patients, like whining little puppy dogs, whom they use to bolster their own grandiosity. She often felt that behind my analytic face, she knew what I was really up to, trying to humiliate her.

The patient made some progress. She managed to return to work, eventually full-time, without feeling excessively persecuted. She married a man 10 years her senior who is protective and gives her considerable support. She has become increasingly able to enjoy life – her claustrophobic terrors have lessened and she can go to concerts and operas. This in particular was important as her mother had loved opera but not been able to afford to go. The circumstances of her family in childhood were of considerable deprivation and poverty. They lived in one of London's poorer suburbs which however borders another suburb of considerable wealth. To go to the opera without fear of being persecuted and enviously attacked meant that there was some evidence of a more benign internal figure. Her interests have considerably widened and deepened. However she was still not able to acknowledge that this was achieved with the help of her analyst, for this would imply acknowledgement of her dependency which would then be subject to the contemptuous derision of the inner organisation.

I would now like to bring some material which came shortly after a session in which she had been able to be much freer and had brought a dream and associations which brought a different picture of the parents. They were represented as together and separate from her whilst also making arrangements that she should be cared for. She showed some real regrets at the way the family wasted so much by living in an atmosphere of cruelty and hatred, and also sadness about the loss of her mother.

The recovery of these memories also seemed to convey that she could begin to contemplate that she and I would part, and could attend to our various concerns without its becoming my triumphantly proving to her that I was the boss and she the contemptible weakling, or vice-versa. In

other words she could distinguish inner and outer reality and gain some strength and feel supported in her life by the analytic understanding. In the following session she was very preoccupied with gradings at work, a frequent preoccupation for this patient, conveying, I thought, an anxiety that she had been 'downgraded' by recognition of her need for support from her analysis.

In the following week she became increasingly unable to talk to me, now imprisoned in a defensive organisation seducing her into believing that to seek help was to be my whingeing lapdog. (Rosenfeld (1971) described this inner organisation, likening it to an internal Mafia.) She had had a good weekend but couldn't talk about it as she knew I would try to ruin it, suggesting, I thought, that the good weekend was not based on the support of the analysis, but on triumph over it. I had been kicked out: she then has to keep me out as I am felt to be filled with all the hatred of vulnerable dependency that she has projected into me.

She could not talk to me in the next session because she had had a dream. Dreams are naturally linked by her with the analysis: to tell me a dream is to convey that she needs help with understanding something going on inside her. She provokes and withholds, shutting me out, but as this continues, I am felt to be more and more terrifying.

The patient came to the following session and announced that she was going out that night and didn't want it ruined by a session in which she says nothing (she had felt quite ill after the previous session). She then told me about a dream which she produced with a stream of associations and bits and pieces of her current life and her history. The atmosphere was more as if she was telling me these things not to further understanding but to evade it and to keep me away.

In the dream,

> her mother and a friend are in the garden. Then a swarm of bees come and the patient runs in. She closes the door – Mother and friend are trying to get in. She has to keep them locked out and yet they are being attacked by the bees. She can't let them in as the bees will come in too. She feels distantly guilty.

The patient, as I said, produced a host of associations and bits of pieces of history in 'association' to the dream, so much so that I felt I was in a swarm of material coming rapidly from all sides and could not think. She mentioned that her neighbours on both sides, are beekeepers.

I want to emphasise only one aspect of this complicated material. The bees clearly convey a persecutory anxiety of a terrible kind, in which the objects which have been violently fragmented are coming

after her. In the context of the session and the previous sessions, in which she has been trying to shut me out, I think one can see that there is a picture of an object (the analyst/mother) which is in a terrible state and yet which she cannot approach or help. Letting the object in will result in her being the target of horrifying attacks (the bees). In her violently locking me out she experiences me as getting into an increasingly bad state, but can do nothing to help. To recognise a helpful mother who is also separate from her, to let her in, and internalise her, also means allowing in all the persecution. Other dreams showed how shutting me out, whilst projecting her own helplessness and vulnerability into me, may be associated with considerable excitement often of a highly sexualised nature.

It is very important to recognise that this material follows a session in which there had been real improvement when she had allowed me in, as a friendly figure. This appears to have stimulated her hatred of her awareness of her need for me.

Though the manifest trauma, the death of the parents, takes place later in life, the difficulties unleashed hark back to the very earliest difficulties of being able to experience a feeding understanding object, to mourn and lose it and so set it up inside as an internal object that can contain anxiety and help her face life and death issues. The unavailability of such an object has led to the construction of a defensive organisation which protects her from psychotic collapse. The patient mentioned that she does have neighbours who keep bees, and these were real adverse circumstances, but the dream shows how adversity becomes horror. Similarly the actual loss of her parents, a major traumatic event, could not be digested and metabolised, in other words worked through, experienced and then learnt from, as such a process, at its inception, is immediately joined up with much more catastrophic internal situations.

To what extent this early failure in acquiring a containing object is due to the mother's incapacity to contain the patient's anxiety and to what extent it is due to the patient's attacking of that function is something that could only be worked out as the analysis developed.

Conclusion

In this paper I have tried to show how external situations – major losses – produce profoundly different effects in these two patients. The first patient was much nearer the depressive position and so was able to bring situations to do with loss and facing damaged objects. Though she

continues to be persecuted by this situation, it is within view and there is a sense of an object whose support she might enlist.

The second patient, however, because of the adverse circumstances of her infancy and childhood has been unable to build up a durable figure in her internal world which can contain and bind psychotic anxieties. To avoid collapse she uses a defensive organisation which supports her wish to disown and project ordinary vulnerability. She projects it and controls it in her objects (the internal father, boyfriends, analyst) where it is violently attacked. She is besieged by anxieties of a much more catastrophic nature, such as the terror of fragmentation (the bees) resulting from her violent attacks on her helpful objects.

Traumatic situations that cannot be faced are constantly re-enacted in ways that are usually deeply unconscious. To quote Freud (1909), '... a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken'. Ms C, in her life, gives life to her worst fears – by triumphing over and destroying helpful objects terrifying persecutors are created.

There is no doubt that early adverse life experiences affect the development of the personality. I think there is also little doubt that severe adversity (such as the early death of parents, or mental illness in one or both parents) has severe effects. There is a paradox, however. Those with the most severe disorders are just those who, because of their fundamental problems in facing internal and external reality, are least able to assess the real nature of their adverse experiences. In many cases it is only after a satisfactory analysis which by securing their relation to internal reality enables them to face external reality, that such patients can decide for themselves the real nature of the external traumas they have suffered.

Part Five

Groups