The use of pain as an autistic object and as a primitive experience of self: ***A clinical report on some possible effects of trauma in infancy.***

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Summary

In this clinical report I present a discussion of an analysis in which pain served as a primary organizing sensory experience for the patient in the process of establishing a sense of self. Four modes of creating a sense of self are described as they were experienced in the transference-countertransference. The most primitive mode through which the patient attempted to create a sense of self involved her giving (sensory) form to herself as pain itself. In this psychological state, the patient existed as a non-object related, sensory-dominated, insular being. The second mode of being that is discussed is a presymbolic, primitively object related state in which the patient projectively created herself <u>*in me*</u> *as the experience of pain. In the third and fourth modes symbolization increasingly replaced sensation-based mechanisms. The patient developed an ability to think and talk about the ways in which pain has served her in the course of her life. She was then able to allow me to know her and to know herself in terms of an emotional vocabulary unrelated to the experience of pain.*

Introduction

Modern medical technology allows an increasing number of premature and severely ill infants to survive albeit in physically and emotionally traumatized states. This report describes the analysis of a woman who underwent life saving surgical intervention in early infancy. This patient made use of pain as a principal organizing sensory medium for the creation of the experience of a bodily perimeter and the most rudimentary sense of self. Experience in the transference-countertransference led to the hypothesis that the repeated re-creation of pain served

this patient, Ms. C, as a principal defense against feelings of disintegration and of not existing. Having suffered from a combination of severe physical illness and, apparently, inadequate maternal holding in the first months of life, Ms. C seems to have developed a particular defensive form of psychic equilibrium. During the years that I have worked with her I have become convinced that she constructed a pathological defensive perimeter by utilizing the painful sensations that were available. I will use clinical vignettes taken from four periods of the analysis to demonstrate four forms of transference-countertransference experience that I believe derived from the defensive organization that the patient developed in the course of her early experience of pain and maternal deprivation.

As far as I have been able to determine the analytic literature has not addressed the way in which pain may function as a psychological defense and as a nidus for psychic organization in the face of psychotic anxiety. There are, however, guiding discoveries that help in the understanding of Ms. C. Early and prolonged trauma results in somatic (sensory) symptoms (Greenacre, 1952) while isolation of infants and minimal holding results in the general slowing of development, the defensive use of psychosomatic symptomatology and (sometimes severe) compromise of the ability to form relationships in later life (Spitz, 1945). Engel and Reichsman (1956) introduced "Monica" into the analytic dialogue. Their patient suffered an identical ailment (esophageal atresia) to the one suffered by the patient I am presenting (Ms. C). Their team of investigators followed Monica for twenty-five years and found that their data confirmed the data of Greenacre and Spitz (see also Viederman, 1979). Other contributions to my thinking about this patient include the work of Bion (1962), De Urtubey (1995), Meltzer et al. (1975), Mitrani (1992, 1994) and Symington (1985). However, my understanding of Ms. C has drawn most heavily on the work of Bick (1968, 1986), Ogden (1988, 1989, 1994a, 1994b), Tustin

(1980, 1984, 1993, 1994a, 1994b) and Winnicott (1949, 1954-1955, 1960, 1963, 1968). Their conceptions of autistic defenses and psychological organizations have most directly and usefully helped me to clinically recognize and address the transference-countertransference experience of the patient's replacement of human relatedness with self-generated, sensation-dominated experience.

While this patient provided a narrative of her early life, the most informative source of data for interpretation and (always tentative) genetic reconstructions was derived from the transference-countertransference experience as it evolved over the first eight years of the analysis. As will be discussed, the countertransference was used to inform my understanding of the transference, but was not offered to the patient in an "undigested" form (Ogden, 1994a, pp. 1-11, 1994b).

I have chosen several clinical vignettes from sessions through which I gradually came to take the view that what was happening in the transference-countertransference provided information about qualities of the patient's infantile and early childhood fantasies, anxieties, defenses and object relations. In the presentation of these examples, I will attempt to illustrate four ways in which the patient struggled to both come alive as a person and to defend herself against what she sometimes experienced as massive (external and internal) assault. These four modes of managing and attributing meaning to experience range from an almost completely non-object related form of experience to a whole object related (depressive position) form of experience.

Clinical Illustration

Ms. C first sought treatment when she was 21 years old. The patient's father died of a heart attack when she was 16 and, shortly thereafter, her first husband shot himself to death. She

became depressed and, after several years of ineffective trials of antidepressants, she was referred to me for consultation. I did not have time to begin treatment with her, and I referred her to another therapist who saw her in psychotherapy for about a year. She terminated that therapy because she "felt well." When she consulted me again, fifteen years later, she was divorced, a single mother of two, and she impressed me as hardened and bitter. I had forgotten the striking contrast between her diminutive physical stature and her evident strength and determination, which had encouraged me about her prognosis when I first met her. She told me that she could no longer bear the numerous psychosomatic symptoms from which she was suffering and that she needed "more serious treatment."

Ms. C was working in a low level managerial position and had recently seen me in the offices of her employer. This chance encounter, across a room and without words, prompted her to phone me to seek treatment "because I could not think of what to do for myself before I saw you." During the course of the first several sessions of consultation, I concluded that she was barely maintaining her ability to function at home or at work Except for attending to the very basic needs of her daughters (aged six and ten), she was spending all of her time at home in her bedroom. She could, for brief periods, present the persona of a solidly integrated single working mother, but in the unsettling setting of the "maybe" therapy (the consultation) she rapidly evidenced partial disintegration into a paranoid state. Her pain, depression and fear were written on her face and were palpable in my response to her. I was intrigued by her, moved by her plight and, I decided to undertake her treatment.

During the first three years of treatment, we met three times a week. The patient sat in a chair situated in such a manner that she had to turn her head to look at me. In this way, Ms. C could regulate the degree of eye contact that she needed at any given time. Shortly after

beginning treatment the patient quit her job and indicated, over the course of several sessions, that she could no longer go on "faking" her way through life. Going out every morning to work required her to pretend that she was normal. It seemed that she had been "holding on by a thread" and used the therapy as a setting in which to give up the remnants of her already crumbling facade. As she regressed, defensive reliance on self-soothing activities such as sitting still in a soft chair, lying on her couch, or staying in bed became more pronounced than before. Ms.C experienced severe pain, usually in the form of excrutiating headaches, unless she was in bed. It seemed that she was living in two types of psychically self-contained "envelopes," one consisting of the consuming experience of pain and the other consisting of the experience of the soft cocoon of bedding and mattress (Kilchenstein and Schuerholz, 1995; Tustin, 1980).

Ms. C told me in the initial weeks of therapy that she weighed two pounds at birth and was found to be suffering from cardiac, renal and gastrointestinal anomalies: a patent ductus arteriosis which closed in infancy, a single kidney which remained asymptomatic, and the absence of the upper-most few centimenters of her esophagus. She said that she hated doctors and nurses and that she felt as if she occupied a different world from the one I lived in. She added that she felt like an alien creature. Ms. C continued to relate what she had heard from her family about her early life. She was told by her mother that she was fed through tubes inserted into her chest for the weeks before and several months after her esophagus was surgically treated and that she remained in the hospital for almost a year. Telling the story of her pain seemed to have an organizing function for Ms. C. Her mother had said that she carried her in a box and was afraid to hold her throughout her infancy and childhood for "fear that she [the patient] would break." The patient added that even later her mother avoided touching her except for an occasional slap on the buttocks for punishment.

I told her that perhaps she imagined that the same anxiety that her mother had expressed was my reason for not having taken her into treatment when she first consulted me. I then said that maybe she expected to again be untouched and unchanged by the analysis as a result of my fear of her fragility and that her work with me would cause her great pain or even death. She became quiet for a few moments. This comment seemed to relieve her, for when she spoke again, it was with a less angry edge and with a hint of calmness.

The operation, the first of its kind ever performed (Ms. C told me that she has saved the newspaper clippings), was the beginning of a long series of treatments continuing until she was five-years old. The dominant memory of her early life is that of her father and aunt carrying her to the doctor's office where, while being held down and with her eyes covered, her esophagus was stretched with a metal dilator. She described these procedures as experiences during which she felt absolutely alone and terrified as a group of people seemed to be torturing her, humiliating her and trying to kill her through their actions. Her mother, according to the patient, could not stand the pain and did not accompany the patient for these sessions. When Ms. C was slightly older, her mother lied to her (and perhaps also deceived herself) by reasurring her that she would never again have to undergo one of these procedures. The patient was then taken by surprise each time she was subsequently subjected to these treatments since the patient no longer experienced difficulty swallowing and the treatments seemed unrelated to any physical sensations that she was experiencing.

The patient's use of pain as a nidus around which to psychologically organize herself will now be examined as it evolved in the course of the analysis.

Mode I: Existing as pain

In the beginning of therapy the patient spent most of her time in bed. Up to this point, the imitation of good psychological health had always been within the patient's capability. She attended family functions and parent-teacher meetings and did other necessary things. This type of "faking" normality was rapidly abandoned soon after the treatment commenced**.** The following illustration is taken from the second year of work and is presented in an effort to convey the experience of being with the patient when she was in her most primitive state of pain. [I take notes during the sessions and regularly record my own affective responses when I am attempting to contain her impact on me.]

> Ms. C entered the office with no acknowledgement of me. Moving somewhat stiffly, she sat on the chair. She was wearing sunglasses which, from the past, I took as an indicator that the patient was suffering from a severe headache and accompanying diffuse systemic malaise. She remained silent for ten minutes. I write, "It's as if we are sitting in a funeral parlor. I feel heavy-headed and unfocused. She sat back and moaned in what sounded like birth or death agony. I am looking out the window at the birds on the bird feeder. This is an unusual state for me but occurs frequently in my sessions with Ms. C. I feel vacant, unused, unrelated, dissociated from her. When I watch her I can see that she is in pain, but she is not available to receive anything from me."

> When these moments first occurred it felt to me as if something personal were happening between us. It took me quite a while to recognize and accept that Ms. C was, in all likelihood, utterly unaware of me and not attempting to have me feel her pain, be moved by it, or even notice it. I felt no sense that she was angry or withholding. I simply felt unused and of no emotional value to her. As Ms. C went on in this silent state, I felt helpless to

intervene. I had the thought that her unselfconscious ignoring of me meant that our work together was flat, a charade, and that she was simply going through the motions of being engaged in therapy, but was incapable of relating. I then began to realize that she was not trying to tell me anything about pain; instead, she seemed to be the embodiment of pain itself. The absence of any attempt to have me share her pain seemed part of a form of human disconnection, a state in which I experienced the patient (or myself) as not fully a human being, adrift, not engaged in human relatedness. I gradually became aware (primarily after the fact) of slowly slipping into a state of self-protective withdrawal.

The feeling that I was of no use to Ms. C as a human being led me to conceive of myself as nothing more than a container in a literal, physical sense. I said to her, "It seems to me that today you have come here to be surrounded by the things in this room." She nodded and otherwise acted unaffected by my comment.

During these "unrelated" moments the patient seemed to be utilizing pain (a poorly differentiate combination of physical and psychological pain) as a sensory form of defense; the patient may have been attempting to create a sense of self by giving (sensory) form to herself as pain itself. In this somato-psychic state, the patient apparently tried to exist as a non-object related, wholly insular being. While this may have helped her to establish a shape (although a frozen one), this was done at the cost of substituting pain for a life in a world of human beings.

She complained of needing to sit or lie in absolute stillness, fearful that if she moved she would die. When walking she felt as if her legs were disconnected from her body and she felt dangerously out of control. She experienced terror during intercourse that she would suffocate, that her body might break, and that she would die. All of her efforts to protect her fragile sense of integrity came to calamity as soon as she or the environment moved.

Mode II: Existing in me as pain

A second state of being came into dominance in the fourth year of our work together. The following clinical material is taken from the first session after I had returned from a two week vacation. Prior to my vacation Ms. C had been more engaged in life (in a way that seemed genuine) than I had ever known her to be, for example, she was dating, going dancing, framing her artwork.

While the model of neutrality and maintaining analytic tension (i.e. refraining from suggestion, reassurance, exhortation and the like) had always characterized our work together, the patient had recently begun using the couch, which was suggested by me in an effort to afford both of us an opportunity to be more fully reflective. The patient had readily agreed to my suggestion. Earlier she had not been able to give up the organizing effect of keeping me in her peripheral vision. Gradually, over the years, she had begun to refrain from looking at me or even keeping track of me in her peripheral gaze.

Ms. C again began the session with an ominous silence that lasted for ten minutes. My having been away for two weeks left me with a desire to talk with her. As the silence continued, however, I began to feel tired and less related, which I understood as a response I often have to a patient who is in a rage (see De Urtubey, 1995). The silence was broken when the patient said, "I feel terrible, I always feel terrible. I hate being anywhere. My eyes bother me so much. I just don't want to be anywhere." I began to feel as if she were attacking me, and I had a desire to cover myself. I had the sense that I was obstructing her vision, as if I were an opaque mass in her way, perhaps covering her. This reminded me of my prior experiences in the countertransference of feeling that, despite my wish to be a

presence in her life, I was not recognized as human, but perhaps served as part or all of a shell that covered her.

She continued to express, in the same ill-defined manner, the feeling of pain she experienced in being alive. I began to feel confused and to experience unexplained sensations in my chest. I felt battered by the toughness of her harsh tone and hammering cadence as she continued her complaints. I thought of her attack as an attempt to shed her second skin formation (me, in my function as the "covering" that both protects her and smothers her [Bick, 1968]). I became increasingly disconnected and exhausted. I then began to have angina-like pain down my left arm, which frightened me. These physical sensations were entirely foreign to me. Not knowing what to make of what was happening, I did nothing and continued to listen. I remembered that Ms. C's father had died of a heart attack when she was sixteen. The patient continued: "I feel unprotected. The world I know is gone. I'm scared. It's choking me, yet there is a different kind of space. I want everything out of my way. I'm really scared. I don't like it out there at all. I feel pushed down or held back."

Ms. C curled up on her side on the couch. There were long pauses, and I felt increasing malaise. She continued, "I don't want to live, I'm too uncomfortable. It makes me so angry, every day I wake up and I'm still here." By this time I felt quite frightened by what I was experiencing physically. I wrote in my notes, "This process is first and foremost a matter of the patient and the analyst surviving. My main anxiety right now is that I will die before this treatment is complete [session is over]." Just as I finished writing the prior sentence, Ms. C said, "I'm hanging in there just for my kids. I wish I would die, get hit by a car or something." I was, in that instant, convinced that my physical experience was as connected

to the patient's projections as my thoughts were consonant with hers. I said, "It seems you are wishing to die, but your concern for life that is currently residing only in your children and perhaps in me, is getting in the way." Suddenly crying, she said, "Where did everybody go? [I felt that she was (unconsciously) thinking about her father.] It has to be better than life. I want to be with everybody else, all the dead people. Life looks flat. It's just a picture in the way. This makes no sense, this is weird. I never bought all that stuff about heaven. There is nothing. It's just over." The pain in my chest and arm as well as my exhaustion began to ease as the patient went on to cry and speak about her loneliness, confusion ("It makes no sense.") and rage about the death of her father (which seemed related to my having left her for the vacation break). I suggested that she might be angry with me for having left her. She quickly confirmed my thought by loudly protesting, "You think my world revolves around you." I now suspect that I endured the pain and did not terminate the session because I fantasied (unconsciously) that I deserved to die for having sent her away fifteen years earlier, for having gone on vacation, and for leaving her at the end of every session. Ms. C's father's death occurred very soon after the patient and he had begun to have a "talking relationship." It occurred to me that the patient was terrified that I would die once she and I were able to talk with one another in a more fully human way.

I conceptualized the experience I was having as a projective identification. It seemed to me that I was experiencing something directly related to Ms. C's fear and felt that I was going to die in her stead. This was not so much a thought or a feeling as it was a physical sensation accompanied by fear. I suggested to her that her anxiety and confusion was related to her worry that something might happen to me as a result of our talking. This comment led to a shift in her tone of voice from angry bitterness to soft and tearful. She went on to talk

about her mother, who she felt had led a wasted, isolated life, and her first husband who had killed himself while still a teenager.

As is evident in the clinical sequence described above, Ms. C underwent a marked affective shift during the time I was away on vacation. Moreover, something changed in our capacities to interact, as was illustrated in the session presented above. Despite the fact that she became angry and distressed, she maintained a continuing capacity to make use of me. This use of me was “ruthless”(Winnicott, 1968), i.e. without concern for (and perhaps without awareness of) me as a separate person. Specifically, Ms. C was now able to experience (although at a distance in the form of projective identifications) aspects of herself that previously had been unavailable to her even for purposes of projection. Her fantasy of the pain of her father’s fatal heart attack and her rage at him and at me for having left her were now being projected into me. In this way she existed *in me* as pain, which I endured as a foreign and life-threatening experience. I sensorily experienced the projected aspects of Ms. C and was subsequently able to verbally symbolize the experience for myself and then for her. She found the projected parts of herself, as experienced and modified by me, more manageable. The process of the experiencing these feelings for herself (her anger and sense of loss associated with her father’s death) relieved me of my containing function. This was evidenced in the disappearance of the pain in my chest and arm, and the intense malaise that I had been feeling.

Mode III: Experiencing pain and discussing its meaning for her

The four types of interaction and modes of being that I am describing in this paper bear a synchronic as well as a diachronic relationship to one another and, therefore, are always intermeshed. None occurred in a “pure form.” The dominance of one set of primitive defenses,

types of communication and forms of object relatedness was gradually succeeded by the ascendance of a more mature form of psychological organization (see Ogden, 1988).

The following excerpts are taken from a session that occurred in the fifth year of our work together:

> Ms. C began by saying, "I'm scared to death of coming here. It's like I'm not who I am." I write in my notes, "She is scared to come here because she hates to confront what she has projected into me and fears I will dump it back into her. She feels 'not who I am' because I (the analyst) am now experienced as herself (carrying her projections) at a distance from herself." She then goes on to say, "I have strange thoughts. Like throwing me up, the nice me. I try to cough it up. I want it to go away. [The patient began to cry.] I want to pretend that it never happened." I am left with the feeling that she is telling me something important, but I do not know what "it" is.

Ms. C's fear of coming to the sessions has had numerous and even opposite meanings over the years. One of these anxieties is the fantasy/conviction that bad things will happen if good things are experienced. For example, if she thinks of me as good for her, she immediately devalues me as useless, self-serving, callous, and so on. In the above vignette Ms. C noticed some "nice" part of herself, and in an unconscious, reflexive response, wanted to rid herself of that part. This is an unconscious fantasy that seemed to be experienced in the sensation (a "fantasy in the body", E. Gaddini, 1982, p.143) of the urge to vomit, expel phlegm and cry; i.e. "throwing me up, cough it up, crying it away."

Here she attempts to specify what "it" might be:

> "A part of me that I know... it's not necessary that good would bring bad. Yet it's like I don't know. It's not something anybody could understand. [She is asking if I

understand.] I had some examples, but I don't know what they were. It was like turning on a light. It's been crushing and confusing. It was too much, like hurting my ears and it was frightening at the same time. I wish I could remember the things that went through my head. Crazy, all boiled down to the same stuff, but it felt big. I was devastated. I wish I could calm down, feel better, whatever. It's just too much. But it's OK. I don't know what I'm trying to say. I know my head is killing me. I was excited at the same time. It's pretty neat, but I don't know how to get a grip. [I think this refers to letting go of her internal object mother and not yet feeling the internalization of me as safe and reliable.] This feels as bad as the bad anxiety." [She formerly defined the bad anxiety as the kind she has when she follows the rules of her mother.]" I said, "It seems that our talking and thinking together is as painful as the dilations were. When we talk it must feel as if my words and ideas are going through your head and are killing you. [I am thinking here of the doctors and their instruments going through her and of her internal object mother ("it" that she tried to cough up) brutalizing her from within.] She responded with an immediate calming.

During the time that the patient was telling me all of the above, I developed a muscular tightness in my head and abdomen along with the thought that if I were to "pull" (psychologically) on her, she would tear apart. I felt concerned that she would be damaged if I were to say anything. I speculated (silently) that this concern on my part might reflect the patient's fearful struggle to experience previously foreclosed aspects of herself. My fantasy about her tearing apart represented a shift from my earlier feelings of being unable to alter her impenetrable fortress of psychological muscularity.

In the foregoing sequence Ms. C is attempting to generate symbols for previously protosymbolic, sensation-dominated experience; e.g. the headache pain that formerly had served as a perimeter of a rudimentary sense of being. At this point the patient is only partially able to generate experience as psychological symbols and patterns of meaning. The analytic dialogue had the effect of exerting a pressure toward symbolization of experience. It became my function to provide words (in the form of verbal interpretations) with which she might begin to think and feel who she is in progressively more mature forms of self-recognition (see Rosenfeld, 1987).

The ebb and flow of projection and somatization.

Gradually during this period of the analysis Ms. C developed a sense of pride in her ability to think between sessions. I, too, was impressed with her much expanded capacity for self-reflective, affect-laden thinking both within and between the meetings.

The patient began a session in this period of our work by telling me, "I realized a lot [in the course of the analysis], but it is so horrible I don't want to talk about it. [The patient seemed genuinely related to me as a whole and separate person for the moment.] You're the only person I could share it with. It's so weird. No matter what we talk about I was always getting the same vision of being in that hospital for those treatments and I couldn't figure out what it was. You asked me, 'When did I die?' 'When did I hide?' When I couldn't stand it anymore, I became like a shell. I could see but couldn't feel. I took all of my feelings and went into a corner. Sometimes I'd just be my head, real tiny, and other times I would disappear so I let my mother's ideas and thoughts fill the shell." Sobbing, she apologized, "It's all my fault. I had to fill myself with something. I couldn't function empty, and my mother was the only girl. I couldn't use my father or brother. I was so angry at them [the

doctors and staff] for making me feel I was bad when I was being humiliated and terrified of dying. The only way to let them think I was OK was to have them think it didn't hurt, and the only way I couldn't hurt was to not be there [except as pain, which she kept hidden from them]. I stayed hidden. I'd have to go through it again, and I didn't know when my life was going to be interrupted [ended]."

I said, "The feeling of not knowing what will happen to you and when the pain will start again continues to be an important part of your life. If you no longer have pain, will you still have a place here?" She responded, "I have thought about that a lot. I can barely imagine not having you in my life, but I know that if I am not sick our meetings will stop."

Here the patient is creating verbal symbols and fantasies which embody the transformation from <u>being pain</u> to <u>creating a verbal narrative</u> through which a self is symbolically elaborated instead of simply existing as raw sensation (pain). This included both the capacity to talk about pain and the ability to think about the ways it currently serves her in maintaining an identity and a tie to me.

As the patient became increasingly able to speak about her pain, she would experience periods of relief in the analytic hours from consuming physical pain. At these times several countertransference thoughts and feelings recurred: I often became anxious, doubting that my interpretations had made a difference in facilitating the changes the patient was evidencing. I fully anticipated that the patient would experience a recurrence of severe (physical/emotional) pain. I believe that this was a manifestation of a projection of Ms. C's belief that she was not a real mother or worker (or human being), but a fake (in the absence of self-defining pain). In this experience (which I came to understand as a projective identification), I was not a real therapist but a charlatan and therefore my work could not really be effective. I felt anxious that without

her pain she would disappear and be lost to me. I feared that I would be left without a relationship with her because she would have no use for me. I hypothesized that these feelings represented projections into me of an object relationship with her mother in which each of them was unconsciously convinced that they both would die if they failed to provide one another an identity constructed in the emotional vocabulary of pain.

Mode IV: Moving beyond pain as a way of defining and creating experience of self

Ms. C began a meeting, in the seventh year of our work, with the following announcement: "I don't feel like a slave anymore." The patient had, in the past, structured her life by shaping herself to the needs, demands and wishes of other people (including her perceptions of my needs). She now began to experience clear desires of her own that she was able to speak in a timely way.

> "Little by little, stuff is coming out of myself that I would never say. For example, my boss asked at the last minute, 'Are you going to be here for a while?' I answered, 'No, I've got a life.' It came out so quick. He got the idea. Then another evening at work, two of us were still on the phone at five-thirty, and I said to her, 'What are we doing here on this speaker phone?' I do get paid overtime. That's the only thing that was keeping me there."

A year later, in an unusual burst of spontaneity and pride, she took charge of a session as it began. This session took place after a two-week period during which I was away on vacation. A break of this sort in the past would have resulted in a severe regression in which Ms. C would have experienced herself predominantly in terms of physical and psychological pain.

> "I really like my new job. There are only four of us working together and I am learning so many new things. It's really exciting." A few minutes later Ms.C told me that life was

easier for her and her younger daughter now that her older daughter was at college. She went on to describe her art work, to which she was devoting more and more of her free time. At the very end of the session she complained of a tenseness in her shoulders and neck and drew her arms up in a protective shape around her head. "Every time I do something I enjoy, I feel like I'm going to be hit. My arms and shoulders hurt from holding them up to protect myself." I responded by saying, "Maybe you are afraid that I will hit you if you think for yourself." She answered, "That is probably true." I then said, "You had not talked about pain until the very end of the session. Are you afraid that I would not recognize you if you did not show some pain?" She laughed and said, "Neither of us would recognize me if I didn't show some pain."

The startling difference in this use of me after an interruption in treatment (in the eighth year) can be seen in the near absence of mention of pain in her conception of herself and the abscence of the patient's engagement in projective identificatory processes involving the experience of pain.

Concluding Comments

In this paper I have discussed aspects of the analysis of a patient who had experienced physical and psychological trauma in the first years of life. I have attempted to illustrate the ways in which pain served as a primary organizing sensory experience in the patient's process of establishing a sense of self during the first eight years of an analysis. I conjecture that the patient under discussion had developed a "frozen" set of sensation-dominated defenses in early life in large part in response to her chronic experience of traumatizing physical and psychological pain occurring in the context of emotional disconnection from her mother. These sensory defenses

held her together, but blocked her from feeling alive and related to people in a way that felt real to her. The analytic work enabled the patient to (re-)experience in the transference-countertransference the internal object relations that constituted the psychological organization she had developed in the face of her early traumatic experience.

The patient unconsciously attempted to use her experience of pain as a substitute for human relatedness in the process of generating a sense of self. Four modes of creating a sense of self were described as they were elaborated and experienced in the transference-countertransference. The most primitive mode through which the patient attempted to create a sense of self involved her giving (sensory) form to herself as pain itself. In this psychological state, the patient existed as a non-object related, sensory-dominated, solopsistic being. The second mode of being that was discussed is a presymbolic, but primitively object related state in which the patient projectively created herself in me as the experience of pain. In the third mode of being the patient developed the capacity not only to symbolize, but to verbalize her experience of pain. This included both the capacity to talk about pain and the ability to think about the ways it has served her in the course of her life. As the patient developed a fourth mode of experience of self, she was able to know herself and to allow me to know her in terms of an emotional vocabulary almost entirely unrelated to the experience of pain.

I have attempted to illustrate these four modes of generating herself through the discussion of selected clinical material from the eight years of work thus far completed. In doing this I hope to have depicted the ways in which pain was used as the nidus around which the patient constructed the rudiments of experience. This fragile foundation was superseded, but never entirely replaced, in the course of the analysis by more mature forms of defense, self-definition, communication and object relatedness.

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