Some Pressures on the Analyst for Physical Contact During the Re-Living of an Early Trauma

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Is physical contact with the patient, even of a token kind, always to be precluded without question under the classical rule of abstinence? Or are there some occasions when this might be appropriate, even necessary, as Margaret Little has suggested in relation to episodes of delusional transference (1957)(1958) or as Balint and Winnicott have illustrated in relation to periods of deep regression? (e.g. Balint, 1952) (1968) (Winnicott, 1954a), (1963a).

I shall present a clinical sequence during which the possibility of physical contact was approached as an open issue. There seemed to be a case for allowing a patient the possibility of holding my hand. The decision to reconsider this was arrived at from listening to the patient and from following closely the available cues from the countertransference. The clinical material clearly illustrates some of the issues involved in this decision.

The patient, whom I shall call Mrs B, is in her 30s. She had been in analysis about 2½ years. A son had been born during the second year of the analysis.

When she was 11 months old Mrs B had been severely scalded, having pulled boiling water on to herself while her mother was out of the room. She could have died from the burns. When she was 17 months old she had to be operated on to release growing skin from the dead scar tissue. The operation was done under a local anaesthetic. During this the mother had fainted. (It is relevant to the childhood history that the father was largely absent during the first five years.)

Soon after the summer holiday Mrs B presented the following dream.

She had been trying to feed a despairing child. The child was standing and was about 10 months old. It wasn't clear whether the child was a boy or a girl.

Mrs B wondered about the age of the child. Her son was soon to be 10 months old. He was now able to stand. She too would have been standing at 10 months. (That would have been before the accident.) Why was the child in her dream so despairing, she asked. Her son is a lively child and she assumed that she too had been a normal happy child until the accident. This prompted me to recall how Mrs B had clung to an idealized view of her pre-accident childhood. I thought she was now daring to question this. I therefore commented that maybe she was beginning to wonder about the time before the accident. Perhaps not everything had been quite so happy as she had always needed to assume. She immediately held up her hand to signal me to stop.

During the following silence I wondered why there was this present anxiety. Was it the patient's need still not to look at anything from before the accident unless it was seen as perfect? Was the accident itself being used as a screen memory? I thought this probable. After a while I said that she seemed to be afraid of finding any element of bad experience during the time before the accident, as if she still felt that the good that had been there before must be kept entirely separate from the bad that had followed. She listened in silence, making no perceptible response during the rest of the session.

The next day Mrs B came to her session with a look of terror on her face. For this session, and the five sessions following, she could not lie on the couch. She explained that when I had gone on talking, after she had signalled me to stop, the couch had 'become' the operating table with me as the surgeon, who had gone on operating regardless, after her mother had fainted. She now couldn't lie down 'because the experience will go on'. Nothing could stop it then, she felt sure.

In one of these sitting-up sessions Mrs B showed me a photograph of her holiday house, built into the side of a mountain with

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high retaining walls. She stressed how essential these walls are to hold the house from falling. She was afraid of falling for ever.\(^1\) She felt this had happened to her after her mother had fainted.

(Here I should mention that Mrs B had previously recalled thinking that her mother had died, when she had fallen out of her sight during the operation, and how she had felt that she was left alone with no one to protect her from the surgeon who seemed to be about to kill her with his knife.) Now, in this session, Mrs B told me a detail of that experience which she had never mentioned before. At the start of the operation her mother had been holding her hands in hers, and Mrs B remembered her terror upon finding her mother's hands slipping out of hers as she fainted and disappeared. She now thought she had been trying to re-find her mother's hands ever since, and she began to stress the importance of physical contact for her. She said she couldn't lie down on the couch again unless she knew she could, if necessary, hold my hand in order to get through the re-living of the operation experience. Would I allow this or would I refuse? If I refused she wasn't sure that she could continue with her analysis.

My initial response was to acknowledge to her that she needed me to be 'in touch' with the intensity of her anxiety. However, she insisted that she had to know whether or not I would actually allow her to hold her hand. I felt under increased pressure due to this being near the end of a Friday session, and I was beginning to fear that the patient might indeed leave the analysis. My next comment was defensively equivocal. I said that some analysts would not contemplate allowing this, but I realized that she might need to have the possibility of holding my hand if it seemed to be the only way for her to get through this experience. She showed some relief upon my saying this.\(^2\)

Over the weekend I reviewed the implications of this possibility of the patient holding my hand. While reflecting upon my countertransference around this issue I came to recognize the following key points: (1) I was in effect offering to be the 'better mother' who would remain holding her hand, in contrast to the actual mother who had not been able to bear what was happening. (2) My offer had been partly motivated by my fear of losing this patient, which was especially threatening to me just then as I was about to present a paper on this patient to our Society. (3) If I were to hold this patient's hand it would almost certainly not, as she assumed, help her to get through a re-experiencing of the original trauma. (A central factor of this had been the absence of her mother's hands.) It would instead amount to a by-passing of this aspect of the trauma, and could reinforce the patient's perception of this as something too terrible ever fully to be remembered or to be experienced. I therefore decided that I must review with the patient the implications of this offer as soon as I had an opportunity to do so.

On the Sunday I received a hand-delivered letter in which the patient said she had had another dream of the despairing child, but this time there were signs of hope.

The child was crawling towards a motionless figure with the excited expectation of reaching this figure.

On the Monday, although she was somewhat reassured by her dream, Mrs B remained sitting on the couch. She saw the central figure as me representing her missing mother. She also stressed that she hadn't wanted me to have to wait to know about the dream. I interpreted her fear that I might not have been able to wait to be reassured, and she agreed. She had been afraid that I might have collapsed over the week-end, under the

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1 'Falling for ever' is referred to by Winnicott as one of the 'unthinkable anxieties' along with 'going to pieces', 'having no relationship to the body' and 'having no orientation' (1962, p. 58).

2 At the time I was thinking that this offer of the possibility of holding my hand might, in Eissler's (1953) terms, be a permissible 'parameter'.

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weight of the Friday session, if I had been left until Monday without knowing that she was beginning to feel more hopeful.

As this session continued, what emerged was a clear impression that Mrs B was seeing the possibility of holding my hand as a 'short-cut' to feeling safer. She wanted me to be the motionless figure, controlled by her and not allowed to move, towards whom she could crawl with the excited expectation that she would eventually be allowed to touch me. Mrs B then reported an image, which was a continuation in the session of the written dream. She saw the dream-child reaching the central figure, but as she touched this it had crumbled and collapsed. With this cue as my lead I told her that I had thought very carefully about this, and I had come to the conclusion that this tentative offer of my hand might have appeared to provide a way of getting through the experience she was so terrified of, but I now realized that it would instead become a side-stepping of that experience as it had been rather than a living through it. I knew that if I seemed to be inviting an avoidance of this central aspect of the original experience I would be failing her as her analyst. I therefore did not think that I should leave the possibility of holding my hand still open to her. Mrs B looked stunned. She asked me if I realized what I had just done. I had taken my hand away from her just as her mother had, and she immediately assumed that this must be because I too couldn't bear to remain in touch with what she was going through. Nothing I said could alter her assumption that I was afraid to let her touch me.
The following day the patient's response to what I had said was devastating. Still sitting on the couch she told me that her left arm (the one nearest to me) was 'steaming'. I had burned her. She couldn't accept any interpretation from me. Only a real physical response from me could do anything about it. She wanted to stop her analysis to get away from what was happening to her in her sessions. She could never trust me again. I tried to interpret that her trust in her mother, which had in a fragile way been restored after the accident, seemed to have been finally broken after her mother had fainted. It was this ultimate breach of her trust in her mother that had got in the way of her subsequent relationship to her. I felt it was this that she was now in the process of re-enacting with me in order to find that this unresolved breach of trust could be repaired. She listened to this, and was nodding understanding, but she repeated that it was impossible to repair.

The following day Mrs B raged at me still for what she saw as my withdrawing from her. The possibility of holding my hand had been the same to her as actual holding. She felt sure she would not have abused the offer. It had been vitally important to her that I had been prepared to allow this, but my change of mind had become to her a real dropping away of the hand she needed to hold on to. To her I was now her mother who had become afraid. Her arm seemed to be on fire. To her I was afraid of being burned too.

Mrs B told me that the previous day, immediately after her session with me, she had become 'fully suicidal'. She had only got out of this by asking a friend if she could go round to see her, at any time, if she felt that she couldn't carry on. She hadn't ultimately needed to see her friend. It had been her friend's availability which had prevented her from killing herself. She then rebuked me with the fact that her friend could get it right. Why couldn't I? I told her that she did not need from me what she could get from others. She needed something different from me. She needed me not to buy off her anger by offering to be the 'better mother'. It was important that I should not be afraid of her anger, or of her despair, in order that I stay with her throughout the re-lived experience of no longer having her mother's hands to hold on to. She needed me to remain analyst rather than have me as a 'pretend' mother. It was also crucial that I do nothing that could suggest that I needed to protect myself from what she was experiencing or was feeling towards me. She listened and became calmer. Then, momentarily before leaving the session, she lay down on the couch. She thus resumed the lying position.

I shall now summarize the next two weeks. Mrs B dreamed of

being lost and unsafe amongst a strange people with whom she could not find a common language.

I interpreted her anxiety as to whether I could find a common language with her. In one session she had a visual image of a child crying stone tears, which I interpreted as the tears of a petrified child (herself). She dreamed of

a baby being dropped and left to die.

She dreamed of

being very small and being denied the only

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food she wanted. It was there but a tall person would not let her have it.

In another dream

she was in terror anticipating some kind of explosion.

Throughout this she persisted in her conviction that she could never trust me again, and she experienced me as afraid of her. Alongside this she told me that her husband had become very supporting of her continuing her analysis, even though he was getting a lot of 'kick-back' from it. This was quite new. I interpreted that at some level she was becoming more aware of me as able to take the kick-back from her, in her analysis.

Shortly after this Mrs B reported the following two dreams in the same session. In the first

she was taking a child every day to meet her mother to get some order into the chaos,

which I interpreted as her bringing her child-self to me in order to work through the chaos of her feelings towards me as the mother she still couldn't trust. She agreed with this but added that she didn't bring the child to me by the hand. She had to drag her child-self by the hair. In the second dream

she was falling through the air, convinced that she was going to die despite the fact that she was held by a parachute with a helicopter watching over her.

She could see the contradictions (sure of dying whilst actually being safe) but this did not stop her feeling terrified in the dream, and still terrified of me in the session. She stressed that she didn't know if I realized that she was still feeling sure that she was dying inside.

On the following Monday Mrs B told me that she had dreamed that
she had come for her last session as she couldn't go on. She had begun falling for ever, the couch and the room falling with her. There was no bottom and no end to it.

The next day the patient felt that she was going insane. She had dreamed

there was a sheet of glass between herself and me so that she couldn't touch me or see me clearly. It was like a car wind-screen with no wipers in a storm.

I interpreted her inability to feel that I could get in touch with what she was feeling, because of the barrier between her and me created by the storm of her feelings inside her. This prevented her seeing me clearly, just as it had with her mother. She agreed and collapsed into uncontrolled crying, twisting on the couch, tortured with pain. At the end of this session she became panicked that I wouldn't be able to tolerate having experienced this degree of her distress.

On the Friday she spoke of a new worker in her office. She had asked him how long he had been trained. She then realized that she was asking him for his credentials. I interpreted her anxiety about my credentials and whether I had the necessary experience to be able to see her through. I added that maybe she used the word 'credentials' because of the allusion to 'believe'. She replied 'Of course, credo'. She said that she wanted to believe that I could see her through, and to trust me, but she still couldn't.

The next week Mrs B continued to say that she didn't think she could go on. She had had many terrible dreams over the week-end. The following day she again sat up for the session. For much of this session she seemed to be quite deluded. Awareness of reality was fleeting and tenuous. For the greater part of the session she was a child. She began by saying she didn't just talk to her baby, she picks him up and holds him. Then, looking straight at me she said 'I am a baby and you are the person I need to be my mother. I need you to realize this, because unless you are prepared to hold me I cannot go on. You have got to understand this! She was putting me under immense pressure. Finally she stared accusingly at me and said 'You are my mother and you are not holding me'.

Throughout this I was aware of the delusional quality of her perception of me. In this session there was little 'as if' sense left in her experience of me, and at times there seemed to be none. It was meaningless to her when I attempted to interpret this as transference, as a re-living of her childhood experience. Not only was I the mother who was not holding her, in her terror of me I had also become the surgeon with a knife in his hand who seemed to be about to kill her. At this point there seemed to be no remaining contact with me as analyst.

I reflected upon my dilemma. If I did not give in to her demands I might lose the patient, or she might really go psychotic and need to be hospitalized. If I did give in to her I would be colluding with her delusional perception of me, and the avoided elements of the trauma could become encapsulated as too terrible ever to

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I now understand this in terms of the psychic immediacy of the transference experience.

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confront. I felt placed in an impossible position. However, once I came to recognize the projective identification process operating here I began to surface from this feeling of complete helplessness. This enabled me eventually to interpret from my countertransference feelings. Very slowly, and with pauses to check that the patient was following me, I said to her 'You are making me experience in myself the sense of despair, and the impossibility of going on, that you are feeling. I am aware of being in what feels to me like a total paradox. In one sense I am feeling that it is impossible to reach you just now, and yet in another sense I feel that my telling you this may be the only way I can reach you'. She followed what I was saying very carefully, and slightly nodded her head. I continued, 'Similarly I feel as if it could be impossible to go on, and yet I feel that the only way I can help you through this is by my being prepared to tolerate what you are making me feel, and going on'. After a long silence Mrs B began to speak to me again as analyst. She said 'For the first time I can believe you, that you are in touch with what I have been feeling, and what is so amazing is that you can bear it'. I was then able to interpret to her that her desperate wish for me to let her touch me had been her way of letting me know that she needed me to be really in touch with what she was going through. This time she could agree. She remained in silence for the last 10 minutes of this session, and I sensed that it was important that I should do nothing to interrupt this in any way.

The following day Mrs B told me what had been happening during that silence. She had been able to smell her mother's presence, and she had felt her mother's hands again holding hers. She felt that it was her mother from before the fainting that she had got in touch with, as she had never felt held like that since then. I commented that she had been able to find the internal mother that she had lost touch with, as distinct from the 'pretend' mother she had been wanting me to become. We could now see that if I had agreed to hold her physically it would have been a way of shutting off what she was experiencing, not only for her but also for me, as if I really couldn't bear to remain with her through this. She immediately recognized the implications of what I was saying and replied, 'Yes. You would have become a collapsed analyst. I could not realize it at the time but I can now see that you would then have become the same as my mother who fainted. I am so glad you didn't let that happen'.
To conclude I will summarize part of the last session in this week. Mrs B had woken feeling happy and had later found herself singing extracts from the Opera 'Der Freischütz', the plot of which (she explained) includes the triumph of light over darkness. She had also dreamed that she was in a car which had got out of control having taken on a life of its own. The car crashed into a barrier which had prevented her from running into the on-coming traffic. The barrier had saved her because it had remained firm. If it had collapsed she would have been killed.

She showed great relief that I had withstood her angry demands. My remaining firm had been able to stop the process which had taken on a life of its own, during which she had felt completely out of control. The same dream ended with the patient reaching out to safety through the car windscreen which had opened to her like two glass doors.

DISCUSSION

This case illustrates the interplay between the various dynamics operating. My initial offer of possible physical contact was, paradoxically, tantamount to the countertransference withdrawal which the patient later attributed to me in my decision not to leave this offer of that easier option open to her. In terms of Bion's (1962) concept of 'a projective-identification-rejecting-object' the countertransference here became the container's fear of the contained. A further complicating pressure came from the fact that I was shortly to present a paper on this patient to our Society, and I was genuinely afraid of being exposed there as having failed had my patient left the analysis, or had she needed to be hospitalized, just prior to my presenting that paper concerning her. By offering the possibility of the patient holding my hand I was in effect seeking to lessen these risks to myself, and this is an example of Racker's (1968) concept of indirect countertransference, in that my response to the patient here was being influenced by some degree of persecutory superego being projected by me on to my professional colleagues.

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The resulting sequence can be understood in the interactional terms of Sandler's (1976) concept of role-responsiveness or in terms of Winnicott's description of the patient's need to be able to experience in the present, in relation to a real situation between patient and analyst, the extremes of feeling which belonged to an early traumatic experience but which had been 'frozen' because of being too intense for the primitive ego to encompass at that time (Winnicott, 1954b, 1963b). (See also Winnicott, 1970). There had come to be a real issue between this patient and me, in the withdrawal of my earlier offer of the possibility of holding my hand. In using this to represent the central element of the original trauma the patient entered into an intensely real experience of the past as she had perceived it. In so doing she was able, as it were, to 'join up with' her own feelings, now unfrozen and available to her. The repressed past became, in the present, a conscious psychic reality from which (this time) she did not have defensively to be psychically absent. During this I had to continue to be the surviving analyst, and not become a collapsed analyst, in order that she could defuse the earlier fantasy that it had been the intensity of her need for her mother that had caused her mother to faint.

The eventual interpretive resolution within this session grew out of my awareness of the projective identification process then operating. I am understanding this here as the product of interactional pressures upon the analyst, from the patient, which are unconsciously aiming to evoke in him the unbearable feeling state which the patient could not on her own yet contain within herself (cf. Ogden, 1979). It is a matter for speculation whether I would have been so fully subjected to the necessary impact of this patient's experience had I not first approached the question of possible physical contact as an open issue. Had I gone by the book, following the classical rule of no physical contact under any circumstance, I would certainly have been taking the safer course for me but I would probably then have been accurately perceived by the patient as actually afraid even to consider such contact. I am not sure that the re-living of this early trauma would have been as real as it was to the patient, or in the end so therapeutically effective, if I had been preserving myself throughout at that safer distance of classical 'correctness'. Instead I acted upon my intuition of the moment, and it is uncanny how precisely and unwittingly this led me to re-construct with the patient this detail of the original trauma, which she needed to be able to experience within the analytic relationship and to be genuinely angry about. It is this unconscious responsiveness to communicative cues from the patient to which Sandler refers in his (1976) paper 'Countertransference and role-responsiveness'. Winnicott also speaks of this when he says: 'In the end the patient uses the analyst's failures, often quite small ones, perhaps manoeuvred by the patient ... and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is now staged in the transference. So in the end we succeed by failing —failing the patient's way. This is a long distance from the simple theory of cure by corrective experience' (1963b, p. 258).

With regard to the recovered analytic holding I wish to add one further point. Because this was arrived at experientially with the patient, rather than by rule of thumb, it became more than just a proof of the rightness of the classical position concerning no physical contact. 'En route' this had instead acquired a specificity to this patient which, in my opinion, allowed a fuller re-living of this early
trauma than might otherwise have been possible.

I shall conclude with a quotation from Bion's (1962) paper 'A theory of thinking'. He says 'If the infant feels [my italics] it is dying it can arouse fears that it is dying in the mother. A well-balanced mother can accept these and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again but in a form that it can tolerate—the fears are manageable by the infant personality. If the mother cannot tolerate these projections the infant is reduced to continued projective identification carried out with increasing force and frequency' (p. 114f). Bion continues 'Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reproject it after its sojourn in the breast has made it tolerable to the

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-infant psyche. If the projection is not accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore reprojects, not a fear of dying made tolerable, but a nameless dread' (p. 116).

I know that Bion is here describing an infant's relationship to the breast. Nevertheless I believe that a similar process, at a later developmental stage, is illustrated in the clinical sequence I have described. I consider that it was my readiness to preserve the restored psychoanalytical holding, in the face of considerable pressures upon me to relinquish it, which eventually enabled my patient to receive her own frightened personality back again in a form that she could tolerate. Had I resorted to the physical holding that she demanded the central trauma would have remained frozen, and could have been regarded as perhaps for ever unmanageable. The patient would then have reprojected, not a fear of dying made tolerable, but instead a nameless dread.

**SUMMARY**

The patient described in this clinical presentation had been seriously scalded when she was 10 months old. At the age of 17 months she had been operated on (under local anaesthetic) to release scar tissue from the surrounding skin. During this the patient's mother had fainted. In re-living this experience, of being left alone with the surgeon who continued to operate on her regardless of the mother's absence, the patient asked and later demanded to be allowed to hold the analyst's hand if the anxiety were to become too intolerable to bear. Without this possibility she felt she would have to terminate the analysis. In considering this demand the analyst decided that it would amount to a collusive avoidance of the central aspect of the original trauma, the absence of the mother's hands after she had fainted. The restoration of the analytic 'holding', without any physical contact, and the eventual resolution of the near-delusional transference at this time in the analysis is examined in detail. The interpretation which eventually proved effective in restoring contact with the patient's readiness to continue with the analysis emerged from a close following of the countertransference responses to the patient and the projective-identificatory pressures upon the analyst during the clinical sequence described.

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