Patients who have suffered multiple psychic traumas during childhood often form an important part of all analysts’ practices. These patients enter treatment lacking the cognitive skills to get better, and their analyses are necessarily long-term, longer than typical. Early severe psychic trauma arrests the capacity for thinking in the processing sense described by Bion. The result is a kind of concreteness, an absence of metaphor, in which the analyst’s capacity for containment helps the patient to make sense of experience. Much as the mother works with the primal projections of the infant, the analyst acts as intermediary between the patient and a terrifying world of reactivated trauma. With time and process, however, the capacity for thinking emerges, led by a new capacity for metaphor. This achievement brings into focus the value of metaphor and metaphor-work to conceptualize experience and point to what is new and not yet apprehended. Clinical examples are provided to illustrate the processes described. By being alert to the presence of metaphor, even when rudimentary in form, a collaborative, co-creative process becomes possible between patient and analyst in which non-symbolized agony can be transformed into meaningful narrative.

Keywords: metaphor, Bion, trauma, mentalization
Des traumatismes précoces sévères entravent la capacité de penser, le processus mental tel que décrit par Bion. Il en résulte une sorte de pensée concrète, une absence de métaphores qui permettrait à la capacité de contenance de l’analyste d’aider le patient à comprendre son expérience. Telle la mère qui agit avec les projections primales du nourrisson, l’analyste opère comme un intermédiaire entre le patient et son monde terrifiant de traumatismes réactivés. Toutefois avec le temps et grâce à ce processus, une capacité de penser émerge sous l’impulsion de cette nouvelle capacité de métaphorisat i on. Cette réalisation met en lumière la valeur de la métaphore et du travail de métaphorisat i on pour apprécier l’expérience et souligner ce qui est nouveau, non encore appréhendé. Des exemples cliniques sont présentés pour illustrer les processus en question. L’attention portée à la présence de métaphores, même sous une forme rudimentaire, permet un processus de co-création entre le patient et son analyste et une transformation de l’an goisse non symbolisée en un narratif signifiant. Mots clés: métaphore, Bion, trauma, mentalisation

Although this is a paper about metaphor, it is also about significant psychic trauma during formative childhood years and the impact on psychic processing and treatment. My thesis, fully articulated mainly in the concluding section, is that early psychic trauma can create significant barriers in emotional processing akin to a type of concreteness. Such patients cannot know what has happened to them until there is a self that is capable of processing. The psychoanalytic time frame is necessarily long in such cases, but when unarticulated agony is converted into knowable psychic trauma, metaphors emerge to push the process forward. Metaphor, apparent in dream and speech, reaches for something new and goes beyond mere symbolization. It is the harbinger of what is yet to be fully understood. By being attuned to the presence of metaphor in such patients when they occur, the analyst can facilitate a mutual exploration that enlarges the stage for thinking and makes a more secure place for what could be understood.

To lay the groundwork, I would first like to address metaphor in general and the metaphoric process in order to situate metaphor among the principal cognitive tools available in human communication.

METAPHOR IN LANGUAGE AND PSYCHOANALYSIS
Although once considered a linguistic oddity and purely figurative device, metaphor is now recognized as foundational to knowledge itself (Casali, 2009; Carey, 2011). The turning point came when Lakoff and Johnson (1980)
published the seminal book *Metaphors We Live By*. They illustrated how metaphor is pervasive in everyday life and serves as a cross-referencing system that is inherent to thought and action. They reasoned that the human conceptual system “is fundamentally metaphorical in nature.” Hence, metaphors are obligatory in human communication, and one cannot view the history of human thought outside of metaphor. As the literary critic I. A. Richards (1965) wrote, “Thought proceeds by comparison” (p. 94).

For example, Lakoff and Johnson observed that the concept that argument is war is ubiquitous in human speech: “She shot down my argument” or “In the debate, he got massacred.” The link between argument and war is mainly preconscious, but we readily understand one in terms of the other. Such conceptual metaphors lie beneath speech and provide the basis not only in order to voice these issues but to think about them as well. How else to discuss abstractions without describing them in terms that are understandable through shared human experience? If argument is war with words, then it is understandable that aggression is mobilized, and the need to triumph over the other is paramount. Conceptual metaphors document collective human history and psychology.

Metaphor combines rationality and imagination, consciousness and unconsciousness, in a kind of word picture. It is how the abstract comes to life through being linked to known—especially corporeal—experience, which serves as the source for our first metaphors. Thus, “seeing” is a metaphor for understanding, “swallowing” is accepting, “biting off more than one can chew” refers to excessive ambition.

It is indeed the body that harbours an original perspective and represents ground zero of human experience. Hence, “up” means things are going well, while “down” designates the opposite. “Live it up” versus “don’t take it lying down” is immediately comprehensible as the result of shared body understanding. Apart from psychoanalysts who insist on the non-location of “unconsciousness,” most consider consciousness as up, while “subconsciousness” is down. When we feel “down,” everyone understands our intent. Thumbs up is good; thumbs down is bad. We are a species that prizes verticality, associating it with health and vigour, while being down, horizontal, is the position of sleep, illness, and death.

Linguistically, we employ metaphors whose origins are often lost to time and usage. If I tell someone that a certain person “kicked the bucket,” they will immediately understand that this individual has died.¹ They could

¹. In Spanish, *estirar la pata*—literally “to stretch the leg” (presumably in the coffin). In French, *manger despissenlitsparlaracine*—literally “to eat dandelions by the roots.” My
respond, “Yes I heard that he gave up the ghost.” The latter is also understandable in the sense of the spirit departing the body. The former metaphor is, however, obscure. Language tends to swallow metaphors and reissues them as common speech. In sixteenth-century England, the wooden frame used to hang animals by their feet before slaughter was called a “bucket.” Kicking the bucket referred to the animal’s death spasms.

The structure of metaphor parallels the structure of the psyche, the distilling of a stream of consciousness into tangible thoughts. Our brains, rich in associative cortex, are wired for metaphor, stitching together apparently dissimilar ideas in ever-increasing association. Neurobiologist Gerald Edelman (2006) came to the conclusion that metaphor precedes logic in that sense making is originally a process of generalization, perceiving patterns and comparing one pattern to another.

Pioneering psychoanalyst Ella Sharpe (1940) also conceived of metaphor as emerging from a psycho-physiological substrate. In this sense, she correctly saw that metaphor flows from the body to the mind and not vice versa. In the choice of metaphor, Sharpe perceived the residue of phase-specific bodily conflicts and early, even preverbal experience, which leaves its imprint on language. Sharpe contends that by studying the quality or typology of metaphors that a patient uses, the analyst can tap the core memories or experiences that are dynamically at play during a particular session.

On the other hand, the many examples she cites suggest an “essentializing” of metaphor, reducing these analogies to a single essence that has supposed universal significance. Further, although an early adherent of Klein, she works from a one-person psychology framework and misses the opportunity to invite analyst and patient to explore conjointly the subjective meaning of metaphor. In this regard, the metaphoric process is always a shared endeavour and represents the reaching for meaning that enlivens and joins the analytic couple in a shared enterprise.

Carveth (1984) turns attention to the ubiquitous presence of metaphor in the field of psychoanalysis and uncovers a further dimension of this same “essentializing” tendency in the way analysts treat their metaphors. Psychoanalysts tend to adhere so intensely to metaphors, both metapsychological and clinical, that they freeze meaning and therefore fail to perceive realities that lie outside of the metaphor assumed to be bedrock. He contrasts “live” metaphors, in which one is still conscious of employ-

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British-born grandmother spoke for years of her anticipated demise, which did not occur until she was 102: “I’ll be pushing up daisies from the wrong side,” she would say.
ing analogy, to “dead” metaphors, where the identity of two concepts is accepted as real. If psychoanalysis is at heart a metaphoric enterprise (Arlow, 1979), then it is overpopulated with “dead” metaphors, which are taken literally. Thus when Freud compared feminine to being castrated, he came to believe it no less than Kohut believed in a fragile ego capable of fragmentation. According to Carveth, the problem occurs when we “forget” that we are making comparisons to further understanding and, instead, adopt a literal perspective that is then defended as “true.”

Nevertheless, Carveth concludes that metaphor is indispensable as a tool to advance understanding by drawing comparisons, as long as there remains a place as well for perceiving difference and relativity in thinking. He underscores the need to counteract the potential reification of metaphor, constructing it as if it were “thing” itself.

Psychoanalyst Ana-Maria Rizzuto (2001, 2009) draws a distinction between metaphor and the metaphoric process. Beyond the linguistic mode, we learn to play with words and images, combining them in novel ways to clarify and express our truths and communicate with others. Metaphor aspires to a “meta” level where something can represent something else while, in the process, advancing our comprehension and ability to convey what we mean. She emphasizes that we not only communicate through metaphor but we also find ourselves through them.

In this regard, I would add that metaphors create perspective by externalizing and clarifying experience. It is only when complex emotional experience is narrated in metaphor that we can get our minds around it and begin to think. As such, the search for metaphor serves therapeutic needs for a transformative experience by reaching for what has yet to be grasped or meaningfully understood.

In psychoanalysis, temporal divisions, past and present, give way to the psychodynamic that connects them. When a patient says that she feels as if she is tumbling into a dark hole, she is offering a metaphoric description of a self-state that is at the same time linked to past traumas in the context of present triggers. The echoes of a toxic state of helplessness and disorientation reverberate in the present through the metaphor, which Arlow (1979) related to unconscious fantasy. He observed that associations to metaphors emerging in a session regularly leads to an unconscious fantasy that is particular to the patient. He found this relationship to be true whether the metaphor was groundbreaking or a cliché.

Whereas symbolization allows something to stand for something else, metaphor extends meaning in the conceptual realm. In this regard, it is teleological in the sense of reaching for new meaning (Enckell, 2010). In
practice, the analyst hears the story, resonates to the metaphoric dimension, and intuitively expands the horizon of discourse. This expansion, or better a deepening, reverberates at all levels of discourse, unearthing the deeper dimension of experience and the fantasies organizing them.

Mr. C struggled with fears of loss and conflicts around intimacy that significantly inhibited his approach to a particular woman:

“I should be rising to the occasion but I am aware that I can drop the ball. Not at my best when things don’t go well. I can be knocked off my horse very quickly. To be honest, I don’t know where I stand with her.”

For the patient, the challenge was to find the words that conveyed his experience. Loss is compared to a failure of the expected in his choice of metaphors. When he was a young boy of eight, his Canadian mother left his father in another country and moved with the children to Canada, after which he only saw his father rarely. She rationalized that this was for his father’s own good, a justification that Mr. C had accepted thereafter. It had meant to him that he should not have feelings about what had precipitously occurred or that what had happened was not a loss but a salvation. Unfortunately, it gave him no place to stand.

I note that Mr. C’s metaphors in this case are common expressions rather than novel creations. Moreover, he begins with two relatively passive metaphors—rising up and dropping the ball (what goes up is good; what goes down isn’t)—but seemingly unsatisfied, he added another—falling off a horse. The third attempt captured the fear of injury that likely better reflected what he was grappling with. In other words, it is a loss that can cause major hurt to the body self. My impression is that patients will generally continue the metaphoric search until the optimal image is found.

Moreover, some metaphors take on huge proportions in treatment, eventually assuming pivotal importance in explaining what has occurred. Mr. D, whom I treated in analysis for eight years, came to view himself as having survived a profoundly devouring and obliterating mother through a series of disguises in which his masculine essence had been kept protected in a psychic safe house deep within the recesses of his mind. He saw it as hidden under the floor and obscured even from his own self until he announced in one turning-point session, “I am here.” It was a metaphor that did not as much create hope as describe it and give it form. It arose from a tension not as much transferential as intrapsychic. If hope springs eternal (itself a metaphor), then the need to conceptualize what constitutes hope or where it can be located in the self-narrative is surely an imperative.

Yet, despite its intrapsychic urgency, the metaphor also links speaker and listener in closer alignment. In this regard, metaphor bridges narrator
and listener through a metaphoric image that both can begin to understand, although this remains a process in itself. The interpersonal element of metaphor must be similar to the communication engine that drives poetry. Indeed, there is no poem without a reader, a receptive other adding what art critic Ernst Gombrich referred to as the “beholder’s share” (Gombrich, 1960). This concept, however, does not fully capture the active collaboration between analyst and analysand in metaphor-work, as it evolves in the clinical context.

Listening to metaphor can reveal underlying conceptual themes that are not conscious and are thus easily overlooked. The analyst needs to listen carefully for the subtle, implicit image that the patient has in mind but is not really elucidating. As an example, the inhibited and schizoid Mr. C was speaking in a session of how “doomed” he felt to disclose his feelings openly with this woman he so admired and whom he found very evasive. He referred to being “bolted down,” and I inquired what precisely he was thinking when he used this description of his self-state. He noted that he imagined himself in a boat with the hatches bolted down. The air was stale below deck but he felt safe, even though the seas were rough. He observed that he feared rejection and loss but was able to laugh when he imagined himself calling to the woman who is on the deck while feeling safe from the anxiety and awkwardness that otherwise so inhibits him. He understood better that his pessimism had little to with the woman’s response and much to do with how impossibly defended he becomes in the encounter.

At the same time, the analyst’s reverie can add meaning even to the seeming banality of a metaphor. Mr. C observed that he felt he was treading water and not able to face his deep anxieties about closeness. I immediately saw a pond in my mind’s eye, with him carefully staying in the middle, paddling in place to avoid the chance of being touched. I shared this image, which led him to comment that he had made a life of withdrawal and becomes terrified when he wants to reach out and touch. Mr. C added that he had come to view me as standoffish and distant, but when I shared this image with him, he could see me differently. I commented that placing himself in the hands of another is frightening for him, and seeing me as distant removes the risk from the equation.

Here we can see how patient and analyst convene through metaphoric language. Metaphors are refined, at times discarded in favour of new, more accurate descriptions. It is a mutual construction in which past experiences are linked to the present, aiming to capture essence and create dynamic clarity and connection. Indeed, Ogden views this process as a type of
Winnicottian “squiggle game” that either invents or gives new life to metaphors (Ogden, 1997). As such, metaphor-work is interactive and at times an intersubjective process within the analytic context.

THE FATE OF METAPHOR IN SEVERE PSYCHIC TRAUMA

Psychoanalysis has tended to use the term trauma in an inclusive sense, underscoring the Freudian insight that the external event does not necessarily correspond to the traumatic impact, which is linked to psychic reality. Nevertheless, I wish to restrict attention in this discussion to “exceptionally threatening” (ICD-10), catastrophic, traumatic events, especially those experienced during childhood. These are linked to external occurrences that lead to a rupture in being for which there is no clear remedy (Tarantelli, 2003). Here, everything is destroyed while paradoxically staying intact. I want to stay close to these major traumas, as they can have a significant impact on the development of metaphoric capacity.2

Individuals who suffer severe psychic trauma often find that they have no words for the experiences they endured. It is not assimilated into verbal discourse and remains in the realm of raw events that are known but not translatable into telling (Laub & Auerhaun, 1993). This is the real problem in conceptual or abstract thinking with individuals who have experienced major psychic trauma during childhood. So much of our knowing is mediated by language, and what cannot be formulated into narrative, risks being continuously activated, causing immense emotional pain and disruption.

When trauma occurs early in life and is severe, the traumatized subject can remain stuck at the level of the actual and what Freud called “actual neurosis” where there is an experience of trauma without the verbal-symbolic representations that make it “tellable” (Verhaeghe & Vanheule, 2008). This is why the goal is not necessarily to interpret but to help the subject develop a capacity for telling. Metaphor provides a significant avenue

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2. For a thorough discussion of severe psychic trauma and its particular catastrophic effects on psychic processing, see Fernando (2009) for his important book on defences and trauma. Fernando emphasizes that trauma involves the breakdown of defences and the unavailability of primary and secondary process thinking, which would normally organize memories and make them available for symbolization, fantasy, and metaphor-work. In this regard, psychic trauma needs to be de-linked from normal development and not be conflated with it. Fernando highlights the unique “zero process” zone of severe trauma, which arises as the result of environmental impact or impingement. The link to Ferenczi’s conceptualization of psychic trauma is evident in his work, where the dangers facing the child are deemed real and serious (Dupont, 1988). This coincides with my focus as well in this paper.
towards representation and narrative, as it necessarily separates describer from description. The subject reaches for the description and must bear at least a moment of perplexity before the metaphor emerges from mind. The achievement of metaphor can be palpable. It is always a relief to communicate, and what better way to bridge solitudes than by conveying a novel experience in familiar terms.

It is not surprising that severe trauma may have a limiting effect on the ability to use language to explore emotions and experience through the metaphoric process. The extreme fear of retraumatization in such patients would seem to encourage a defensive reliance on concrete thinking apart from any developmental tendencies.

The mechanisms generally used to defend against traumatic re-enactment, including dissociation, detachment from others, numbing, or emotional blunting and avoidance, occur because there is no capacity to tell or no confidence that the other will hear. Trauma, in this regard, is a relational disturbance apart from a purely psycho-economic one. The traumatized subject is always at base alone with his trauma as the result of a rupture with otherness. This underscores in my view why the other is essential to the cure. Indeed, if one focuses on the symptoms of PTSD, including its chronic form, the characteristic detachment and avoidance might be less a result than a predispositional cause of the disorder in the first place. In other words, traumatic syndromes replay an earlier moment of breach between self and other that remains mostly unhealed with the threat of reinjury a hair’s breadth away.

The concreteness of individuals suffering from early trauma reflects the failure of alpha function. In Bion’s terms, “alpha function” is the substrate for thinking, dreaming, and memory in support of the reality principle (Brown, 2012). Bion views this as a pre-psychoanalytic concept to document how thoughts give rise to the necessity of a thinker to process them. Beta existence refers to life on an intense raw, sensory affective level without the need of a thinker, where internal tensions are evacuated or projected rather than processed. The subject, in this case, is likely to fear emotional

3. Beyond cases of explicit abuse, Ferenczi understood that trauma was often less about wrongdoing than a critical absence of response from the caretaking other, leaving the traumatized child radically disconnected from human responsiveness and unable to sustain life-promoting forces (Ferenczi, 1929). Traumatized patients often highlight a world constituted around aloneness, where numbness and dissociation offer the only reprieve from chronic emotional pain or where adrenalin substitutes for eros (Gerson, 2009). It is this gap or void that both defies representation and yet is all that the traumatized subject needs to symbolize and communicate.
experience and will create an impenetrable barrier against feeling. Bion refers to this barrier as a “beta-screen” (Sandler, 2005). This is certainly descriptive of severely traumatized patients who defend against feeling, especially feelings that could trigger the dreaded exposure to trauma.

Dreams, in the case of psychic trauma, often lack associations. Such patients tend more to hallucinate dreams, which are often nihilistic and disastrous; they are states on the edge of non-being. The patient will not be able to “dream” the session or facilitate the analyst’s free-floating reverie, so essential to the analyst’s alpha function. In other words, the subject will lack the means to create visual and verbal images (i.e., metaphors) with which to describe experience. Impaired alpha functioning prevents the patient from dreaming, waking, sleeping, or retaining an unconscious realm, according to Bion (1970).

This concrete state of thinking is also reminiscent of what Marty, d’M’Uzan, and David (1963) referred to as “pensée opératoire” reflecting a lack of mentalization capacity, little to no use of metaphor, and impoverished fantasy life. This was observed to be a specific risk factor predisposing the individual to illness. Besides the cognitive and affective disturbance noted in these patients, Krystal (1997) also observed a severe inhibition in self-soothing and self-regulation in this population. In particular, for our purpose, this concept of “pensée opératoire” highlights those states where the self does not become fully psychical. Early psychic trauma leaves the subject in the hands of the external world, while the self, and in particular the body, is experienced as a site for agony.

There is also a failure of the past to be past as it is lived in its primal, undigested, and “actual” form rather than processed mentally. Lacking full psychical capacity, the severely traumatized subject cannot join time or be inserted subjectively in it. Thus, what is “actual” should not be confused with a capacity to live in the present (Scarfone, 2006). Traumatic affect in this sense has no history and is always “actual,” with a penchant to being actualized. In this way, severe psychic trauma not only severs the subject from an enlivening world of which he is paradoxically still physically a part but also from being in time with its myriad opportunities to rework the past and chart a future. Indeed, our ability to occupy the present is likely dependent on a dynamic capacity to process and reprocess the past. Hence, the severely traumatized subject is caught in the particular timelessness of chronic repetition.

When the analyst can bear the load of the patient’s projections and maintain an empathic presence during regressive, traumatic moments, the capacity for symbolization can begin to emerge. It is the dream that
often anticipates a higher level of symbolic function and the emergence of an alpha function capacity. This is heralded by the stimulation of the analyst’s interpretive work. The value of the dream in supporting mental health is unmistakable, as is the analyst’s freedom to interpret, which reflects a growing confidence that the patient can be counted on to think or process for himself. Memories are then freed from traumatic, repetitive fixation, and a living past emerges.

Behind this remarkable evolution in alpha functioning is the capacity for metaphoric thought, which in itself reinforces dream life. In this regard, metaphor and the metaphoric process prove to be an essential element in thinking and by no means a simple literary device. Here we can appreciate most clearly that the development of alpha function is related to the internalization of the interactive dream team that comprises analyst and patient. Psychic capacity emerges from the analyst’s willingness to “think” the session on the patient’s behalf in eventual anticipation of the time when the patient can “dream” the session autonomously (Bion, 1962b).

Thus, the path to metaphor-readiness is by no means a simple dialectic to be contrasted with concreteness. Indeed, concreteness itself is highly complex, particularly when seen clinically, as much as it often reflects underlying defensive and regressive forces in the face of overwhelming anxiety and dread. Moreover, it would seem evident that concreteness suggests a specific breach or rupture with otherness in which the conditions for linking and symbolization do not exist. Hence, what Bion called “nameless dread,” often linked to primal trauma, actually represents a failure of maternal reverie in which annihilation anxieties are intensified, projected, and re-internalized as dread (Bion, 1962a).

Such unmitigated dread can only be repeated or evacuated, as it cannot be represented and, therefore, thought about. Indeed, the inception of thinking, marked by a capacity to represent experience, including the use of metaphor, highlights the slow-to-achieve analytic dividend in such cases of severe trauma. Pure formless agony can finally be represented psychedically and made available for thinking. In this regard, thinking accelerates problem solving and fosters emotional development as well as being dependent on it.

Let me now turn to a case to illustrate. It is typical of a genre of analytic patient who requires much longer treatments than typical.

**BARBARA**

Barbara, 61, first came to see me 20 years ago, and we began to work in twice-weekly sessions. She is married to a successful chartered accountant
and has no children. Barbara has a teaching qualification, but when we started treatment she had been unable to work. Her husband, she feared, was losing patience, and she found herself in a regressed, dependent state in their relationship. Their sexual life had ceased. She felt that she was barely surviving as a person.

Barbara could not tell me what was wrong. There was a paucity of words and descriptors for her suffering. It was not long, however, before I began to receive urgent calls from Barbara between sessions. There were no words after introducing herself on the phone. Silence was followed by a profound, primitive wailing until I could make some affective contact with her and put words to her terror. This required me to connect the strands of her life that had emerged in sessions. I became a receptor and interpreter, deciphering the blood-curdling sounds of panic and returning these archaic non-verbal projections in manageable experiential form.

Her primitive agonies lacked any symbolization. I had the impression of a helpless infant or the aphasic patients I used to see in the hospital whose brains no longer allowed them to form or think in words. Sessions were often a transcribing experience—putting meaning to sound and helping her articulate what occurred.

When Barbara could review her history, what stood out were a series of six surgeries on her eyes and a leg between 4 and 10 years of age. She required surgery to treat a congenital Achilles tendon malformation, as well as surgery to correct ocular damage caused by strabismus and anoxia. She could recall a terrified and catastrophic state during these procedures. The terror of not knowing her fate, the felt absence of her parents, the lack of perceived empathy from staff all contributed to a scene of horror, which had done profound damage to her psyche. It was much later that she told me of waking from her first eye surgery at four years of age with patches over both eyes and her hands tied to the bed rails.

What struck me repeatedly about Barbara was and absolute concreteness in an otherwise intelligent woman. She was unable to metabolize or process affective experience on her own. She often had no idea what she was feeling. Her dreams were stark and lacked elaboration: she was divorcing her husband; she was dead; something sexual with another jolted her into terrors of separation from her husband. Shifting scenes lacked any thread of connection, more like snapshots than moving pictures. I had the impression of being present in function more than in person. She did not seem to see me.

Three major themes arose during treatment that elaborated or contextualized the trauma. The first was a primitive guilt, which she experienced
as a terror of separateness or aloneness. Any “good time” in life created distance from a damaged maternal introject with whom she had to stay in total contact. Hence, she would be shaken into a state of fear and a clamping down on pleasure. The second theme centred on a fear of merger with a maternal object associated with suffocation and claustrophobia. Her recourse was to hate her mother in a way that kept her psychically separate but not so autonomous as to provoke terrors of isolation and absolute aloneness. The third theme evolved later around her husband’s passive sexual fantasy that triggered thoughts of being sexually dominating and acrobatic in bed that frightened her because of its connotation with autonomy and strength. Strength could alienate her.

Barbara’s mother appeared to be an emotionally frustrated woman who had been very sportive in her youth and had married a schizoid but athletic partner. They were great sportspersons during their youth, but the marriage was seemingly quite empty and unfulfilling, for her mother in particular. Her mother complained once to Barbara of her husband’s lack-lustre sexual performance and spoke of having wanted to leave him. It was by all accounts a disappointing union. Barbara viewed her mother as unfulfilled, highly negative, depressed, and easily overwhelmed.

Barbara could make little distinction between dreaming and waking life, apart from fearing that her dreams were premonitory or clairvoyant. She worried intensely about breaks and disruptions in the treatment and initially found weekends difficult to endure. She clung to the therapy but used it to claw her way back into her marriage and teaching career. Barbara’s discourse remained locked by past trauma, with no real capacity to reach for new understandings and new levels of synthesis. Metaphor thus had no place in her speech, as there was no grappling with what she could become or what she could think. Patients like Barbara remain in full-time damage control.

As her capacity for thinking evolved, however, dreams became more interactive and narrative. Nevertheless, associations were meagre at the onset of this change, and she could not link the dream to her life. On the other hand, trauma-fuelled regressions became more focused on medical exams and procedures. In other words, traumatic triggers came into clearer focus and became more specified as the zone of trauma decreased.

As she progressed, memory itself evolved from general to specific. Memories erupted in sessions with startling freshness, such as lying on a hospital gurney outside the operating theatre, or an event in which the nurses refused to call her parents when she told them she was lonely and scared. I was obliged to intervene with her family physician when she arrived for
a medical appointment only to find that a complete physical exam was planned. The lack of warning was highly stressful for Barbara and she had dissolved in tears, much to the distress of her pragmatic physician.

The evolution in her capacity to think, in the Bionian sense of psychic transformation, was notable. Nameless states of dread and tension along with single-frame dreams gradually gave way to more articulated experience. Her capacity to process psychic material evolved. Whereas thoughts of her mother initially caused panic and a sense of impending doom, Barbara was able to feel sympathy for her mother and express regret that her mother missed having a satisfying adult life. She took comfort, however, in old photos of her mother frolicking as a teenager and young adult at the family cottage.

In general, I have found no particular need to fully separate the dream from other narrative material, as both registers can plumb the unconscious dimension. In this regard, metaphor, whether in speech or dream, paints pictures and is stimulated by the subject’s reaching towards new comprehension. This stands in contrast to the vertical tunnel of trauma in which there is a “no-thought” zone, filled instead by highly charged, overwhelming rawness. As the tunnel of trauma retreats, however, the mind is freer to think and process. This realm of “no-thought” is reminiscent of Fernando’s description of “zero process” (Fernando, 2009).

Illustrating her normalizing dream capacity, Barbara recently reported a dream. She could not remember too much but recalled that there was “broken crystal” of the Czech variety. In other words, it was fine crystal. She had several associations but recalled that it was a bowl or container of some sort. Her mother-in-law, who had just died, collected this glass, and Barbara saw the image as a metaphor for death. Barbara had felt contained by her husband’s family. Her mother-in-law’s recent peaceful death contrasted to the violence and turmoil of her own mother’s cognitive decline and death. Barbara was accepted into the family by her frequently caustic mother-in-law and, despite some caution, had always felt held by her. Here, Barbara was able to use the dream to elaborate, associate, contrast, and compare. This is the hallmark of alpha functioning: a bedrock mental capacity for higher level associative work that incorporates memory, affect, and cognition through the evocative power of metaphor.

It was this type of therapeutic experience that made me aware that at these moments especially I was functioning as an analyst with Barbara and that she was taking her place as an analytic patient. In other words, the burgeoning alpha function corresponded with an internalization of a containing and therefore processing dyad. This is not to imply that
Barbara’s concreteness and narcissistic vulnerability were not still a factor. Nevertheless, moments like these revealed an exit from the solipsistic state of trauma that had cut her off from communication of foundational trauma that had held her in its grip for so long.

I would like now to sketch the outline of a second case to illustrate the moment the analyst becomes aware of the prior absence of metaphor.

**JIA**

Jia suffered from severe rage attacks that stem from acute underlying toxic states of traumatic helplessness and vulnerability. These can still bring out the worst in Jia: bilious, raging cruelty in the eyes of her family that are lived out in states of pure trauma. She is married for the second time and has three children.

The patient reported that her family had made a harrowing escape from her native country and relocated in Canada when Jia was 9. Her mother had also suffered imprisonment and severe abuse in her own teen years as a result of political oppression. Having arrived in Canada and settled into their new life, her mother died of ovarian cancer. Her father remarried within 10 months and then violently committed suicide a year later by throwing himself under a train. Jia was 17 years old. Later, Jia pieced together that she was often alone while her parents, newly arrived in Canada, focused on survival, immigration, work, and integration into a new life. Jia remembered serving as translator and guide, particularly for her mother, who spoke no appreciable English.

Jia has an older half-sister, their father’s child by a first wife who was murdered during the time of political oppression. This sister was deeply ambivalent about Jia, partly sibling rivalry but mainly, I speculated, unresolved envy over Jia having a mother who survived. The sister was particularly harsh, rejecting, and unsympathetic.

Jia’s memories focused on a specific incident before the family escaped to a refugee camp. When she was seven years old, tanks rolled past Jia’s home. The family fled to a basement hole used as cold storage. Jia fell down the ladder in the dark and then crouched with her parents, hearing the tanks and shooting outside. It was a moment of panic, but what stuck in Jia’s mind was the helplessness or impotence of her parents at that time to protect her. She was on her own. It was the moment that the external world impinged abruptly and totally and pushed her violently out of her own psyche.

The sisters travelled by carts under hay to avoid detection, separately from their parents. When they were reunited, Jia’s mother was openly
terrified that they would be tricked and led back into the hands of the government.

Jia’s mother’s death, and especially her father’s sudden suicide, completed the circle of trauma marking her childhood. Nonetheless, Jia recalled thinking that she would have her own family someday and this would reconstitute a family unit. Meanwhile, she completed high school and most of her university training in education. Her personality is strong, determined, ambitious, and naturally assertive.

I will not attempt to provide exhaustive details of what has been an attempt over many years to keep Jia afloat and mend her broken, traumabattered psyche. There have been many recurrences, all extremely hard for her and her family to bear. In particular, I would highlight her divorce from her first husband that was calamitous, as was her reaction whenever her children left the city for school or work.

Jia’s life improved much faster than her capacity to defuse the undermining impact of trauma. Nonetheless, she is a much more stable and insightful person now, but chronic psychic trauma has been decidedly limiting. To this end, I recommended two years ago that Jia try Eye Movement Desensitization and Reprocessing (EMDR), an emotive treatment specifically designed for psychic trauma, as an adjunct to our sessions.

I believe that the addition of EMDR helped Jia in the short term. It did not reduce the frequency or intensity of traumatic episodes, but it did seem to strengthen her capacity to think in our sessions. My impression is that Jia’s meagre self-analytic capacity had been taxed to an extreme in the analysis and that the addition of the exposure and abreaction-based EMDR treatment shared the load at a critical moment, much as the adjunct use of psychoactive medication might liberate a therapeutic couple to work more effectively. Jia reported that she became less overwhelmed by the raw disruptive power of intrusive traumatic experience as a result. Nonetheless, she stopped on her own accord after approximately six months of biweekly sessions.

One day, Jia used a metaphor to describe her traumatic reaction: “It is like an overloaded electrical circuit in my brain that explodes.” I reacted, shocked into new awareness. What struck me was that in our years of treatment, Jia had never used any metaphor to describe her state of mind when overtaken by trauma. Equally remarkable, Jia reported that she had experienced a nightmare in which she was being raped. Dreams were reported rarely, and in this case the metaphor and the dream were linked in her narrative.

I commented, “When you can imagine your trauma being like an overloaded circuit, it gives you a way to think about what has happened; then
you can have a dream about it as well. Your words and your dream help soak up the trauma.”

Jia was puzzled but understood that she had never been able to describe what she experienced, as the reactions simply overwhelmed her capacity to think. In other words, she could not get her mind around the traumatic affect, which was exploding in her mind. The trauma swallowed her whole. It was this extraordinary change in position that seemed noteworthy, and I was aware of what had preceded it only when she used this simple, almost hackneyed metaphor.

Jia progressed to finding more words for her experience and I experienced the power of narrative to absorb traumatic affects and facilitate processing.

“I have no filter,” Jia said. “I go from zero to death; it is like the end of the world.” It reminded her of death, pain, and suffering. “It is a fight to the death,” she added, “a feeling that I cannot bear to be hurt.” Jia realized that when she enters this traumatic zone, she speaks for the seven-year-old stuck in a war zone. She added details that she had never previously mentioned: she had to leave the safety of the cellar to have a bowel movement, and her parents also made her go up to get washed. It was terrifying to leave the protected hole beneath the house. When the family escaped her country, she knew too much about what was happening and carried money for her family. Jia reflected on the power of her trauma and its refusal to be relegated to the past.

WORKING WITH METAPHOR
Metaphors begin with words but end with images. These images, free of logical connotation, can expand meaning. There is an enormous advantage gained when an individual can actually “metamorphize” experience, particularly when it is otherwise hard to express. What alerts the analyst to the occurrence of something novel is that his reverie focuses on the image painted by the patient’s words.

Jia’s use of a simple metaphor, an explosion in her brain like an overloaded circuit, says much about her trauma. Metaphors are not chosen by accident. Explosions bring to mind the shelling in a war zone, her life being ripped apart by her father’s suicide on the heels of her mother’s death, and the explosion in her first marriage when her husband insisted on ending their union. Her life being blown apart reflects a faulty apparatus damaged by having to bear the unbearable. In this regard, Jia’s trauma is of the explosive kind inasmuch as there is no forewarning to prepare.
Metaphors emerge as the patient reaches for understanding and communication. As the subject finds his or her own analytic rhythm, the session serves as a tableau painted through word and image. The analyst hears but also sees, not only in the metaphoric sense of understanding but also in the pictures created by metaphor. The analyst can use the metaphor as a springboard to expand and deepen reflection. It is important, however, for the analyst not to assume what the metaphor means. Understanding and working with metaphors is a constructive process that takes place in the analytic working-through.

Part of this process includes paying attention to the choice of metaphor, which can carry over-determined signification. As an example, Mr. R, a thoughtful but self-suppressed man, was transfixed by a phrase in a book he was reading: “inextinguishably proud.” When I asked what it meant to him, he spoke of loyalty and commitment to a pathway and added, “to paddle your own canoe.” The compelling image of the canoe was infused with personal significance in his case. The hunger for pride was in effect the hunger for identity that had been in perpetual danger of being eclipsed since childhood, weighed down by a wet blanket of guilt-infused compliance. Metaphors are more than descriptive devices; they shape how we think and view the self. Hence, the image of competence and self-sufficiency conveyed by the solo paddler captured precisely what Mr. R was trying to discover and communicate. It fit well with how he conceptualized his ideal but also conveyed the struggles he had with partnership and relationship. There was no bow and stern working in close alliance to reach a shared goal.

Without metaphor, the subject is forced into a concrete world where new learning can be hard to come by. If we can speak about things only as they are, how can we comprehend what we do not yet see?

I am not suggesting an exclusive place for metaphor in the patient’s discourse. Rather, I propose that when the analyst’s reverie latches to the metaphor, a complementary process may be occurring in which speaker and listener co-reach for understanding through metaphor. The pictogram of metaphor can be compelling and can tell stories not consciously recognized by the patient or the analyst. Metaphor, in this regard, creates an immediate role for the listener that can enliven the analytic field towards mutual discovery.

Hence, when the patient uses a metaphor to describe an experience, the analyst brings a personal contribution to the process. It is the reciprocal interaction then that elicits potential meaning useful to the analytic work.
The presence of metaphor stands in contrast to discourse devoid of metaphor. Trauma cycles repetitively with no opportunity for transcendence. The effects of de-symbolization create an impasse in which one cannot know what has been experienced, even if, at the same time, paradoxically, the traumatic event(s) plays out endlessly in compulsive repetition. The patient experiences intensely but cannot think through the moment.

For many years, Barbara was totally dependent on my making sense of her inner world, which she experienced as alien and threatening. She was constantly at risk of merging with a defective, life-suffocating, maternal object, and this terrified her. She needed and relied on her hatred to maintain separateness, and this became a necessity of her psychic stability. When Barbara lost this vital autonomy from her mother, I had to remind her to hate.

It is through patients such as Barbara that one can appreciate the alpha function of the mother in her reverie (Bion, 1962b). For the analyst, this includes being aware of our thoughts, feelings, and fantasies, or whatever other experience catches our attention when treating the patient (Ogden, 1997). This use of reverie is highlighted in the treatment of concrete patients. It describes the port of entry into the apprehension of reality and how, according to Bion, the mother translates or transforms sensory data and emotions into thoughts. Otherwise, the subject is bombarded by undigested experience, and living becomes quite frightening.

This is precisely how I would describe Barbara’s dilemma. In Bion’s terms, she could neither sleep nor wake, which require alpha elements, the building blocks of dream-thoughts. Her dreams were treated as “things” that had happened or were about to happen. She feared death, madness, divorce, or any symbolic equivalent for the trauma that framed her life. She could feel better through the holding intervention of the analyst but she could not make meaning on her own terms. In this regard, the intersubjective roots of metaphor-work had yet to evolve or had failed to evolve from the natural context of human attachment and relatedness during childhood (Benjamin, 1990).

So much of verbal discourse between patient and analyst takes the form of trying to acquire the shared metaphors that will best capture the

4. In Bion’s words (1962a, p. 21), “The idea seemed to illuminate sometimes but became dynamic only when I related it to defective alpha-function, that is to say that when it occurred to me that I was witnessing an inability to dream through lack of alpha-elements and therefore an inability to sleep or wake, to be either conscious or unconscious.”
patient’s experience and help reveal its dynamic underpinnings (Ogden, 1997; Ingram, 1996; Meares & Anderson, 1993; Reider, 1972). Finding the right metaphor to characterize an experience can be a painstaking process for patient and analyst that takes place in the background of the analysis.

Jia demonstrates the kind of psychological “locked-in syndrome” that characterizes patients whose life has been de-symbolized by trauma and reduced to raw experience. Surviving the unbearable became the focus of her life, despite her accomplishments. What made the appearance of the metaphor so powerful was that it was unprecedented in her discourse. It represented a shift that allowed a traumatic dream to emerge. Metaphor and dream both have the capacity to absorb traumatic affects and promote thinking. Compare this development to her previous survival strategy, which was to attack the other, with the slim hope that she might be heard and understood.

Jia had long underscored the importance of feeling safe in her therapy, but this had not translated into the type of internalization that kick-starts alpha function. The overwhelming of what Freud (1920) labelled the Reizschutz or “protective shield” underscored the rupture of the guaranteeing function of parental containment. This is the essential condition for alpha function to evolve, pointing to the fact that alpha function is a developmental achievement inextricably linked to the original maternal dyad (Brown, 2012; Benjamin, 1990).

As an element of psychoanalysis, containment in cases of severe trauma appears to work much more slowly than it does in normal development. Annihilation terrors are omnipresent, leading to almost exclusive reliance on mechanisms of survival such as externalizing, detaching, and numbing defences. Hence, at the outset, emotional processing is next to impossible, as if the elemental, containing human other must, in some sense, be reintroduced. Only then can thinking evolve with its dividend of metaphor. This is well illustrated by both Barbara and Jia.

Finally, it is not uncommon for severely traumatized patients to dream of marital or family dysfunction and other traumatic events (Laub & Auerhahn, 1993). Hence, the dream of rape is not atypical, nor was Barbara’s recurrent fear of divorce.

CONCLUSION
New meaning is found in the open space created by metaphors that suspend the literal meaning while reaching for a second unrealized signification. This is what creates the possibility of new understanding and new experience. Metaphor grasps for something beyond.
Before full conceptual maturity has evolved, severe psychic trauma can leave the individual tied to concrete representation, unable to reach beyond. In this state, meaning cannot budge from traumatic fixation, and the transcending function of metaphor fails to evolve. In this regard, the absence of metaphor stalls forward movement, which is another way to restate the problematic of psychic trauma, especially in the cases and context I describe. The après coup of trauma invades the present and prevents the future.

As Winnicott (1974) implied in “Fear of Breakdown,” what took place in the past as a primitive agony beyond representation can become psychic only when there is a subject capable of thinking about it. In the sense I am proposing, the patient’s ongoing susceptibility to trauma moderates only when she can “know” what has happened to her.

Paradoxically, as much as the individual might experience the reverberations of trauma, there is no immediate capacity to construct a relation of meaning between what is occurring and what happened. Here, I am not referring to a reassignment of meaning to the past (Nachträglichkeit) but rather to an original assignment. What precedes knowing is precisely what Winnicott calls primitive agony, an experience that occurs before there is a subject able to process it. It is the “subjectifying” of the analytic experience that enables the individual to have a past and thus to have a future. This subjectification depends on the internalization of a facilitating containing relationship. The risk of psychic fragmentation and impaired capacity for abstract thinking persists until this arrestment can be addressed. The capacity for metaphor is a direct benefit of this achievement.

Psychoanalytic treatment time in this patient group is longer than for most analytic patients. They come into analysis lacking the means to get better. However, when the necessary self-development occurs, progress is made. The patient reaches for the analyst, who can now acknowledge the helplessness of the traumatic experience but also represent what happens after. Importantly, the patient begins to tell the story as if for the first time, with the benefit of metaphor. A montage is created. The analyst joins in the construction, and gradually an image appears. What emerges is a self-portrait, an impressionist image constructed of a meaningful past pointing to the future. Analyst and patient can begin to apprehend what comes next.

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