

UNDERSTANDING THE TRAUMA OF RACIAL VIOLENCE IN A BLACK PATIENT

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ABSTRACT Racial violence arises when infantile anxiety and hatred of 'difference' or 'otherness' become too unmanageable within the self and are displaced into the racial arena via splitting and projective mechanisms. The body of the 'other', particularly skin colour differences, becomes a salient target for locating and attacking these feared and unwanted aspects of the self.

Those on the receiving end can experience a profound attack on their identity, with feelings of rejection that can result in a severe narcissistic blow, puncturing and even shattering the individual's psychic skin and existing defensive organization. This failure of containment can send tremors throughout the psyche to some of the most vulnerable areas in individuals functioning, giving fresh life to both oedipal and pre-oedipal anxieties to do with separation and loss.

Where these early anxieties are felt to be unbearable, the individual resorts to encapsulating them in a portion of their mind, effectively sealing them off from conscious awareness or access, but they are unconsciously re-enacted. A case study aims to describe some of these phenomena.

Introduction

When the capacity to tolerate and relate to others who are racially and culturally different from us breaks down, the result is often racial violence. Like any traumatic event, racial violence can rip apart our physical and psychological well-being and bring to the surface our deepest anxieties and fears. However, what it exposes in the deeper layers of the personality will vary from one individual to the next which is the subject of this paper. It describes a rather unusual case of a black man's early experience of racial violence perpetrated by his black father, what this exposed in the deeper layers of his personality, and how some of the dynamics of this early experience were re-enacted in the transference relationship in the course of his treatment.

A Model of Trauma

Freud (1920) used the metaphor of a membrane or psychic skin to understand the impact of a traumatic event. This skin was thought to act as a protective layer or shield around the mind which could be violently pierced

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by an overwhelming event, breaching the walls of the psyche and throwing the mind into disarray.

An initial impact is thought to flood the mental space with the raw contents of the event and force the individual to regress into a prolonged state of helplessness, accompanied by the most intense fear of annihilation, anxieties that are characteristic of the earliest stages of infancy. If the impact is so sudden and violent, there is literally no time to think because the capacity to think is 'smashed up'. Inner and outer realities have collided in such a way that the sheer intrusion damages the capacity to discriminate between what belongs to the inside and what belongs to the outside. This means the capacity to symbolize the event in its proper context of time and space is disrupted, a capacity which would ordinarily enable one to think about the event rather than become enmeshed with it.

This disruption is portrayed in severely traumatized patients who often 're-live' the experience in a concrete way, while talking about it as if they are experiencing it at that very moment and are unable to separate the past from the present.

What we witness in such patients is a breakdown in their existing mental organization, amounting to a failure of containment because their mind is damaged, a type of failure that will trigger some of the earliest experiences of failures of containment in the maternal situation. The traumatic event will touch and link up with specific fears and phantasies in the internal world and transform the external event into a shape that is recognizable as an existing form of internal object relationship (Garland 1991).

For example, a violent event can be felt as though it has happened internally, mirroring the external situation, giving fresh life to primitive anxiety and fears. A patient reported how the door of a cupboard opening abruptly led to her curling into a ball, reminiscent of her childhood when she tried to protect herself from her mother's violence. She was convinced and terrified that her mother's hands and feet were hitting her. This patient was terrified of disciplining her children out of a fear of becoming like her violent mother, so much so that the mere act of raising her hands felt to her as if they were her mother's hands.

Because of the anxiety associated with traumatic events, the experience is often encapsulated in a portion of the mind, unprocessed and blocked from conscious awareness, as a defence against acknowledging more primitive anxieties such as the fear of being annihilated. It has been amply observed and documented in those who have suffered from massive external traumas such as in post-traumatic states in Vietnam veterans (Smith 1986) or victims of external disasters such as the Kings Cross Station fire and the Zeebrugge ferry disaster (Garland 1991), amongst others. Encapsulations have been thought of as psychic capsules, a protected psychic space, within which the traumatic experience and the associated pain and defences are repeatedly re-enacted (Hopper 1991).

However, the study of encapsulations stems from work on the mechanisms of disavowal and foreclosures, processes by which a traumatic event is both perceived and registered but, through mechanisms of splitting and denial, the experience remains unavailable at a conscious level. In fact, Freud (1918) first introduced the concept of disavowal to explain the main features in the case of the 'Wolf man' in his discussion of fetishism. Encapsulation phenomena has also been thought to mask deeper and more complex difficulties such as delinquency and perversions (Limentani 1989).

Primitive annihilation anxieties (Klein 1946) have been variously described as 'primitive agony' (Winnicott 1974), 'nameless dread' (Bion 1962) and 'aphanisis' (Jones 1927), and are thought to be more basic than the 'paranoid-schizoid' anxieties associated with initial splitting processes. This type of anxiety refers to the situation where persecutory feelings and primal depression are both intertwined and undifferentiated. It has been suggested that the fear of being annihilated is connected to an early experience of absolute helplessness and failed dependency, following a catastrophic loss. When the infant is in an unintegrated state of mind, undifferentiated from his mother, the experience of a traumatic break from the mother is likely to be experienced in terms of a loss of parts of himself (Hopper 1991). For example, a loss of the breast can be experienced by the infant as a loss of his mouth if he has not differentiated between the two.

A loss of this kind at this stage of development is likely to be associated with the experience of utter chaos or a sense of nothingness or meaninglessness, often expressed in the sense that one is falling into a 'black hole'. Patients who experience these sensations often speak about falling into 'bits and pieces' or 'leaking out'. In order to ward off these anxieties, various attempts are made to maintain a sense of feeling held or contained in order to replace or establish a skin and membrane that would enable a sense of being held within a skin boundary which might have failed. An early experience of severe and cumulative trauma resulting from failed attempts to make relationships with mothers who are perhaps uncontained and depressed themselves, and therefore emotionally unavailable to their infant, have been strong factors in patients with this type of fragility (Hopper 1991).

This early attempt to hold one's mind together is also elaborated in Esther Bick's (1968, 1986) work which suggests the crucial role of the skin in containing the infant's catastrophic anxieties in the earliest phase of development. In this preverbal period, parts of the personality are felt to have no inherent binding force that keeps the contents of the mind together and fall apart unless passively held together, by the skin functioning as a boundary. For example, in the unintegrated state, the infant's search for containment leads to a frantic search for an object, be it the mother's voice, her smell or nipple which can focus the attention and thereby be experienced as holding the parts of the personality together. In other words the containing object is experienced concretely as a skin. However, the internal function of

containing parts of the self is dependent on the introjection of an external object that the infant experiences as being capable of this function. Only then is the stage set for the development of a notion of an internal space within the self which allows the construction of a good object to take place via further introjective processes.

An early failure in this type of 'skin containment' leads to pathological projective identification (Klein 1946) which takes the place of normal introjection. The result is a confusion of identity and persistent states of unintegration. This failure to distinguish between self and object in separate skins leads to what Bick refers to as a 'second skin', a substitute structure or prosthesis through which dependence on the object is replaced by pseudo-independence.

Her use of the term 'adhesive identification' refers to a form of attachment to an object in which there is a failure of both introjective and projective processes, rather more like sticking to the surfaces of objects than connecting to them in any depth or meaningful way. In patients with this type of internal structure, experiences of separation and discontinuity are felt to be a catastrophic experience resulting from the feeling of being torn apart from the skin of the other and falling into an unknown space.

The hypothesis of the 'second muscular skin' is also reminiscent of the 'character armour' formulated by Wilhelm Reich (1949), Rosenfeld's (1987) work on 'thick' and 'thin' skin in narcissistic disorders and Meltzer's (1975) work on the 'adhesive personality', while Bick's notion of the 'first skin' corresponds to the concept of the 'skin ego' formulated by Anzieu (1989) who suggests that the 'second muscular skin' is usually overdeveloped when it has to compensate for serious deficiencies in the first containing skin.

In fact, in his 'Project for a scientific psychology' Freud (1950) suggested a dual layered structure in the ego which acts as a 'protective shield' against stimulation, whose origins lay in the mother's capacity as an auxiliary shield for the infant until the infant is able to take over that function. This concept has been developed by Khan (1963) when he describes the use of the mother as an 'auxiliary ego' and by Bion (1962) as the notion of 'maternal reverie' which helps the infant contain excessive anxiety.

The Dynamics of Racial Violence

A relatively coherent sense of oneself, a comfort within one's own physical and psychic skin, is what is precisely at stake when an individual is at the receiving end of racial violence which can involve anything from verbal harassment to an outright physical attack.

Racial attacks are primarily driven by a perception and anxiety of 'difference' or 'otherness'. The category of race is falsely but closely associated with skin colour (Sherwood 1980; Kovel 1972) which is one of the most visible differences that can get seized upon. In that sense racial attacks have

nothing to do with race as such since it is a category that has no scientific or explanatory value in itself (Rustin 1991). What is under attack is what the notion of 'difference' or 'otherness' represents in the unconscious. It is essentially rooted in the recognition of dependency on and separation from the maternal object. This means that a constellation of anxieties within the maternal situation such as feelings of helplessness, loss of control and annihilation anxieties which are hated are likely to be triggered by 'difference'. Skin colour appears to be the visible sign of this situation. The types of anxieties experienced will vary from one individual to the next, but what is common is the wish to evacuate and therefore disown the feelings experienced in the self by the mechanisms of splitting and projection into skin colour differences. While common observation tells us that skin colour is often the easiest target of violent racist projections, what remains unclear is why there is such an 'automatic' and effortless quality to this type of violence.

On the face of it what is intolerable is a person's skin colour; however, what underlies this are the intolerable feelings associated with the infantile situation. This is the real target of the attack falsely associated with skin colour differences. In fact, if we examine the content of racist imagery closely, it is related to the infantile situation in a very concrete way, for example, black or brown-skinned people are often imagined to smell, be more dirty, loud, aggressive or uncontrollable and so on.

In racial violence the hatred of the infantile situation is projected into the 'other' where it is concretely enacted often in a cruel and vicious manner by control and domination of the object representing the 'other' (Tan 1993; Timimi 1996). The way this infantile situation is mismanaged is the basis on which an 'internal racist organization' is said to operate in all of us to varying degrees (Davids 1992). Frightening and unmanageable feelings associated with the infantile self are projected into persons with black or brown skins and then related to as if they are infants. This 'downsizing' is thought to occur along the dynamics of historical race relations so that the dynamics of 'master-slave' or 'colonizer-colonized' gets 'mapped' onto the dynamics of the early 'mother-infant' relations. This downsizing is the split-off infantile self which is projected into the body of others, kept at a distance and related to in a cruel and sadistic way by the enactment of a sado-masochistic relationship (Rosenfeld 1971).

It is not particularly surprising that the recipient of racial attacks can come to feel rejected and excluded with a sense of feeling small and humiliated often leading to a narcissistic rage in a vulnerable personality (Kohut 1972), with secondary reactions of depressive withdrawal or a retreat into an arrogant, grandiose, paranoid state of mind. These reactions have been thought to be protective responses to the sense of fragmentation or break-up of the self while certain states of depressive withdrawal have been thought to serve the function of restoring the damaged psychic skin. This can take the form

of a retreat into ruminations that have a sado-masochistic self-flagellation or feelings of grudge and fantasies of revenge and triumph (Mollon & Parry 1984).

One would expect from the model of trauma presented here that the narcissistic injury will trigger other vulnerable areas of the personality, such as early developmental conflicts in the area of oedipal relations where painful feelings of exclusion in relation to a parental couple, real or imagined, are likely to take centre stage. Perhaps in an attempt to avoid further injuries to the self, black patients with serious conflicts about their skin colour have been known to minimize the differences to avoid conflict with others who might hate their colour. However, this wish can often be quite psychotic in nature when it translates into washing the skin with bleach or even contemplating a wish to peel it off.

Perhaps the most serious damage that can result from a racial attack, that may lead to a psychotic breakdown, is when the attack triggers some of the earliest experiences of failures in being contained via the maternal skin in a concrete way. This would also be consistent with the fact that the capacity to think and symbolize is the first to be damaged, in a violent intrusion into the mind leaving the individual dominated by the concreteness of his experiences (Segal 1957). This means that the individual would no longer feel physically, and therefore psychically 'held', which is felt to be a catastrophic experience.

It is the early experiences of maternal failure that are often encapsulated in a portion of the mind, unavailable for thinking about and working through and therefore re-enacted. Where there has been a failure in the satisfactory development of the 'first skin', and therefore no real sense of an inner world of objects that are more or less containing, the individual is at particular risk of breaking down from a serious racial attack.

Case Study

The patient, whom I will call Mr A, was seen in once-weekly psychoanalytic psychotherapy for approximately two years. I have chosen a particular session in his treatment to describe how a relatively innocuous situation was experienced by the patient as a narcissistic injury which became racialized in his mind, triggering feelings of rage aimed to attack me racially as a way of restoring the damage that he felt had been done to his sense of self. His responses in the session suggested that the narcissistic injury gave fresh life to his oedipal and pre-oedipal anxieties which had felt quite unbearable for him, and were probably defended against by encapsulating them in a portion of his mind to ward off more primitive anxieties of his mind falling apart.

Mr A was a 39-year-old single black African man who referred himself to an outpatient clinic asking for help to understand his racial identity. He said it was time to put his life more 'together'. He was quite a tall, well-built man

who appeared highly anxious and always went to the toilet before seeing me. When he entered my room he always felt he had to get his 'bearings right' to 'be prepared' and often looked from the corner of his eyes when there were silences in the session as if to keep an eye on me or to gauge what impact he was having on me. He often looked extremely anxious as if he felt invaded by my presence.

His parents were of African origin, the patient being the youngest of three brothers, one of whom was a drug addict. His father was previously married to a white woman and was thought to have suffered from a mental illness which became worse following a racial attack by a gang of white youths. The few memories of his father revolved around his violent behaviour towards the family members, particularly his mother and himself. He reported episodes of listening to his mother getting beaten up and not knowing whether she was alive or dead. Violence towards her usually followed his accusations that she was having an affair with another man. Mr A would frequently be dragged out of bed in the early hours of the morning when his father, in a psychotic state, would force him into a bath and whip him with a belt, shouting that he was washing the black colour off his skin. He thought the patient was too black to be his son. According to Mr A his brothers had a lighter coloured skin compared to his.

Other accounts described his father's fits of violent temper, which resulted in him being restrained by the police and ambulance staff. Mr A thought that when his father was well, he could be very generous and pleasant to be with but he would often change instantly into a violent and frightening figure. After his parents' divorce Mr A tried to distance himself from his father and felt much regret for not having made some contact before he died nor having attended his funeral.

Mr A was clearly very possessive of his mother whom he regarded as a pillar of strength, as she had brought the children up in very difficult circumstances. During the day he and his brothers fended for themselves but always waited eagerly for their mother to come home from work. His rather idealized view of his mother as a martyr was in sharp contrast to the betrayal he felt when she sent him to a boarding school fearing for her son's life from her husband's violence. He recalled scathingly his mother's words that at boarding school he should always remain polite, keep out of trouble and speak proper English. Mr A felt that his mother had thrown him to the 'wolves', as he not only became the target for racism at school by white boys but gradually began to feel alienated from his sense of being black. He began to project his own feelings of powerlessness by racially abusing other foreign children in an attempt to bolster his poor sense of self.

When he left school he got involved in a drug culture, became addicted to heroin, which took him into the world of criminality and, eventually, went to prison for attempted armed robbery. He described prison life as safe because there was structure and routine which he valued despite his contempt for

prison authorities. He said he always tried to demand solitary confinement, a confined space which seemed to represent a type of mental retreat perhaps like a scaffolding to hold the contents of his mind together. It was obviously crucial for his psychological survival as he often felt that his mind was falling apart, like 'scrambled eggs', whenever he came out of solitary confinement. In prison he began to read books and to think about his life which prompted him to enter a rehabilitation program for addicts when he left prison.

During his treatment with me he sought out a course in helping others through counselling, which seemed more like a manic flight from the experience of being a patient in need of help. He eventually left the course after bitterly complaining to me about the white students' racist attitudes towards him. He then tried to make friendships with black people, something he felt terribly anxious about because he felt that they could see right through him and recognize him as a 'fake'.

His sexual relationships were mainly with white women with whom he would feel trapped once they started to get close to him. He would react to these anxieties by leaving them. In the course of treatment he met a black woman with a small child of her own with whom he initially struck up a friendship which gradually began to develop into a more serious sexual relationship. Mr A saw this as an opportunity to 'father' her son in a way that he would have liked for himself; however, this also served as a 'wedge' to prevent his girlfriend from getting too close to him. As I mentioned earlier, Mr A was highly anxious in the sessions and his general reaction to the ending of each session was to feel quite wounded. He often felt as if he had no life outside the sessions and used the gaps between our sessions to 'get stoned' on 'soft' drugs when the thoughts and feelings that emerged in the session felt too difficult to cope with. He would often relate to me as if he was teaching me about 'black culture', something he felt genuinely excited about in his readings but, listening to him, it felt as though this was another 'second skin' of words, which perhaps gave him a sense of feeling held between the sessions. It was paper thin as if his black skin did not connect internally to a sense of being black.

Whilst these were attempts to let me know that he was quite capable of working things out for himself and did not need me, there was a healthier aspect to his rivalry in the way he sought some recognition from me of his discoveries. However, to mention his need for me would feel as though I was engulfing and trapping him, telling him that he was no good without me.

His initial preoccupations about whether I was experienced in working with black people and the racism they experienced were aimed at testing my general robustness as a therapist. The unconscious agenda was about a number of important issues such as what attitudes I held about him as a black person (for example, whether I was going to belt him for being black like his father and dominate his mind with my thinking) as well as attitudes I held about myself (whether I was comfortable in my skin or felt 'fake' as he did).

Some of these issues were frequently played out in the transference, often in the form of a cruel and sadistic re-enactment of his relation to the father. For example, his preoccupation with whether I was 'qualified' implied that I was not black enough to help him, just as he was not white enough for his father, but this also masked a hidden feeling that he was not being offered the best therapy which he secretly thought would be with a white therapist. The underlying phantasy was that a white therapist would in some way transform him into the white man that his father wanted him to be. However, the most critical issue of all was whether deep down he felt he was worth helping at all, since much of his daily preoccupation centred on feelings of self-hatred.

Clinical Session

In this particular session, he arrived early and was seated in the waiting room. After greeting him, I walked into another office which was separated by a glass door and shut the door behind me to join a conversation with some colleagues. I should say that this is not the most desirable arrangement of the waiting room and office in an institution but is a reality that has to be worked with in terms of the patient's experience of it. On other occasions Mr A did not react in the way that I have described here.

When it was time, Mr A entered my consulting room, furious, asking me how long I had been qualified and telling me that he wanted a black counsellor who would be able to help him better. He thought I had closed the glass door behind me to let him know that he was black and inferior, shouting to me that this was his daily experience of always being excluded by white people.

He said, 'I hate you lot, you've done the same to us as the whites, giving us designer compassion.' He thought Asians were not to be trusted because there was ample evidence in history that they were white people's puppets and were always coming in between blacks and whites. He thought my suit and tie only confirmed that I was a puppet of the white establishment. He wondered whether he was my guinea pig, a subject of an experiment because he felt like that all the time in his life. Should he clean and shine my shoes, he asked? Did I think he was being an aggressive nigger because that is what he would be called whenever he lost his temper? I put to him that my closing the door and talking to some of my colleagues had made him feel small and left out, and he was now trying to make me feel small and inadequate by rejecting my help.

Mr A calmed down and then told me about a painful episode he had experienced on the way to the session. He saw two elderly women walking together when one turned to her friend, made some innuendo about a 'black man' behind them, clenched her handbag and walked hurriedly away from him. In the session, Mr A shouted again, 'I am sick of this, what have we

done to you? I am sick of trying to teach you what it's like to be black (pointing to his arms), this skin, I am sick of it, man, everything depends on this, I have to carry it everywhere'. Mr A slumped into his chair and told me more about his frustration:

I am trying to find accommodation but they tell me I'm not ill enough and here I am trying to get better. I have no friends, feel lonely and I'm in a bad way, nothing is going right for me at the moment . . . I just have sheer admiration for the whites, they have everything.

Mr A felt like an outsider looking in and couldn't wait for the day when he would be wearing my shoes. He said he hated being the patient.

Discussion

Mr A felt shut out from the conversation that was taking place when I shut the door, a conversation that he probably heard but was shut out from when I entered the room and talked to my colleagues. He probably thought I had been insensitive and felt a sense of outrage, with all this in the context of the earlier experience with the two elderly women which must have felt like rubbing salt in the wound. Why this closing of the door should produce such a narcissistic rage leading him to attack my skin colour is worth thinking about. To put it bluntly, what made him pull the belt out and make an attempt to wash the brown colour off my skin?

As the glass door had been left ajar prior to my coming in, it is likely that he was listening and seeing a conversation taking place which was interrupted by my arrival and closing the door. Now he could only see but not hear the conversation, frustrating him that he was being titillated and then shut out, previously a participant observer and now an outsider in an oedipal scenario.

His feeling that Asians were not to be trusted because they came 'in between' the whites and blacks seems to confirm this internal oedipal situation where he experienced me as shutting him out to make him feel inferior. Mr A experienced my shutting the door as spoiling his access to the conversation he was probably listening in on ('the Indian coming in between the Whites and Blacks'), moreover, he thought I had done this deliberately to humiliate him. My arrival and the closing of the door seemed to represent an intrusion and shattering of a narcissistic phantasy of just himself and his mother. He felt I had castrated him by shutting the door and put him in touch with feelings of 'smallness'. His envy of the 'whites who have everything' is exarcebated by the reaction to feelings of being small, suggesting that in his oedipal phantasy he was the baby who desired 'everything'.

The oedipal exclusion brought to his attention the painful fact of the 'difference' between us, that he was dependent on me. By closing the door he felt not only shut out from the conversation but also from me which felt like an injury to his psychic skin that became equated with his black skin in

a concrete way, causing damage to his already fragile sense of self. The difference between us stirred up the hatred in him by his wish to exact revenge on a 'tit for tat' basis by targeting my skin colour and trying to wound me in a way that he felt had been done to him. Anxieties of feeling excluded and powerless are perhaps also reminiscent of what drove his father to racially attack his son. We know from the patient's account that his father was also the brunt of a racial attack which left him rejected and damaged but there is also the implication from the patient's account that his father felt excluded from his wife in his accusation that she was having an affair, suggesting that he too felt narcissistically wounded in an oedipal scenario. It is possible that the father might have equated his anxieties of exclusion and powerlessness with being black and projected them into his son's dark skin where he dished out the belting as a punishment for being black. Both father and son held a phantasy of becoming white as an escape from infantile anxieties which were felt to be too unbearable.

For Mr A, however, to be white was oddly enough to be in identification with his father, a mad man who behaved like a white racist, dominating others more vulnerable in a sadistic way versus another kind of madness, the feeling of being an utterly helpless child. Thus feelings of dependency were fraught with anxieties of a sense of profound rejection, humiliation and utter helplessness. He would do anything to get out of his skin or get rid of it.

What we know is that a traumatic event can impact along already established 'fault lines', which are vulnerable areas in the personality determined in the course of the developmental history of the individual. For Mr A the early trauma of being attacked by his father was probably experienced as a violent intrusion that shattered the 'skin' of his oedipal phantasy of having exclusive access to his mother. This is what seems to have been triggered in the waiting room situation where the early oedipal scenario was played out in terms of skin colour, 'white parents' versus small and humiliated 'black child'. It is confirmed in his anger at the two elderly women whom he felt had 'ganged up' on him to make hurtful comments about him as a potential thief, an association he brought to my interpretation about feeling small.

The phantasy of being a helpless black child ('puppet of the white establishment') against tyrannical white parents who gang up on him is also reminiscent of the destructive aspects of narcissism described by Rosenfeld (1971) in which a cruel and tyrannical part of the patient creates various obstacles to prevent the infantile self from making any moves towards dependency. In fact this type of internal scenario, also mirrored Mr A's external world of drug-addicted companions and the various criminal gangs to which he belonged with their own rules and regulations of 'macho' behaviour.

What was revealing was the way he rejected my skin colour as a reaction to what he felt was an attack on his skin by 'coupling up' with a wish to have a black therapist, the aim being to wound me in a way that he felt had been

done to him. In his outrage, he was telling me that I had stepped out of line, I was behaving as if I were a white man in charge of the little black boy who needed help, and he was going to have none of it so he tried to put me in my place by attempting to give me a 'belting' and let me know that I did not have the right shade of skin colour. I was to know in no uncertain terms that it was he who was in charge.

When Mr A became furious with me, it was unexpected and for a moment I felt unable to think about what he was getting angry about as if he and I were re-enacting something very important in his early experience. In effect, I closed my mind down while he was trying to make his rage known to me. When I managed to recover I recalled the violent experience with his father which had been re-enacted with me and I, like the patient, shut out the intrusion. His complaint that he was sick of trying to teach me what it felt like to be black conveyed his utter frustration with me of trying to let me know just how hurt he felt whenever he experienced feelings of being excluded, since he found it difficult to see how they were not necessarily connected to the colour of his skin.

His plea to be 'accommodated' in a flat captures this sense of frustration of trying to be an independent man with his own flat but being shut out on the grounds of not being ill enough. I think Mr A felt that I was giving him mixed messages, expecting him to be a good patient, coming regularly to his therapy and then expecting him to get on with the rest of his life during the week when he did not feel he had the resources to do this. It was reminiscent of his mother sending him to boarding school and asking him to be a good little boy, when he must have been feeling terribly anxious and ill prepared.

In the transference he was telling me that seeing him once a week was tantamount to not 'accommodating' him properly. His sense of frustration, therefore, revealed difficulties that went beyond the oedipal situation to the earliest relationship with his mother. When the glass door closed he was able to see but not hear the conversations which meant that he too could be seen but not heard. Could it be that when the door shut he found himself in a place which was no longer safe without the familiar banter of the staff, a frightening place in his mind where he suddenly lost his voice to express his distress or even hear another voice? What comes to mind are the violent beatings by his father which everyone in the family was witness to but felt unable to intervene and help him.

Did the glass door represent the maternal skin that had abruptly failed to 'hold' him when it closed? One that he perhaps wanted to break through but which he feared would shatter and therefore shatter himself? This would be consistent with his general demeanour in the sessions, of walking on 'eggshells' anxious not to put his foot wrong with me. This is one reason why he asked me in the session whether I thought he was an 'aggressive nigger', moments after he was furious with me, to see whether I had or was going to shatter into pieces by his anger.

These early anxieties and terrors were channelled into his criminal activities by projecting them into others in a vulnerable situation. It gave him an enormous sense of excitement, power and triumph over others, not unlike the feelings of being on a 'high' from his heroin injections. It was a manic defence which warded off his depression that often drove him to suicidal despair. The gaps between our sessions caused him so much anxiety that he would resort to 'soft' drugs to obliterate his feelings. It was also an indication of how precarious his identifications were. To leave each session felt as if he was having to emotionally and physically tear away from me, producing quite catastrophic anxieties in him between the sessions.

It was perhaps not surprising that he often spoke of wanting to get caught and placed in prison where he felt safe, although in the past this culminated in a sado-masochistic relationship with prison authorities where he fulfilled an unconscious wish to be punished. This would be consistent with his taking the 'rap' for a crime that he claimed he did not commit in order to stay in prison.

Prison and boarding school must have provided him with an external structure and routine that he largely lacked internally but which he related to as a 'second skin', always in danger of collapsing when it was taken away from him. He described this experience vividly, when he spoke of his mind falling into pieces, like 'scrambled eggs' when he was taken out of solitary confinement and had to make desperate demands to be returned to the confined space. This is why he was so desperate to get accommodated in a flat of his own, a solid structure that he felt would hold his mind together in moments of falling apart, particularly in the gaps between each session. He lacked an internal space with an object with whom he could identify and form an emotional connection with. Thus he was not able to 'use' an object to bridge a transition into the outside world (Winnicott 1971) and develop into a man who felt comfortable in his black skin, a psychic skin that could hold his mind together, rather than continually seek out a second skin in the form of the concrete accommodation. This situation was, of course, all the more difficult in the absence of a good enough father. He had a father who not only beat him, which was bad enough, but racially attacked him, the one person he would normally have turned to for protection. For Mr A, however, there was only one way to avoid anxiety, to get inside the skin of the other, expressed in his wish to wear my suit and shoes, literally get inside my skin in order to stop feeling like an 'outsider'.

While his experience of feeling like an 'outsider' is something he felt white people were responsible for, it had deeper origins in the earliest relationship with his mother. Being an 'outsider' meant a catastrophic anxiety of falling apart, pointing to experiences of failures in containment which made the task of separating extremely difficult, particularly if the separations were abrupt. His subsequent experience in life seems to have been a repetition of this early failure.

What is known about the early history is the volatile home atmosphere, being a frequent witness to his mother being beaten and long periods of her absence when the children were left at home without any adult carers. Separations during the night from his siblings when he was yanked away to be beaten must have felt as abrupt and violent intrusions into his mind, not to mention the subsequent placement in a boarding school away from home which he saw as a mixed blessing. When patients report such violent early experiences, it is not uncommon to find in their accounts a difficulty they have of linking their thoughts together as if the intrusions have resulted in their inner experience being broken up into pieces.

Mr A's basic vulnerability in his sense of self meant that experiences such as being slighted, ignored or treated without respect or empathy could lead to a deep wound. Even a relatively innocuous closing of the door could send tremors throughout his psyche and touch the experiences of his earliest relationship to his mother whom he experienced as fragile, perhaps like the glass door, someone he could see but not communicate his distress to. The glass, of course, could have other meanings such as being seen through, a feeling of transparency which is not unconnected to how Mr A felt about having a 'thin' skin.

His narcissistic rage and frustration with me and, more generally, the white world at large were about not being able to get through to an object felt to be impermeable, increasing both his frustration and anxiety about shattering it. It seems likely that time and again he was coming up against this internal 'glass mother' who could not be penetrated, leaving him with a feeling of being a perpetual outsider. This inner experience could be easily projected into others such as white people whom he perceived as cruel and impervious to his needs. Instead of feeling contained by his father, Mr A was the recipient of his father's violent projections, but this scenario (as far as the patient was able to report) also points to a mother who was absent and not always available to intervene for his safety. Thus embedded in this violent scenario was a less obvious and dramatic situation that was already in place in his earliest relationship to his mother. Mr A's question to me about whether I found him aggressive was precisely about his anxieties about the early container and his impact on it. The likely failures in his early containment also raise questions about the fate of his aggressive impulses, whether in fact he turned them on himself by projecting them into his black skin, which would have left an area in his personality vulnerable to racist projections. It echoes his father's displacement of anger and rage into his son's skin.

There was no doubt that his black skin was endowed with fearful qualities which he felt he had to get rid of but it is also possible that he saw his skin as a physical barrier that had to be peeled off in order to get inside the object as a defence against the profoundly terrifying experience of being an 'outsider'. The wish, however, to be incorporated or incorporate the object is also the basis of sado-masochistic tendencies and actions (Biven 1982) which

are quite central to the understanding of this patient. In the session presented here, Mr A's question of whether he was my guinea pig or should clean my shoes was most certainly a provocation and a self-flagellation, inviting me into beating him physically or symbolically and re-enacting his sado-masochistic phantasy (Freud 1919). His past history of drug addiction, particularly, the action of penetrating heroin needles into his skin, raises important questions about this phantasy, particularly as masochistic behaviour involving the skin surface is thought to serve the function of bolstering a precarious body image (Stolorow 1975). While incorporation was a term first used by Freud (1905) in the context of orality to represent the 'taking in' of food through the mouth, the term is now used more broadly to involve the taking in of the object via any of the erotogenic zones, including the skin (Laplanche & Pontalis 1973), whether part or whole, into the body in order to assimilate and retain it. In this way anxieties of separation and loss can be defended against but other functions may also come into play such as the fulfilment of a wish to be penetrated or to destroy the object and appropriate the object's power or indeed its good qualities.

Mr A's past heroin injections into his skin is interesting in this respect. One can speculate that the injections represent a homosexual phantasy in which his father was kept inside him, expressed concretely in terms of the injection, a toxic phallic object, penetrating him. In this way the heroin could represent a kind of paternal strength that he wished to keep inside him but it is more likely that this was in the service of delaying the mourning of the loss of his father. He was racked with guilt about failing to attend his funeral to say one last goodbye to him. However, incorporating him concretely into his skin would have enabled him not only to avoid feelings of loss but also repeat a sado-masochistic relationship to him, since one could see, underlying his addiction and criminality, a quest for excitement and illusions of triumph (Limentani 1979) as a defence against depressive anxieties. He was searching for a paternal object to both confront and be punished by (Hopper 1995).

Heroin use, in contrast to cocaine use, is also thought to produce a sense of merging to fuse and confuse one's self with the craved object and to obliterate all other objects that are experienced as obstacles to this in order to create total passivity. This is consistent with the interesting association to the word heroin ('her-who-is-in me') mentioned in Hopper's (1995) formulation of addiction, in which he suggests that the heroin addict's unconscious phantasies are about being a woman and the wish to be a passive receptacle in order to recreate the skin of the breast. Injecting would become synonymous with feeding himself (white heroin) and taking control of the maternal relationship in phantasy, expressed in his past history of being a 'dealer' who 'fed' others. His passivity is also captured in the image of the puppet ('white people's puppet') that he accused me of being. To be dependent was to be at the mercy of others' control. The puppet also conjures up images

of a lifeless (a lifeless maternal situation?) doll which needs to be filled up from the inside with a substance that in fact represents death rather than life.

Summary and Conclusions

Because the effects, certainly the long-term picture of any traumatic event is rather unique to the individual given his/her personality disposition, it is difficult to make generalizations about the effects of racial violence. What we do know about traumatic events is that they pierce our psychic equilibrium, impairing our capacity to think, triggering and linking up with earlier experiences of failures in containment.

Traumatized patients often cling desperately to particular experiences in their life with conviction to explain their emotional ills. However, we know from clinical work that this often serves the function of 'organizing' their internal experiences in such a way that it binds and gives some kind of coherence to their inner pain when in reality their psychic experience may be far more confusing and fragmented. For Mr A, the violent episodes with his father and everyday experiences of racism were the most important memories that organized his understanding of his emotional state. However, what emerged was the possibility that the trauma went beyond these episodes to his earliest experiences within the maternal situation where it is likely that a 'psychic disaster' had taken place in the form of the early failure in the skin container function which was destined to be repeated in a painful and dramatic way with his father and the subsequent loss of his home when he was sent away and experienced further racist attacks. Closing a transparent door on him or a racist gesture could link up in his unconscious mind to a mother who was experienced as not being emotionally available to contain his anxieties. There is little doubt that Mr A was living on the edge of a precipice and relied throughout his life on a 'second skin'. It held his mind together but only just, always on the verge of repeating a breakdown that had already occurred in his distant past.

His world of criminality and drug addiction became another arena for repeating the earliest trauma in which he could turn his feelings of helplessness into becoming powerful in phantasy ('whites have everything') by trying to make others dependent or victims of his terrorism.

Since experiences of pain and pleasure appear to be so intimately connected to our skin and unconscious phantasy life (Anzieu 1989), skin colour differences may well serve as visible signals of the infantile situation in the unconscious. Skin surface can be used as a stage on which an unconscious drama about an internal conflict related to separation and loss unfolds in a most dramatic and disturbing way. The racial attack is a wish to obliterate anxieties of the infantile self often using the language of colour, bringing temporary relief to a desperate psyche.

Whether it is racism that involves being marginalized, devalued or physically assaulted, those on the receiving end experience a tear in the very fabric or protective skin of their inner and outer worlds, revealing hazard and danger. In that moment it is a landscape which is hostile, echoing earlier experiences of not feeling heard or acknowledged. In the precarious personality where even the most rudimentary 'holding' function is damaged, it can lead to experiences of utter dread, touching on feelings of whether one even exists.

The aim of treatment, as with any psychotherapeutic work on trauma, is to offer a space for the beginning of thinking to take place in such a way that past and present events need not be enmeshed or encapsulated from the rest of the personality. Treatment provides an opportunity of being contained or, in Mr A's words, properly 'accommodated' in the hope that this function can be internalized with an internal space that allows thinking about and better management of one's anxieties.

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