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Trauma and its sequelae: Issues of separation-individuation, precocious ego development, repetition, and activity and passivity

Ziegellaub, Miriam Ruth, Ph.D.

City University of New York, 1990

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A

TRAUMA AND ITS SEQUELAE: ISSUES OF SEPARATION-INDIVIDUATION, PRECOCIOUS EGO DEVELOPMENT, REPETITION, AND ACTIVITY AND PASSIVITY

by

MIRIAM R. ZIEGELLAUB

A dissertation submitted to the Graduate Faculty in Psychology
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy, The City University of New York

1990

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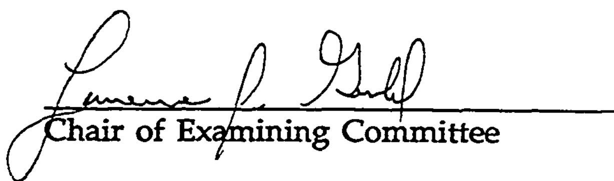
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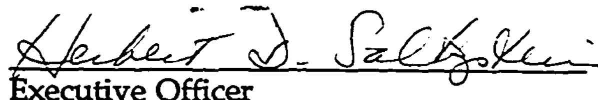
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Abstract

TRAUMA AND ITS SEQUELAE:
ISSUES OF SEPARATION-INDIVIDUATION, PRECOCIOUS EGO DEVELOPMENT, REPETITION, AND ACTIVITY AND PASSIVITY

by

Miriam R. Ziegellaub

Adviser: Professor Lawrence Gould

There is increasing documentation of young children being exposed to trauma, including sexual abuse, physical abuse, and serious neglect. The purpose of the present study is to further understanding of the psychological sequelae of abuse.

The method of the study rested on the systematic analysis of detailed records of my 4 1/2 year simultaneous treatment of a child, who had been sexually abused by her father for the first 2 years of her life, and her mother, who had also been sexually abused in childhood. Material from 9 other related cases was also brought to bear on the questions under study.

The principal findings of the study are, first, that serious trauma impairs the development of self and object representations, disrupts the process of separation-individuation and impedes the development of adequate object relations. Second, early trauma was found in some, but not all cases, to result in a premature development of certain ego functions, in which the infant takes on and enacts failed maternal functions. Finally, traumatized children were found to re-enact the trauma both in their lives and in treatment. Repetitions of this kind were viewed as multiply

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determined, involving: attempts at mastery; re-enactment of earlier faulty object relations; and a failure to achieve signal anxiety and a consequent regression to traumatic anxiety.

The implications for treatment, and for the theory of trauma and its sequelae, are discussed. Suggestions for further study are presented.

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Acknowledgements

I would like to thank my committee members, Dr. Anni Bergman, Dr. Steven Ellman, and Dr. Lawrence Gould, for their contributions and support, and for the role each has played in my education as a clinical psychologist.

I had the good fortune during my training to be in supervision with Dr. Anneliese Riess and Dr. Stephen Solow. It has equally been my good fortune to have them as outside readers.

Dr. Anni Bergman gave generously of her limited time during the long process of writing this dissertation. Her clinical wisdom and theoretical insights enriched my own understanding. Her spare but pointed questions regarding the case went to the heart of the matter, and helped me to clarify my thinking.

Dr. Fred Pine supervised this case during a difficult phase of treatment. His sensitive attunement to the clinical process was, as always, inspiring. His encouragement was a needed help during that critical period of work. His previous supervision during my internship year had a profoundly formative impact on my clinical work.

Many other supervisors and teachers played an important role in my clinical training, and hence contributed to this dissertation. Among these, Dr. Jan Drucker supervised the first year of treatment of this case. The late Dr. Arthur Arkin's rare combination of erudition, modesty, and empathy made him a model, as well as a valued teacher and supervisor.

I wish to thank Dr. N. for information regarding the six months of her treatment of this mother and child. My own work was greatly facilitated by her skill in handling the initial engagement of this fragile family.

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My thanks to Ms. Margaret Peet for her skilled assistance in the preparation of this manuscript.

Above all, I thank my husband, Dr. Richard J. Eichler, without whom this dissertation would never have been. His outstanding clinical abilities, his ability to articulate and conceptualize, his genuine compassion for the suffering of others, have always been a source of admiration and stimulation. He gave freely of these talents, which combined with his unflagging confidence in me, were my main support during the struggle to complete this dissertation. There are no words to thank him.

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Chapter I
Introduction

This dissertation is a study of trauma and its impact as seen in the simultaneous treatment of a mother and daughter, both of whom were sexually abused in childhood.

There is increasing documentation of young children being exposed to trauma, including sexual abuse (Browne and Finkelhor, 1986); physical abuse (Galdston, 1981); and serious neglect (National Center on Child Abuse and Neglect, 1981). Yet there continues to be disagreement about the impact of trauma on child development and its sequelae in adulthood (Lewis and Sarrel, 1969); about the factors contributing to the repetitions of trauma within a person's life time and across generations (Steele, 1970; Steele and Pollock, 1974); and about the factors contributing to mastery of this trauma within a therapeutic setting. The purpose of this study will be to elaborate these vicissitudes of the psychological sequelae of abuse.

The ways in which trauma affects personality organization and object relations, and comes to function as an organizing principle (Greenacre, 1967) for successive phases and stages of development, will be examined, as will both the adaptive and pathological efforts to master trauma. Additionally, the repetition of trauma throughout the course of life and in the treatment setting will be discussed. Finally, the importance of the psychodynamic shifts between activity and passivity in these repetitions will be addressed.

These aspects of trauma and its sequelae will be examined through the systematic analysis of detailed records of my 4 1/2 year simultaneous treatment of a child, who had been sexually abused by her father for the first 2

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years of her life, and her mother who had been sexually abused in her third year of life.

In this family, the trauma of sexual abuse had a pathological impact on the process of separation-individuation, which in itself came to be experienced as traumatic. The clinical material will therefore be presented within the context of the separation-individuation process. Material from nine other cases of children who experienced trauma—of either sexual abuse, physical abuse and/or severe neglect—will also be brought to bear on the questions under study.

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Chapter II

Review of the Literature

Freud's Theory of Trauma

Freud's concept of trauma and of the role it plays in the etiology of the neuroses began with the notion that trauma is the causative factor in subsequent pathology. The revisions his theory of trauma underwent bear at each stage the imprint of the developments in his psychoanalytic theory. Yet he repeatedly returned to his original notion. In his final writing on the subject he did not believe he had come to a definitive conclusion. "It may remain an open question whether the etiology of the neuroses should in general be regarded as a traumatic one" (Freud, 1939, p. 91).

In his earliest writings, Freud assigned trauma the central role in the genesis of hysteria. Psychical trauma was posited as the causative factor in both the common hysterias he investigated with Breuer, and in the traumatic paralysis he had observed in Charcot's clinic in the 1880s. However, Freud believed that a series of affective impressions was at the root of the common hysterias whereas a single major trauma was operative in hysterical paralysis (1893b/1959). At this stage in the development of his theory, Freud believed that "Every experience which produces the painful affect of fear, anxiety, shame or of psychic pain may act as a psychic trauma" (Freud, 1895/1959, p. 356). Affects were considered traumatic because they result in "An accretion of excitation in the nervous system, which the latter has been unable to dispose of adequately by motor reaction" (Freud, 1887-8/1959, p. 137). Freud's assumption that accumulated tension is traumatic follows from his implicit adherence to Helmholtz's "principle of constancy" which holds that

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organisms strive to keep constant their sum of motor excitation. Freud only made explicit his application of the constancy principle to mental economics in 1892.

In 1893, Freud elaborated further the economic viewpoint. Every psychical impression, he wrote, is provided with a quota of affect—"Affektbetrag" (1893a/1959, p. 172). If the ego is unable or unwilling to divest itself of this Affektbetrag, it attains the status of a trauma. Freud placed considerable importance on the particular moment at which a potentially traumatic event occurred (Freud, 1887-8/1959). For example, he theorized that people are more vulnerable to trauma when daydreaming. In addition, he believed, as mentioned above, that trauma need not be one event, but could result from a series of events: by summation, they gain the importance of a trauma.

As economic factors, sexual constitution, and the role of fantasy became more prominent in his general psychoanalytic theory, Freud increasingly emphasized these internal dimensions in his theory of trauma as well.

In the mid-1890s, in his correspondence with Fliess, Freud speculated further on the etiological factors necessary for the development of neurosis. Here he narrowed his views to specify that it is only sexual traumas before the age of understanding (i.e., sexual seductions in early childhood) that are pathogenic (Freud, 1897/1959). In addition, Freud now saw trauma as underlying not only hysteria but periodic depression as well. Periodic depressions of this kind were classified as a form of anxiety neurosis provoked by psychical trauma. In the etiology of both forms of neurosis, Freud wrote that experience is repressed and becomes "a trauma by deferred action" (p. 356). Later in life the memory of the repressed experience becomes conscious and has a traumatic effect, arousing then "an affect which it did not

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arouse as an experience . . . because in the meantime change has made possible a different understanding of what was experienced" (Freud, 1895/1959, p. 356). It should be noted that this description, based on a case of molestation in latency which became traumatic after its repetition in puberty, predated Freud's discovery of infantile sexuality.

In 1896 Freud for the first time delineated what was to become the classic formulation of the development of neurosis. The first step, as he had earlier written to Fliess, is a premature traumatic sexual experience that is subsequently repressed. This is followed by: the arousal of the memory of the repressed experience, its repeated repression and the formation of a primary symptom; a stage of successful defense, equivalent to health, except for the primary symptom; and, finally, a stage of the return of the repressed, in which the struggle between the repressed and the ego results in the new symptoms of the illness proper (1896/1959).

Not long after arriving at this formulation of the traumatic theory of the etiology of neurosis, Freud abandoned it when he renounced the seduction theory. Prior to 1897 Freud had regarded infantile sexuality as dormant. In this view, infantile sexuality is only aroused by adult seductions, which are passively experienced by the child, and have pathogenic consequences. Depressed by his lack of success in treating his patients, Freud concluded that their frequent reports of seductions were attributable to the lack of reality in the unconscious, which therefore could not distinguish between fact and fantasy (1897/1959). He further decided, in part from his self-analysis, that sexual impulses operated in children without the agency of adult intervention.

Freud's discovery of infantile sexuality, and his abandonment of the seduction theory, were not published until 1905 in the "Three Essays" and

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were further expounded in 1906 in "The Part Played by Sexuality in the Etiology of the Neurosis." In the latter essay, Freud recapitulated the process by which he had arrived at his revised view of the mechanism of hysterical symptoms. These were no longer regarded as direct derivatives of the repressed memories of childhood experiences (traumatic seductions). Their production was mediated by childhood fantasies, mostly produced in puberty, which lay between the childhood impressions and the symptoms. " 'Infantile sexual traumas' were in a sense replaced by 'infantilism of sexuality' " (Freud, 1906/1959, p. 274). Freud attributed to some of these fantasies the function of warding off memories of the subject's own sexual activity. (In this respect, the fantasies turned active into passive.)

Formerly, accidental influences on sexuality had borne the responsibility for the causation of illness. Particular types of sexual trauma had, during this period, been limited to particular neurotic outcomes (i.e., to the "choice of neurosis"). Now, however, Freud stressed the factors of heredity and constitution. The history of normal childhood sexuality does not substantially differ from the history of neurotics. "That which separates the normal from the abnormal is but a relative increase in the single components of the sexual impulse and what course they may take during development" (1905/1959, p. 165n). The issue is not so much one of varying childhood experiences, but of varying responses to these experiences. Especially decisive is whether childhood experiences result in repression. "The essence of these illnesses (psychoneuroses) lies in disturbances of sexual processes" for which no single pathogenic influence is sufficient (p. 87). (In his "Three Essays" Freud had outlined a number of influences that converge to cause neurosis: constitutional factors; premature sexuality; heightened

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adhesion; and fixation through "accidental excitement of the sexual impulse through outside influence" [p. 98].)

Despite these changes, Freud was to return intermittently to the concept of trauma as pathogenic. Thus, he wrote to Fliess in 1898, in a discussion of early childhood from ages one to three, that "what is experienced sexually in it produces psychoneuroses" (Letter 84).

In summarizing the development of psychoanalytic theory in *On the History of the Psychoanalytic Movement* Freud described how his discovery of the sexual activity of early childhood had shifted emphasis to the importance of inherited constitution. Disposition could exaggerate impressions that otherwise would have been commonplace, which thus became traumas and gave rise to stimulations and fixations. Experience could awaken factors in disposition that otherwise would have remained dormant. He referred to Abraham's later work (1907b/1955) as demonstrating that the sexual constitution of children was particularly calculated to provoke sexual experiences that were traumatic (Freud, 1914a/1957, p. 18).

As Freud developed the economic viewpoint, the amount of stimulation experienced—and modes of protection from excessive stimulation—gained in importance in the definition of trauma. In Lecture XVIII of his Introductory Lectures, Freud wrote:

> Indeed, the term "traumatic" has no other sense than an economic one. We apply it to an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances of the manner in which the energy operates (1917/1959, p. 275).

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In this lecture, Freud also alludes to the tendency of victims of traumatic neurosis to repeat the traumatic situation in their dreams, a point he repeated in his paper, "The Uncanny" (1919b/1959). Noting this compulsion to repeat in children and in patients in psychoanalysis, he postulated that it must derive its strength from an instinctual source, and must be powerful enough to override the pleasure principle. In addition to his observations of children's play (the "Da-Fort" game), Freud's experiences with the traumatic neuroses of World War I were a powerful factor in his reformulation of trauma and in his emerging conceptualization of the death instinct (1920/1961).

Concurrently with his increasingly economic view of trauma, Freud introduced the concept of the stimulus barrier as a protective shield against the potentially lethal energies of the external world. In 1920, he redefined as traumatic "any excitations from outside which are powerful enough to break through the protective shield" (1920/1961, p. 25). The traumatic neuroses were now seen as the "consequence of an extensive breach being made in the protective shield against stimuli" (p. 25). While such a breach could result from insufficient preparedness for anxiety, Freud emphasized here the economic factor, hypothesizing that when the strength of a trauma exceeds a certain limit, even with preparedness, the protective shield will fail. If the stimulus barrier is breached, a regression to more primitive modes of functioning occurs in which the pleasure principle no longer prevails—as in the traumatic dreams of war neuroses or the repetition of unpleasurable events in children's play.

The stimulus barrier, as originally conceived, had the function in infancy of protecting the child from *external* stimuli—Freud later suggested the stimulus barrier was an incipient ego function (1939). This protective

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function was of almost greater importance than the reception of stimuli. It could work by exclusion or by a diffusion, or weakening, of the the intensity of the incoming stimuli. The stimulus barrier was endowed with its own store of energy.

In *The Ego and the Id,* Freud wrote that the ego's fear of being overwhelmed or annihilated stems from both external and internal sources—"from the external and from the libidinal danger" of the id (1923/1960, p. 47).

James Strachey makes the point that this notion of the ego being overwhelmed is connected with the "traumatic situation" of *Inhibitions, Symptoms and Anxiety* (in Freud, 1926/1959). There Freud used both "traumatic situation" and the term "anxiety trauma" for the experience of helplessness which he now placed at the center of trauma.

In *Inhibitions, Symptoms and Anxiety,* trauma was given a key role in Freud's conceptualization of anxiety and the development of its signal function. Freud termed anxiety "on the one hand an expectation of trauma, and on the other a repetition of it in mitigated form" (p. 92). The infant's experience of birth trauma becomes the prototype for all future anxiety. "Traumatic" or "automatic" anxiety is a product of the infant's helplessness.

What is remembered of this prototypic trauma is not the visual percept, as Rank had suggested, but something else, Freud argued. "The situation of non-satisfaction in which the amounts of stimulation rise to an unpleasurable height without its being possible for them to be mastered psychically or discharged must to the infant be analogous to the situation of being born—must be a repetition of the situation of trauma" (1926/1959, p. 63).

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Excessive stimulation occurring in the context of helplessness and of lack of preparedness for anxiety were key ingredients in the experience of trauma. Preparedness becomes possible through the development of the signal function of anxiety. "Anxiety is the original reaction to helplessness in trauma and is reproduced later on in the danger-situation as a signal for help" (p. 93). Through the repeated experience and subsequent association of anxiety reduction with the presence of a protective, soothing object—the mother—the infant gradually transforms automatic anxiety into signal anxiety.

Within the framework of the structural theory, the strength of the ego and its preparedness, as well as the strength of stimuli, have become significant in determining whether or not a situation is experienced as traumatic. In the traumatic situation "in which the subject is helpless, external and internal dangers, real dangers and instinctual demands converge" (p. 94).

Signal anxiety serves to ward off trauma. By setting in motion the ego's defenses, it generates a state of ego preparedness, which, in turn, defends the ego from being overwhelmed and from experiencing the state of helplessness. It is noteworthy that by 1926 Freud's emphasis has shifted almost completely from the external (e.g., actual sexual experiences) to the internal: fantasy, in and of itself is now seen as potentially traumatic. In addition, Freud now implies that ego weakness alone can increase susceptibility to trauma.

Another innovation of *Inhibitions, Symptoms and Anxiety* is Freud's delineation of a developmental line of anxiety, or more accurately of the danger situations that are phase-appropriate precipitates of anxiety at different stages in the development of the mental apparatus. Annihilation anxiety—

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fear of psychical helplessness—is appropriate to the period when the ego is more immature in early infancy; separation anxiety is appropriate to early childhood; castration anxiety, to the phallic phase; and fear of the super-ego, to the latency period. Freud speculated that each form of anxiety is the motive force in the defensive formation of a specific neurosis: loss of love is linked to hysteria; castration anxiety, to phobias; and super-ego anxiety to obsessional neurosis (pp. 68-69). Thus, Freud saw in each phase of development a susceptibility to a particular neurosis, and to the experience of a particular danger as traumatic. However, he also acknowledged that "all these situations can persist side by side and cause the ego to react to them with anxiety at a period later than the appropriate one; or again, several of them can come into operation at the same time" (p. 68).

In his *New Introductory Lectures* (1933/1959), Freud spoke again of the importance of the first five years of life in creating a predisposition to later illness. These early years are important because, in the first flourishing of sexuality in this period, determinants for the sexual life of maturity are laid down, and because impressions of this period can act like traumas upon the immature and feeble ego. The only defense the ego has, at this stage, to fend off "emotional storms" is repression, and it is repression, of course, which Freud implicated in the disposition to future illnesses and functional disturbances (p. 147).

In a preceding lecture (XXXII), "Anxiety and Instinctual Life," Freud named the "traumatic moment" as the object of anxiety. That is to say, what is feared in the experience of anxiety is the repetition of a trauma: a moment in which the ego is overwhelmed, and the pleasure principle breaks down because excitation cannot be mastered. Clearly, in this reformulation Freud reverted to describing trauma in purely economic terms; it is, he wrote, "a

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question of relative quantities" (p. 94). In that same lecture, he wrote that the origin on anxiety is twofold: a direct consequence of the traumatic moment and a signal of the threat of repetition of the traumatic moment.

In his "From the History of an Infantile Neurosis" (1919a/1959) Freud provided clinical material as evidence of the creation of predisposing factors to neurosis in early life. Specifically, he demonstrated how, in the case of the Wolf Man, trauma became pathogenic by deferred action. The Wolf Man's memory, dating back to age 1 1/2, of observing his parents together (possibly in a primal scene or possibly a "primal phantasy") gained significance when it was reactivated at age 4, because of his greater understanding. At age 4 the earlier memory operated like "a new trauma, like an interference from outside analogous to the seduction" (p. 109). Freud went on to speculate about the existence of a primitive unconscious whose nucleus consisted of instinctive factors. The significance of early childhood traumas would be their contribution to this unconscious, which would save it from being worn away by subsequent development. Freud felt this emphasis on phylogenetic aspects was justified in cases such as the Wolf Man where the presence of infantile symptoms and disturbance was so clearly documented.

Freud's final discursion on trauma is to be found in *Moses and Monotheism* (1939). Here he returned to the question of the pathogenicity of trauma without reaching a decisive conclusion. Again he spoke of the deferred action, via repression, of early traumata.

> The impressions we experienced at an early age and forgot later, to which I have ascribed such great importance for the etiology of the neuroses, are called traumata. It may remain an open question whether the etiology of the neuroses should in general be regarded as a traumatic one. (p. 91)

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Freud went on to write of those individuals who have not suffered an obvious trauma and concludes that they have had unusual reactions: a "hereditary and constitutional" disposition is the only available explanation for the neurosis, which must have developed slowly. However, shortly thereafter, Freud continued, "Our researches have shown that what we call the phenomena or symptoms of a neurosis are the consequences of certain experiences and impressions which, for this very reason, we recognize as etiological trauma" (p. 93). It is noteworthy that here again Freud has reverted to the concept of traumatic experiences proper as opposed to the concept of the traumatic situation (i.e., the feeling of helplessness) in his discussion of the etiology of the neuroses.

Freud elaborated three characteristics of "etiological trauma," which are either experiences or impressions (perceptions):

1. They occur within the first five years of life;
2. They are subsequently forgotten, as a consequence of infantile amnesia; only residual "screen memories" survive in awareness.
3. Potentially traumatic impressions concern sexuality and aggression—which are not clearly distinguished at that age—or narcissistic injuries.

For the first time, Freud divided the results of traumata into positive and negative effects. By the positive results, he referred to the tendency to remember the trauma or repeat it; by the negative effects, attempts to forget or avoid it. He summed up the positive effects as "fixation to the trauma" and "repetition-compulsion" and the negative as "defensive reactions" that can culminate, in their attempts at avoidance, in an inhibition or a phobia. However, as he himself realized, the distinction is not all that clearcut since attempts at forgetting "represent fixations on the trauma no less than do the positive reactions" (pp. 95-96).

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The contradictory effects of trauma create a conflict, from which neurotic symptoms arise as a compromise formation; at times the positive effects predominate, at times the negative, without achieving resolution. Both these aspects contribute to the formation of immutable character traits, the historical origins of which are ultimately forgotten.

The positive and negative effects of trauma can be seen to encompass tendencies to repeat actively and passively, a point which will be elaborated in a subsequent chapter. The positive effects are seen in the active repetition compulsions, whereas the negative results find expression in passive repetitions, in that the experience of heightened stimulation itself can trigger the repetition of traumatic anxiety.

In this discussion of the positive results of trauma in *Moses and Monotheism* Freud noted the object relational aspects of the repetition of trauma, whereas in many past writings it is the economic and structural aspects that are stressed. The active repetition compulsion, he wrote. can include an affective relationship that is "revived in an analogous connection with another person" (p. 96).

Freud noted further that physiological latency interposed an opportunity for undisturbed development between childhood neurosis and adult neurosis. In typical cases, the delayed effect of trauma only becomes apparent at puberty or somewhat thereafter. Freud attributed this to the resurgence of the instincts at puberty, and to the inadequacy of the earlier defensive organization at coping with the new life tasks.

Freud's changing concept of trauma bears the imprint of the historical development of his psychoanalytic theory. Beginning with a view of trauma as external, he shifted to emphasize internal aspects—constitutional contributions, fantasy and economic factors—and culminated in a structural

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view, in which the overwhelming of the ego is an intrapsychic situation. His theory was varied and broad enough to provide a basis for a range of emphases in the contributions that followed his. In the light of current object relations theory and infant research it is noteworthy that in his final writing he did not renounce the dimension of external reality and experience in his understanding of trauma and the role it plays in the development of pathology.

Predisposing Factors, Trauma, and Psychopathology

From 1905 on, Freud assigned constitutional factors a place in the etiology of trauma. However, as discussed above, his thinking varied in defining the innate factors that create a predisposition to trauma. Other writers pursued this theme of predisposing factors in some detail.

Abraham (1907a/1955; 1907b/1927) contended that the same unconscious processes are at work in the formation of dementia praecox as Freud had found in hysteria. According to Abraham, abnormal infantile sexual development represents a predisposition to psychopathology. Where there exists such a predisposition to pathology, sexual trauma is unconsciously desired because it represents a form of infantile sexual activity.

Abraham distinguished between traumas that take a child unawares and those which it provokes. Children, or adults, who provoke a trauma subsequently tend to expose themselves to repetitions of this trauma. Abraham viewed this phenomenon of repetition as proof that these patients unconsciously wish for such traumas.

Bender and Blau, in a 1937 study of sexually abused children, offered clinical data that supports Abraham's contention that children may play an active, or even an initiating, role in establishing sexual relationships with

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adults. Moreover, they reported that the 16 children they studied did not for the most part experience sexual relationships with adults as traumatic or frightening; and, indeed, often derived some emotional satisfaction from such relationships. However, the effect of the experience varied, according to the predisposition to pathology. The children characterized as "potentially normal" developed only minimal neurotic features, whereas the outcome was more varied for the other children in the study.

While Abraham did not distinguish between the wish for repetition, on the one hand, and the wish for the actual resulting traumatic experience on the other, later analysts were to make this distinction, arguing that what is sought is not the trauma itself, but the fulfillment of an unconscious fantasy. As early as 1905 Freud had observed that what neurotics long for in fantasy, they flee from if presented in reality. Later, Ferenczi spoke of a "confusion of tongues" (1933/1955) between adults and children. Whereas what children desire is a "situation of tenderness," this childhood wish may be re-interpreted by adults in their own terms, stimulate seduction, and culminate in sexual trauma. Similarly, Furst (1967) pointed out that the term "provocation of trauma" is misleading because it is not the traumatic event *per se* that is desired, but, rather, the compliance of the environment in the fulfillment of an instinctual wish.

Although Abraham concurred with Freud that an abnormal psychosexual constitution predisposes to psycho-pathology, he differed from him in finding that trauma does not cause mental illness. Rather, Abraham believed that trauma shapes the specific symptom formation of the subsequent psychopathology. Abraham observed this in a number of cases of dementia praecox. One patient had been raped as a child by her uncle in a barn. The uncle threatened to burn down the barn if she revealed the rape.

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Later in life, this patient succumbed to psychosis, and in the psychotic state hallucinated that the barn where she had been raped was in flames. She also hallucinated the voice of this now long-dead assailant, as well as the voice of another, protective, "good" uncle. Abraham noted that two of this patient's siblings who had not been raped also suffered from dementia praecox, and that, conversely, other children survive rape without becoming psychotic. Thus this patient's illness did not follow directly from the trauma to which she was subjected, but rather from the predisposition to which her siblings were also subject. However, once she succumbed to psychosis, the specific features of her hallucinatory symptoms were shaped by early traumatic events.

The notion of predisposition also figures prominently in the psychoanalytic view of the war neurosis. Abraham (1921/1955), Ferenczi (1916-17/1926); (1919/1926) and Lorand (1943) all concluded that a preexisting instability or abnormality in the sexual make-up underlies the formation of a traumatic war neurosis subsequent to the experience of trauma in war. Ferenczi (1916-17/1926) distinguished between two types of war neurosis. In one type, symptom formation parallels conversion hysteria, while in the other, symptom formation conforms to anxiety hysteria. Ferenczi further observed that the preparation for shock prevented the development of traumatic neurosis. Here his views were in line with Freud's formulation that the state of preparedness prevents the overwhelming of the ego.

Subsequent writers also emphasized the formative, predisposing impact of early life events. Greenacre (1941/1952) stressed the importance of such events in determining a predisposition to anxiety. Specifically, she postulated that the earlier in life sever traumas occur, the greater are the somatic components of their imprints.

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Following Freud's formulation in *Inhibitions, Symptoms, and Anxiety* (1926/1959) that certain dangers are more likely to precipitate a trauma if they occur in a specific developmental phase, Greenacre (1950/1952) suggested that phase specificity may also determine what the effect of the trauma will be: whether it will serve to reinforce the libidinization of the dominant phase or instigate a regression to, and fixation on, an earlier phase. Lewis and Sarrel (1969) suggest that the developmental tasks which are specific to the phase in which a trauma occurs are the most vulnerable to impaired resolution.

In addition to the vulnerability of specific phases to specific traumas, writers have expanded on the notion (Freud, 1917/1959; Abraham, 1907b/1955; Ferenczi, 1933/1926) that the experience of trauma predisposes to future repetition. Fenichel (1945/1972) conceptualized the repetition of traumatic events as one category of repetition compulsion, which also includes two other types—psychoneurotic repetition and instinctual (based on the periodicity of the instincts' physical sources, e.g., cycles of hunger and satiety). The repetition of traumatic events serves the purpose of achieving belated mastery, as seen in children's games, repetitive dreams and symptoms, and the repetitive phenomena of traumatic neurosis. In this type of repetition, the ego's attitude is ambivalent: repetition is desired to relieve the painful tension, but the repetition itself is also painful. Therefore, the person tends to avoid it, resulting in compromise formations of smaller scale repetitions.

Fenichel suggested that the likelihood of an incident having a traumatic effect is in "direct relationship to the unexpectedness with which it occurs" (1945/1972, p. 118). This conclusion derived from the notion that the ego is specifically developed for the purpose of avoiding traumatic states: i.e., it generates a state of preparedness so that it will not be overwhelmed. Thus

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the predisposition to traumatic neurosis is an insufficiency of the basic ego function of overcoming past traumata and avoiding future traumata.

In a similar vein, Bergman and Escalona (1949) found that children with unusual sensitivities develop a precocious ego organization to supplement their weak protective barriers against stimulation. These premature ego organizations are fragile, and prone to break down under stress. These children are hence especially vulnerable to trauma.

The mother's role as an auxiliary stimulus barrier or ego, and her failures in this regard, have also been implicated in predisposing the infant to trauma (Khan, 1963). Greenacre (1958/1971) suggested that early maternal failures become embedded in specific character traits. She further suggested (1967) that trauma is more likely to occur if preoedipal difficulties exist. Boyer (1956) found that maternal overstimulation or deprivation can have traumatic consequences. Putnam, Rank and Kaplan (1951) link the infantile ego's predisposition to trauma to its inability to recognize whole objects, a characteristic result of inadequate caretaking. They base this observation on Rank and Macnaughton's (1950) earlier work, which concluded that a failure to introject the whole object makes the child incapable of acquiring the synthetic function necessary for the control of drives.

Winnicott, in his writings on the good-enough mother and good-enough holding environment (1949/1958; 1960a/1965; 1960b/1965) described the mother's initial task as assuring the infant's experience of "going-on being." Maternal failures in protecting the infant from impingements on this state result in a premature defensive organization which is the basis for ego weakness and the development of a false self, which, in turn, predispose to future breakdown. Steele (1970, 1982, 1986) has noted that the mother's failure to act as a protective shield is one of the maternal inadequacies

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resulting in trauma, that is found in cases of child abuse and neglect, and in failures of attachment. These failures create cross-generational patterns of abused children who in turn become neglectful or abusive parents.

Ferenczi (1933/1955) had earlier noted that "precocious maturity" was a sequalae of sexual trauma, which, in a positive vein, he also termed "traumatic progression." However, he had noted the dangers of this premature development as well, for it included only part of the personality: the rest was split off and regressed. Repeated shocks resulted in repeated splits, which could lead to fragmentation and ultimately atomization.

The Adaptive Function of Trauma

Other writers have written about the adaptive—or potentially adaptive—function of trauma. Hoffer (1952) designated the infant's states of psychological helplessness "silent traumas," which he equated with Mahler's concept of "organismic distress." Hoffer deduced it is the object's assistance that enables the infant to recover its state of pretraumatic organization: a recreation of the feeling of self lost under the stress. He thereby concluded that an active drive toward objects emerges from the occurrence of trauma and anxiety.

Stern (1953) distinguished between "normal primary traumata" and secondary "pathogenic traumata." Though the former can become pathogenic, they serve an adaptive function, in being responsible for the development of general functions such as anticipation. Stern described these traumata as normal occurrences during the first months of life that result from disruptions of homeostatic states by stress. Murphy (1958) viewed trauma as serving an adaptive function insofar as the need to master early traumas contributes to the rise of ego nuclei. Whereas the proper dosage of

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trauma may assist the development of the integrative faculty, too great a trauma may have a pathogenic effect, i.e., lead to dissociation. Stern too ascribed a potentially pathogenic effect to normal primary traumata if constitutional—i.e., predisposing—factors are present.

Rangell (1967) similarly views trauma as states that can resolve into either favorable adaptation at a higher level of functioning or into a more pathological psychic state. The adaptive outcome is not inherent in trauma—not is the pathogenic one. Rather, adaptive outcomes are a consequence of reparation by the ego. Ekstein (1963) conceptualized trauma not only as an inevitable part of human experience, but also to a large degree as apparently needed. Greenacre (1967), in discussing the view that it is the content of fantasy that is the traumatic determinant, as opposed to the drive or sexual event *per se*, speaks of the maturational pressure that causes children to utilize the slightest opportunity for experience, and hence to provoke or create traumas.

Changing Concepts of Trauma

Broadly speaking there are two discernible trends in the psychoanalytic formulation of trauma since Freud. One trend, prominent in the 1950s and the 1960s, broadens the concept to include ongoing stresses; the other, more recent trend, largely restricts it, emphasizing one or another aspect of Freud's view.

Glover (1929/1956) described the memories of traumatic events as well suited to the defensive purpose of screening repressed material. As illustration, he cited a patient who could recall burning his hand between the ages of three-and-a-half to four, even while maintaining amnesia for his circumcision, which occurred during the same period of time. Anna Freud

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(1951) added that such a screen memory can stand for a group or series of traumatic events.

A number of theorists have rejected the notion that a break in the stimulus barrier is a fundamental criterion for the definition of trauma. Loewald (1955) equated Freud's concept of the hypnoid state during which a person is vulnerable to trauma (1887-8/1959) with the infantile state of psychic functioning. In this state no psychic elaboration, abreaction or associative absorption of the traumatic event is possible. The memory traces laid down are primarily somatic in nature, and can be reactivated later.

Kris (1956) developed the term "strain trauma" to designate the effect of long-lasting situations which may have traumatic consequences "by the accumulation of frustrating tensions" (p. 324). He distinguishes this from "shock trauma" in which reality "powerfully and often suddenly impinges on the child's life" (p. 324). Kris added that analysts are rarely able to uncover the single "event" in part because it is often a whole period in life being dealt with' or, if there is a single event recalled, that event is often a function of—as A. Freud (1967) pointed out—the telescopic nature of memory. Additionally, Kris believed that the course of life seems to determine retrospectively which experience becomes highlighted as traumatic.

M. Khan (1963) used the term "cumulative trauma" to designate repeated breaches in the mother's role as a protective shield that are not traumatic at the moment of occurrence, but gain the value of trauma cumulatively and in retrospect, as do strain trauma. These strains and stresses are experienced in the context of child's ego dependence on its mother, occurring over the course of development from infancy to adolescence. Khan, like Kris, differentiates these traumas from gross intrusions resulting in an overwhelming of the ego.

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According to Rubinfine (1962) when the mother fails to function effectively as a protective shield, the infant develops a premature awareness of the object, and a premature differentiation of aggression with which the object is then invested. Although he did not use the term "trauma," Rubinfine's description of these "chronically prolonged, intense inner experiences" are similar to Hoffer, Kris and Khan's descriptions. However, like Hoffer, Rubinfine focused exclusively on early events from the first half year of life and their pathognomic impact.

Sandler (1967) speaks of "retrospective trauma," following Freud's early notion of "trauma by deferred action" (1895/1966, p. 356). A memory of an earlier experience is evoked by a situation and "under present conditions becomes traumatic." Solnit and Kris (1967) in describing the interaction of strain and shock trauma in the case of a three-year-old girl, demonstrated that strain trauma makes the individual vulnerable to shock trauma, in part by its adverse effect on development (e.g., fostering rigidity in ego defenses). Additionally, the acute, traumatic threat of abandonment this child experienced at three-and-a-half reactivated and magnified the impact of a separation from mother eight months prior so that, retroactively, it too was experienced as a trauma.

Neubauer (1967) delineated three factors he considered significant in determining the occurrence of trauma: 1) object relations, inasmuch as the object is the source of protection and gratification for the infant; and fear of object loss or separation from the object is basic to infantile trauma; 2) the state of developmental organization; 3) the strength of constitutional versus environmental factors. He noted the broader view of trauma as a consequence of deprivation. Such deprivation had been described by Spitz (1945, 1946) in his observations of institutionalized infants, deprived of

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maternal care and stimulation, suffering from marasmus and anaclitic depression. Bowlby (1958, 1960) noted, as well, the negative impact on development of maternal failures in infant care. Greenacre (1967) noted that the absence of stimulation needed for development, even though the stimulus itself is uncomfortable, can constitute deprivation trauma.

In broadening the concept of trauma, some psychoanalysts have come to view anxiety itself as potentially traumatic. For instance, Rangell (1967) wrote of "symptom producing anxiety." In his view, anxiety can act as a traumatic insult in certain circumstances, or can lead to traumatic effect. Similarly Robertson (1956), in discussing the impact of a tonsillectomy on her four-year-old daughter, suggested that anxieties become pathogenic—i.e., traumatic—when they rise above a specific level. Robertson believed that it is not the external danger which accounts for the traumatic value, but instead that it is how the danger merges with, and is transformed by, internal experiences such as wishes and fantasies.

The notion of symptom-producing anxiety is at variance with Freud's 1920 view that anxiety can not produce a trauma: "There is something about anxiety that protects its subject against fright and so against fright neurosis" (p. 6-7). In taking issue with the idea that anxiety itself can be traumatic if of sufficient intensity, Furst (1967) returned to Freud's notion that anxiety serves to ward off trauma, observing that if it does not do so it has failed to achieve its function of signal anxiety.

Eissler (1966) addressed the question of whether anxiety in dreams can precipitate a traumatic experience, and concluded that only excessive id stimuli or external stimuli can do so.

Greenacre (1967) saw trauma not as confined to circumscribed episodes, but as including traumatic conditions. She defined these, along the lines of

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Freud's more broadbased view of 1906, as "any conditions which seem definitely unfavorable, noxious, or drastically injurious to the development of the young individual" (p. 128). Thus, she recognizes that some degree of trauma is inevitable and ubiquitous. However, she believes that overt traumatic events when associated with an underlying fantasy, create a more intense impact, with greater likelihood of fixation. In a later paper (1980), she argued against the sole emphasis on the fantasy component of trauma as its determinant, to the exclusion of external reality factors. This view has in fact begun to predominate in recent years, as the emphasis has shifted to a narrower construct of trauma.

A. Freud (1967) suggested that the term trauma was most useful if confined to a narrower usage that included a return to the structural characteristics of the traumatic situation described by Freud in 1926: a breakthrough of the stimulus barrier followed by helplessness of the ego in the face of the overwhelming excitation, whether of external or internal origin. She specified two aspects of Freud's description as essential: 1) the suddenness and unexpectedness of the overwhelming excitation which vitiate against successful defense; and 2) visible, immediate aftereffects which are signs of ego disruption. She noted that under her more restrictive definition the events termed retrospective, screen and strain "trauma" might predispose to trauma, but are not considered traumatic in and of themselves. Additionally, she recommended that the concept of trauma be confined to the stage of development when sufficient structuralization has taken place to allow for ego mediation. Thus, in her view, the infant in the undifferentiated phase experiences distress but not trauma—a distress which is equivalent to the state of helplessness following a trauma. To A. Freud the essence of a trauma is that the ego is put out of action.

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The concept of "stimulus barrier," central to Freud's formulation of trauma, has also come under attack. A. Freud (1967) termed it a metaphor. More recently, Esman (1983), after reviewing the literature on the stimulus barrier in the light of neonatal research, concluded that the metaphor of "stimulus screen" was more apt. The "screen" would function to admit stimuli most consonant with the infant's adaptive needs and exclude those overtaxing its adaptive capacities. The mother's auxiliary role is as a titrator, providing stimuli appropriate to the infant's stage of development and protecting the infant from inappropriate stimuli.

A final contribution of A. Freud (1965) to the theory of trauma is her observation that the specific meaning of trauma to a child requires examination. Schafer (1983) has developed this point further. According to Schafer, danger situations refer to the meaning of the situation rather than the force. As Freud (1926/1959) observed, the instincts are not dangerous in themselves but become occasions of danger when defined as such. Situations are phase specific personal constructions.

> The point of phase specificity, then, is that situations are never given. The child and later the adult fashion and perpetuate situations and do so unconsciously as well as preconsciously and consciously, and always in terms of the bodily and developmental issues and the level of cognitive maturity that predominate at the time. (Schafer, 1983, p. 100)

This is a point made also by Greenacre (1950) and Kris (1956), and stressed by a number of participants in 1986 workshops on the reconstruction of trauma (Rothstein, 1986). Among these, Blum (1986) was in agreement with A. Freud's conceptualization of psychic trauma that restricts it to the phase of ego differentiation, emphasizing the helplessness of the ego in overstimulation and deprivation as well as the intrapsychic meaning of

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trauma. He observed trauma to be associated with automatic anxiety and with intense rage.

Brenner (1986) disagreed with the economic criteria of trauma, arguing that even the intensity of stimuli can only be measured in terms of its meaning to an individual. An event is traumatic because of the way it impinges on a person's preexisting psychic conflict and thus because of the individual's subjective experience.

In Brenner's view the term "trauma" can therefore be applied only after the fact, i.e., only if there was psychic damage.

Dowling (1986) also rejected the view of trauma (Freud, 1920/1961) as an overwhelming of the stimulus barrier, which he viewed simply as a metaphor based on physical trauma. He found Freud's 1926 definition—the experience of helplessness on the part of the ego—more useful. Dowling viewed trauma as an organizing event, but concluded that the psychological process of dynamic interaction with the environment in the event of trauma has been inadequately studied.

McDougall (1986), although in agreement that the intrapsychic meaning determines the traumatic nature of an event, still stressed the importance of the first two years of life, prior to structuralization. She also viewed certain traumata as ubiquitous: otherness, sexuality, and death. These are compensated for with fantasies of omnipotence, bisexuality and eternal youth. Rothstein (1986) considered all psychic trauma to be narcissistic injuries, resulting in the use of "sadonarcisstic and masochistic identifications" (p. 221). This is in line with an earlier paper by Glenn (1984), which observed masochism to be a significant feature in the pathology of victims of assaultive medical and surgical procedures in early childhood.

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Trauma has frequently been viewed as having an adverse affect on development. As has been discussed above, the pathognomic consequences of trauma are sometimes viewed as predisposing the subject to future repetition. Nunberg (1956), following Freud's delineation in *Moses and Monotheism* of the positive and negative effects of trauma in childhood on character formation, described the ego as forming character traits that determine whether trauma is repeated or averted. Ill consequences attributed to trauma have included: premature but fragile ego development; concomitant failures in object relations; failure in drive integration and fusion; and rigidity of defensive structure, among others.

Wieland and Rudnik (1961) have suggested that one type of autism may be a consequence of severe trauma during the period of formation of object relations. Thus object relatedness itself is equated with danger and avoided. A. Freud (1969) has also speculated on trauma as a causative factor in autism. Specifically, she suggested that trauma resulting in total regression to an objectless state is an attempt at adaptation.

Ritvo (1981), in his study of patients with severe neurosis who suffered from repeated, intense anxiety attacks, noted that they had experienced traumatic conditions in the first few years of life. Beres and Obers (1950), in their study of 38 adolescents and young adults who had been separated from their mothers and institutionalized during infancy, observed similar underlying pathology—a maldevelopment of ego and super ego. However, they found that subsequent growth is possible, so that the pathognomic effect of this infantile trauma on psychic structure is not necessarily fixed.

Eissler (1950) discussed delinquents with a pathological feeling of omnipotence, who vacillated from behaving as if invulnerable and omnipotent to behaving like helpless infants. He theorized that this quick

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succession from immunity to helplessness reflects an early traumatic situation, occuring during the period when the child feels omnipotent and attributes omnipotence to others.

Peto (1955) described the states of depersonalization and derealization as consequences of trauma, following Freud's (1936/1964) formulation that these states are symptoms as well as defenses originating in an actual infantile trauma.

A. Katan (1973), in her discussion of six adult patients who had been sexually abused in childhood, notes a failure to differentiate the sexual and aggressive drives. Sexuality and aggression become defused and confused. As Fenichel (1945/1972) noted, heightened excitation itself becomes a threat of trauma repetition.

Child Sexual Abuse

Hitherto, I have discussed the theoretical literature pertaining to trauma generally. I will now briefly survey the literature concerning a particular type of trauma—sexual abuse of children—that is relevant to the case study which follows.

Child abuse in general, and sexual abuse in particular, are increasingly reported phenomena. One of every 22 murders in the U.S.A. involves a parent killing his or her child (Fontana, 1975). The incidence of incestuous abuse of young girls has been reported at three percent or more in the general population (Finkelhor, 1979; Goodwin, 1982). Some studies report that 16% of women before the age of 18 are victims of sexual abuse by male relatives (Russell, 1986).

Browne and Finkelhor (1986), who have done an extensive review of the research in this area, defined sexual abuse as either sexual behavior which

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is forced on a child and/or sexual activity, whether or not coercion is involved, between a child and a person five or more years older. From a psychoanalytic perspective, Steele defined "sexual maltreatment of children" as "the involvement of dependent, developmentally immature children in sexual activity that they do not fully comprehend" (Etezady, 1987).

Child sexual abuse most commonly involves a young girl and an older male. Female victims are reported 10 times as frequently as males. The most common age of the victim is between eight and twelve years, according to Browne and Finkelhor (1986). In other studies, however, 50% of sexually abused children were found to be under five years of age.

Child molesters are usually known to their victims. In 50% of all cases, the abuser is a parent or other close relative; in 40%, a close family friend; and only in 10% of all cases, a stranger.

Contrary to common belief, child abuse and sexual abuse are not correlated with particular socio-economic status (Fontana, 1975; Steele and Pollock, 1974) or ethnicity (Russell, 1986). There is a correlation with fragmented, dysfunctional families, though not with separation or divorce as a measure of chaos (Mannarimo and Cohen, 1986). However, in cases in which the father is the abuser, Mannarimo and Cohen found over 75% of the parents had already separated or divorced.

Manifold immediate and long term effects of child sexual abuse have been reported in the empirical literature. Initial effects of abuse have been found to include fear, anxiety, depression, anger and hostility and inappropriate sexual behavior. However, the studies from which those findings derive are sketchy, and lacking in statistical rigor in that comparison groups are inadequate, and outcome measures are not standardized (Browne and Finkelhor, 1986). Long term effects noted in empirical studies of adult

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women abused as children include: depression, self-destructive behavior, anxiety, feelings of isolation and stigma, low self esteem, tendency toward repetition of the abuse, substance abuse, and sexual dysfunction (Browne and Finkelhor, 1986; Goodwin, 1981). Some studies also identify prostitution as a sequel to sexual abuse in childhood (Silbert and Pines, 1981).

There persists a controversy over the impact of sexual abuse, with some researchers suggesting that the impact has been exaggerated or is not traumatic (Constantine, 1980). However, the preponderance of long term studies suggests that the experience of sexual abuse in childhood predisposes to pathology or maladjustment in adulthood (Browne and Finkelhor, 1986; Finkelhor, 1979; Sedney and Brooks, 1984). Browne and Finkelhor (1986) report that Tufts found 20% to 40% of sexually abused children seen by clinicians manifest pathology in the immediate aftermath of abuse. As adults almost 20% of the victims manifest significantly greater pathology than non-victims. Russell (1986) concluded that the experience of being sexually abused has a pathological effect on the ways incest victims rear their children.

Empirical studies have also researched which factors contribute to pathological outcome for victims of sexual abuse, but do not concur. Browne and Finkelhor (1986) do note trends in their review of research on the impact of child sexual abuse. They list the following factors in abuse as correlating with greater subsequent pathology: abuse by father or stepfather (versus other perpetrator); genital contact; use of force; families unsupportive of victim; removal of victim from home; abuse by male versus female, and adult versus teenager.

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Separation-Individuation

I will close with a brief presentation of the theory of separation-individuation, as the treatment described in Chapter VI is conceptualized within this framework.

Mahler (1972a/1979) has described the first three years of human development as a progression from the absolute dependency on mother to what she calls a relative dependency, which persists, in part, for life. According to Mahler, the process originates in a phase of "normal autism," a phase she views akin to Hartmann, Kris, and Loewenstein's "undifferentiated phase" (1946). This is followed by a phase of "normal symbiosis," akin to Anna Freud's "need-satisfying" phase: a period of secondary narcissism, in which the boundaries of mother and infant are fused, and the infant experiences itself as one with its mother except when in a state of need.

The subsequent course of separation-individuation consists of four sub-phases: differentiation; practicing; rapprochement; and the consolidation of individuality and the beginnings of emotional object constancy (Mahler, 1965/1979; Mahler and La Perriere, 1965/1979). "Separation and individuation are conceived of as two complementary developments: separation consists of the child's emergence from symbiotic fusion with the mother (Mahler, 1952) and individuation consists of those achievements marking the child's assumption of his own individual characteristics. They are intertwined, but not identical, developmental processes; they may proceed divergently, with a developmental lag or precocity in one or the other" (Mahler, Pine and Bergman, 1975, p. 4). Object relations develop along with, and as part of, this process of differentiation from the mother-infant dual unity.

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The subphase of differentiation, beginning at around five or six months, sees the decrease in the complete physical dependency on mother that exists earlier, coincident with locomotor maturation. Explorations are largely of self and mother, carried out in close proximity to her. Mahler also notes the better functioning and the mood consistency of the baby of up to 10 months when near mother, and the baby's preference for playing around her feet (Mahler, 1972a/1979).

The beginnings of the practicing subphase from about seven months to ten to twelve months overlaps with differentiation, and sees the beginnings of locomotor functions (e.g., crawling, climbing) that enable physical distancing from mother. The practicing subphase proper is characterized by free, upright locomotion. Mahler observes three discriminable yet interrelated developments toward separateness and individuation in the early practicing phase: "rapid *body differentiation* from the mother; the establishment of a *specific bond* with her; and the *growth and functioning of the autonomous ego apparatuses in close proximity to the mother*" (Mahler 1972a/1979, pp. 123-124). In practicing proper, the infant becomes absorbed "in his own autonomous functioning to the near exclusion of mother," yet returns to her for periodic refueling (Mahler, Pine, and Bergman, 1975, p. 4). The delight in the spurt in autonomous functions, particularly upright locomotion, is apparent in the elated mood (Mahler 1972a/1979) that is often dominant. Greenacre aptly named this phase (from 10-12 to 16-18 months) the "love affair with the world" (1957, p. 57) in which the infant is relatively impervious to falls and frustrations.

Rapprochement, the third subphase, begins as upright locomotion is more fully mastered, which, in conjunction with cognitive maturation, leads the toddler (aged about 16 months) to an increasing awareness of separateness

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from mother. Greater independence and separateness is combined with a demanding insistence that mother participate in all new activities. There is increased possessiveness toward mother, increased acquisitiveness, and directed aggression—all hallmarks of the anal phase, which coincides with rapprochement. There is also the beginning of verbal communication (Mahler, 1965/1979).

The crossroads of this phase, the rapprochement crisis (Mahler, 1972a/1979; 1972b/1979), is brought on by the child's gradual realization that his love objects are separate people, with their own interests—a realization the mother must also make in regard to the child. This realization necessitates his gradually giving up his delusion of shared parental omnipotence. This renunciation is painful, and not achieved without struggle, frequently with stormy fights with the mother. "Here in the rapprochement subphase, we believe, is the mainspring of man's eternal struggle against fusion on the one hand and isolation on the other" (Mahler, 1972a/1982, p. 130).

In the fourth and final subphase, rapid and complex ego differentiation, the "establishment of mental representations of the self as distinctly separate from representation of the object paves the way to object constancy" (Mahler and La Perriere, 1965/1979, p. 40).

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Chapter III

Hypotheses

Two types of trauma as conceptualized in the theoretical literature and in research on trauma in childhood (Terr, 1987; Kiser, Ackerman, Brown, et al., 1988) will be addressed in this study. One type of trauma, sometimes called "shock trauma" (Kris, 1956) is the sudden experience of helplessness on the part of the ego in response to unmasterable excitation (Freud, 1920, 1926) and as seen in subsequent regression in ego functions (A. Freud, 1967). This type of trauma occurs in the period when some differentiation between ego and id has presumably taken place (A. Freud, 1967). The other type of trauma is the exposure to chronic or repeated stress. Kris' "strain trauma" (1956) and Khan's "cumulative trauma" (1963) are two conceptualizations of this type.

Shock trauma and chronic trauma often occur in tandem. For instance, chronic failures in parenting functions, which in itself have adverse impacts on a child's development (i.e., strain trauma), are often implicated in allowing the child to be exposed to repeated sexual abuse, or shock trauma.

The following hypotheses regarding the consequences of these two types of psychological trauma will be examined in the light of case material.

1. Serious trauma will impair the development of self and object representations and will therefore (a) disrupt the process of separation-individuation (Mahler, 1966/1979) and (b) impede the development of adequate object relations (Kernberg, 1967).

These adverse effects will be manifest in the clinical material in some or all of the following ways:

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a. difficulty in actual, physical separation from the primary maternal figure (Guntrip, 1969);

b. intolerance of being alone (Winnicott, 1958/1965);

c. extreme efforts to deny the experience of anger toward the primary maternal figure, and to shield that person from anger (Kernberg, 1966; 1975).

2. Efforts to master trauma may result in a premature development of certain ego functions (i.e., James, 1960; Winnicot, 1960a/1965; 1963/1965).

These efforts represent early attempts at mastery, in which the infant takes on and enacts the failed maternal function.

3. Traumatized children will re-enact the original trauma both in treatment and in their lives generally. The repetition of traumatic events will be multiply determined, and involve (a) attempts at mastery (i.e., Fenichel, 1945/1972); (b) re-enactment of earlier faulty object relations (i.e., Pine, 1985); and (c) a failure to achieve signal anxiety and a consequent regression to traumatic anxiety (i.e., Freud 1926/1959).

In these repetitions, passive as well as active roles may be taken; and activity may be experienced dynamically as passivity, and vice versa (Rapaport, 1961/1967).

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Chapter IV
The Family History

Presenting Complaints

Hillary A. and her mother, Anna A., were referred to a community mental health center in January 1984, when Hillary was two years five months of age. Anna requested this referral from Special Services for Children because of the intensity and severity of Hillary's symptoms in the months following the discovery of Hillary's sexual abuse by her father.

At that time Hillary's functioning was disturbed in almost every area. In addition, she was becoming increasingly phobic, terrified of anything that related to her father.

Hillary spent her days in a constant state of anxiety. Her mother's days were spent trying to calm and console her. Hillary refused to walk, either at home or in the street, and insisted that her mother carry her around. Anna spent hours each day walking around the neighborhood, with Hillary in her arms.

Hillary's anxiety escalated to panic any time she was reminded of her father: if she saw old clothes of his, foods he preferred, toys she associated with him, or any man with a mustache, as her father had had one. She panicked every time the phone or the doorbell rang. Words could produce the same panic as corporeal reminders: the word "diaper" was particularly terrifying to her, and her own name was abhorrent to her. She frequently stated, "No Hillary, no baby, no kid," all names her father had used for her, and insisted on being called by other names, such as Mickey Mouse, or the dog's name.

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Hillary refused to enter the bathroom. She had to be washed with a cloth at the kitchen sink. Only rarely, and after much calming and coaxing, would she allow her mother to wash her hair. It was difficult for Anna to change Hillary's diaper without Hillary resisting, anxiously and angrily.

Hillary would not look at herself in the mirror. She often said that she wasn't pretty or that she wasn't good, and even pulled at her head saying she wanted to put it in the garbage. The only way she would go to sleep was if she was lying in bed between her mother and grandmother. Even then, she woke repeatedly during the night, in a state of terror.

Anna did note one area of progress in Hillary's functioning: as soon as her father had been removed from the home, she began to speak in full sentences, and thereafter she continued to be very talkative. Before his departure, her verbalizations had been sparse, mostly words and phrases.

Anna A.'s Story

Hillary's mother, Anna A., is a 41-year-old woman from the Bronx, and like her daughter, an only child. She was conceived during a brief liaison in which her mother, Mrs. T., became involved soon after leaving her husband because he was physically abusive. This liaison ended before Anna was born, and Anna never knew her father.

Mrs. T. was the youngest of 10 children; her parents were of Irish and German descent. Her childhood was marked by deprivation and chaos. Her father was a laborer. Her mother, a diminutive woman with long honey-colored hair, died of a miscarriage when Mrs. T. was 11. She remembers blood everywhere, and an ambulance coming to the house to take her mother away. All nine siblings were placed in foster care for several years, following their mother's death. Only Mrs. T., because of her fragile health, was

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permitted to remain at home. Mrs. T. idealized her parents, and though the family was poor, sometimes hungry, and dysfunctional, she attributes no blame to her father.

Although Mrs. T. has been unwilling to specify the precise events, she has told Anna that there were incestuous activities between a number of her siblings, and that she protected herself from being molested by barricading her door at night with furniture and possessions. Several siblings became alcoholics; others were Nazi sympathizers.

Mrs. T., as a result of a congenital heart ailment, reportedly had several "heart attacks" in childhood, and was in a convalescent home for almost one year. In young adulthood, she had several severe depressions, which were treated with medication. For a time she saw a psychiatrist, and it was at his advice that she finally left the husband who was abusing her.

Anna's infancy and childhood, like that of her mother, were also scarred by disruptions in the continuity of her care, failures of protection and ongoing deprivation. At birth, or shortly thereafter, Anna was placed in a foster home where she remained until 10 months of age. Her current understanding is that the Welfare Bureau would not allow her mother to take her home from the hospital, as she lived in a single room without running water, deemed unsuitable for a newborn. Mrs. T. eventually moved back in with her father, Anna's grandfather, in order to regain custody of her daughter.

Anna tells a story from that period that she has learned from her mother. Although it may be apocryphal, this family myth is surely emblematic of Anna's childhood. The story goes like this: When she was in foster care, Mrs. T. visited her infant daughter every Sunday. Although Anna's foster parents seemed to Mrs. T. caring and attentive, each Sunday

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afternoon when she left their home, she was disturbed by Anna's reaction to her departure. In relating the story, Anna is unable to remember whether her mother was distressed because she was completely silent, or because she cried continuously. On the other hand, Anna's reaction to the loss of her foster parents at 10 months, which must have been a severe blow, coming as it did during the height of separation anxiety, is passed over in silence in the family history.

This story encapsulates several prominent features of Anna's, and in turn her daughter Hillary's, history. Major life events are often unnoticed or unremarked upon, or their significance is belittled or denied. Attempted communications of needs are often misunderstood and the roles of the communicants reversed: i.e., the infant bears the responsibility for clarifying cues for the mother. Thus, maternal failures of attunement or protection become the child's failures. An epithet was applied to Anna from childhood: "She never opens her mouth." Similarly, since her daughter Hillary was abused largely when she was preverbal, no one could "know" she was being abused. Now Hillary is frequently adjured to "speak up" to "tell," and Anna says, "I'm glad she has a mouth." Hillary should be what her mother was not, and what she herself was not capable of in infancy: to evoke adequate caretaking by a "loud mouth" that can break through the most recalcitrant denial.

Anna and her mother lived with Anna's grandfather until she was almost three. Anna was passionately attached to him. In her eyes, he could do no wrong. She avers she never missed having a father, because she had her grandfather. The day she was told that she and her mother were moving away from her grandfather's is emblazoned in her memory. She ran and hid under her bed, refusing to come out as the grownups searched for her and

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called her name. Her grandfather finally found her and pulled her out. She was told they were moving because her pediatrician had said it was not healthy for her, with an incipient heart murmur, to live in the same household as her alcoholic uncle. As an adult she had thought there must have been more of a cause for their departure. Thirty-five years later, as she sat in a therapy session with her daughter Hillary's first therapist, the memory came flooding back to her: this alcoholic uncle had molested her. By latency, she had repressed the memory. (She has not yet been willing to specify what this uncle did to her, except to say that it was "not as bad" as what happened to Hillary, by which she suggests there was no penetration, and the abuse did not happen as often, though it did take place more than once.) She believes she was about 2 1/2 when her uncle abused her.

These early separations and the molestation to which she was subject, as well as the general quality of her early childhood experience, left Anna with a longing for protection that has never been satisfied, and a hunger that is unappeasable. She was left too unable or unwilling to specify her fears and needs, presumably because her early infantile gestures had not elicited appropriate response. Later, as Anna reinterpreted events, casting herself in a more active role, a fear of the ill she might provoke, and therefore a need to obscure herself and inhibit all such tendencies, warred with the thrust to actively recreate such experiences, and test the limits of safety.

One of the earliest expressions of the impact of her traumatic upbringing was Anna's longing for death, which she can trace back to her fourth year, to the funeral of a great aunt. Seeing her aunt lying in her coffin, Anna recalls no fear: only a longing to join her and be at peace. When she was asked what she would like to be when she grew up, at the age of five she was replying "an angel."

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Early on, too, came a dread of attention. People frequently inquired of her mother, "Can she talk?" Her silence masked a tumult of rage that she never expressed. Her fierce possessiveness was quite evident without words, however. For instance, she would sit on her grandfather's lap, as she did at her great-aunt's funeral, and try to shield him from the view of her numerous cousins, so that he would belong to her and her alone. Her silence represented a wish to be understood without words, as well as a conviction that her words would be unheeded or themselves the cause of ruin and destruction.

As much as she dreaded to be heard, she dreaded to be seen. These fears coalesced in her loathing to recite in school. She could not bear to stand up in class and be looked at, and when made to, she often could not force the words out of her mouth, even if she knew the answer.

Photographs of Anna from her elementary school years show her to be very pretty, with striking, loosely curly, red hair and green eyes. She was frequently complimented on her hair during her childhood, and found these compliments excruciating. (She began to dye her hair when she was an adolescent.) Likewise, she could not bear sympathy for illness, and would stoically endure pain (including highly painful cystoscopies) without a murmur to avoid commiseration. She routinely lied about being ill for this reason.

Her wish to obscure her body, and to find a sanctuary from the assaults of the world, found expression in her desire to be a nun. She converted to Catholicism when she was nine or ten, after several years of attending Catholic Church, and her mother followed suit a few years later. When she imagined being a nun, she pictured herself in the traditional long, dark, enveloping habit and wimple, which would effectively screen her from the

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eyes of the world. (For her, "bosom of the Church" was no mere metaphor, but truly denoted the nurturance and succor for which she yearned.)

The union with the church would protect her from future separations, though it meant replacing her mother with the mother church. This was the one form of individuation she could imagine. Otherwise, her life had been wracked with the dread of being wrenched apart from those she loved—as she had been from her foster family and her grandfather.

Starting school was experienced as a separation from her mother enforced by malignant authorities. On the first day of school, to allay Anna's fears, Mrs. T mendaciously assured her she would be waiting in the hall. Eventually, Anna could no longer bear the anxiety of being apart from her mother, and dashed into the hall to find her. Panic stricken at not seeing her mother, she ran out of the school, and was several blocks away when her teacher caught her. Though she did not again run away from school (until she began to cut as an adolescent), she remained preoccupied with her mother during the day, imagining her mother would be injured or fall ill while apart from her.

These preoccupations, and her inhibition of all exhibitionistic impulses, prevented her from learning and functioning in school. Though a fluent reader—she read at the fifth grade level in first or second grade—and interested in math, she routinely received poor or failing grades. After she and her mother moved out of her grandfather's house, they were often hungry, and this too impeded her focusing on the external world.

Anna never let on to her classmates the poverty of her living situation. If asked by classmates what she had for lunch on days on which there was nothing to eat (she went home for lunch), she invented delicious sandwiches. She could not bear the stigma of poverty, which she felt marked her as

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different. Unconsciously, there was an equation between the stigma of poverty and the stigma of abuse.

In addition, she could not bear to reveal her poverty, because she could not tolerate asking for help: it marked her as helpless, and vulnerable to abuse; or left her open to rejection, disappointment or rage; or would unleash her insatiable, all-consuming neediness, which would in turn provoke the rejection, abuse, or disappointment that she experienced as the inevitable consequences of dependency.

In fact, there were instances in which her and her mother's pleas for help truly fell on deaf ears: no more so than with her aunt and cousins, to whom an intense attachment intermingled with resentment still persists. After several moves, Mrs. T. and Anna came to live near Mrs. T.'s sister, Aunt E., her husband, and their three children. It was to this sister that Mrs. T. most frequently turned when she was short of money and food. At times Aunt E. and her husband would help out Mrs. T., but on other occasions they would not only refuse assistance, they would also take their meals in the presence of Mrs. T. and her hungry child without inviting them to partake. At other times, Mrs. T. might be asked to do Aunt E.'s sewing or ironing for pay, which was then not forthcoming. Yet Aunt E.'s children were regular playmates of Anna's and her cousin Eileen, in particular, used Mrs. T. as a confidante, discussing with her concerns she would not reveal to her own mother. In fact, many cousins found Mrs. T. an accessible surrogate mother, in contrast to Anna, who would not tell her mother anything.

With these family members Anna felt like a poor relation. Other aunts seemed to exclude them when there were family get-togethers. When she was an adult, she learned that her Aunt E. had routinely turned down invitations for them, saying they would never come, even though this was

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not the case. Of course, in as much as Anna is not a wholly reliable informant, the reality of their relationship is sometimes hard to judge. There were periods, for instance, when Mrs. T. did not like to leave the house.

There is one incident of particular significance to Anna, which to her is paradigmatic of the entire relationship with her aunt and cousins. She and her mother had run out of money and food, and having no one else to whom to turn, after several days of extreme hunger, wrote a letter to Aunt E. describing the situation. For five or six days there was no reply. Anna says she and her mother were weak and dizzy from lack of food, and were reduced to spending their days lying on the bed. Finally, her cousin Eileen dropped by, nonchalantly excusing her slow response to this family emergency.

Despite her lack of trust Anna did form attachments, though they usually ended with her feeling betrayed and disappointed, which confirmed her sense that it was dangerous to love anyone besides her mother and grandfather. When she and her mother moved out of her grandfather's home, her mother rented a furnished room in a woman's apartment and they both became attached to her. However, their pediatrician again recommended a move, ostensibly because the women's three sons—in their late teens and early twenties—had raging fights, largely about politics, as Anna remembers it. The pediatrician thought these displays of anger were having a deleterious effect on Anna's health. Certainly Anna became convinced of the dangers of jealousy, of anger, and of divided love.

This was no more evident than in Anna's relation to her childhood therapist, Dr. V., a child psychiatrist at a large teaching hospital. Around the age of five, Anna had begun to suffer from recurring bouts of uncontrollable diarrhea, alternating with vomiting; and retention of urine, alternating with loss of bladder control. These symptoms might overtake her anywhere,

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including the street, and were a source of great shame and embarrassment. When her local pediatrician could not ascertain the cause, he referred her to Dr. V.'s hospital for a thorough workup. This involved painful, intrusive procedures, including cystoscopies and catheterizations, which had to be repeated over the years; and a referral to the child psychiatric unit for evaluation, to determine if there were contributing psychological factors.

Anna was seen by Dr. V. and remained in psychotherapy with her for five to six years. Both Mrs. T. and Anna viewed Dr. V. as a rival for Anna's affections. It is clear that Anna was greatly attached to Dr. V., if only by the intensity of the disappointment and hate that still persist. Though Anna still calls her "that cold bitch," she is aware that the intensity of her feelings suggests a period of love, and over the course of her current therapy has been able to recover memories from the period of positive, more hopeful attachment.

Her overall impression is of sessions conducted in silence. She would be silent, and would not play with dolls, though she might paint or do puzzles. She remembers once seeing her chart brought down, as thick as an encyclopedia, and peeking in, to find that it was filled with "she said" and "I said." These entries, Anna avers, must have been concocted by her psychiatrist, as she is convinced she rarely said a word.

For all her present-day animosity, Anna remembers that when she was hospitalized at age seven because of a severe bout of diarrhea, she longed for Dr. V. so desperately that she once tried climbing down the fire escape to reach her office. Dr. V. in fact visited Anna daily during her hospitalization, and intervened forcefully with the nurses on her behalf. Anna's impression of Dr. V. is of a big, tall, blond woman, like a "Valkyrie," who made her feel

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safe because of her size and strength. (By contrast, Anna's mother is short and slight.)

Anna now traces her disillusionment with Dr. V. back to an incident when she was about eight (though it is not completely clear, chronologically, when other conflicts took place). As Anna tells it, one day when Dr. V. opened her office door to call her in, Anna threw her arms around Dr. V.'s knees and began to cry. She believes if Dr. V. had responded empathically, she would have been able to talk to her, to "tell her everything." Instead, she remembers Dr. V. pushing her away, saying, "Big girls don't cry." Anna froze inside. This rebuff is still so painful, humiliating and enraging that it took her a number of sessions after she first spoke of the incident to reveal what she had been crying about. She and her mother had been without food for several days, and only had enough money to take one of the two buses required for their journey home from Dr. V.'s office. Anna wanted to ask Dr. V. to lend her two dollars—not for herself, but for her mother. This would have been the first time she revealed the dire straits in which she and her mother routinely found themselves. As she relates it, this "shut me up for good."

Both Anna and her mother believe Dr. V. unfairly blamed Mrs. T. for Anna's separation anxiety, a problem which Anna claims was exclusively her own: she simply could not let her mother go.

According to both Anna and her mother, at one time Dr. V. insisted Mrs. T. undergo a gynecological exam, to prove somehow that she was not a prostitute and an unfit mother. Most overtly, in terms of a competition over Anna, Anna and her mother believe Dr. V. once attempted to have Anna hospitalized on a psychiatric unit. Concurrently, years of fruitless testing and observation suddenly yielded the finding of an actual obstruction in Anna's

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bladder that was causing urine retention and some of her other symptoms. Upon learning this, the chief of the medical clinic reportedly said Anna should be discharged from therapy. Nevertheless, according to the family's recollection, Dr. V. told Mrs. T. that the recommendation was for Anna to continue in therapy. When Mrs. T. confronted Dr. V., she recanted, and treatment came to an end.

A striking phrase reverberates throughout the telling of this story: Mrs. T. being told, by social workers and pediatricians who sided with her, "You're the mother," "It should be up to you, you're the mother." For this was indeed the question throughout Anna's childhood: who was her mother? i.e., who could adequately mother her. Seemingly each parental figure to whom Anna turned failed to protect her, abandoned her, and disappointed her.

There is a second version of how Anna's psychotherapy with Dr. V. ended, markedly different from the version in which Mrs. T. triumphantly wins her daughter back after it was proven that the illness was all in her body. In this version, which Anna also relates, Dr. V. terminated the therapy because she became pregnant. Anna recalls feeling a jealous rage, and believes Dr. V. essentially said she would not need Anna any more because "now I'll have a little girl of my own." It should be noted that up until this time Anna had experienced Dr. V. as wooing her, seducing her, and that she felt a pull. She recalls Dr. V. telling her she would take her to see her house, and describing what a nice house she had. Thus it was a dreadful blow to her when she learned that she would be "replaced" by Dr. V.'s baby.

Anna was about 11 when her treatment with Dr. V. terminated. That an unresolved longing for her persisted is evidenced by Anna seeking her out at the age of 18 to resume psychotherapy. Again, she was rebuffed by Dr. V.,

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who said she only worked with children under 18. Anna experienced anew the feeling of safety that Dr. V.'s tall blond presence inspired in her during this brief encounter. She was impressed to observe that Dr. V. could manage the out of control children in her waiting room, and remembers her ejecting an aggressive one.

Thus in childhood, despite all the rivalries and disappointments, Dr. V. must have seemed like a safe haven, a "Valkyrie" who could have protected Anna from the world, and withstood and contained her rages, if only she could have told Dr. V. what she needed protection from. For Anna needed to be saved not only from her poverty. What she "did not tell" in her sessions was her apprehension of some nameless ill being perpetrated by her uncle; and the actual repetition of sexual abuse when she was eight or nine by her cousin who was five or six years older.

Anna did not clearly recall the abuse by her uncle. The memory was unconscious, but a fear and fascination persisted. Thus she unconsciously put herself in repeated jeopardy with her uncle, simultaneously longing for her mother to protect her.

There are several memories that reveal this ongoing process. For instance, Anna remembers one brutally hot summer's day that she agreed, at her mother's urging to wear only her slip, inasmuch as she was indoors. But then, her uncle came in, and upbraided her, for being so indecently dressed, and she was suffused with shame. On another occasion, her uncle said he would take her to buy shoes, which she urgently needed. Mrs. T. was hesitant to let her go, but Anna insisted she be allowed. Yet she recalls, at the same time that she was urging her mother to let her go, longing inside for her mother to forbid it. She then recalls waiting outside a bar while her uncle drank inside. She could not explain these contradictory impulses any more

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than she could explain her outbreak of tears when she learned he had died. An adult at the time of his death, she still had amnesia for the molestation, but consciously had always loathed him.

In addition to being molested by her uncle, when Anna was almost nine she was molested by her 14-year-old cousin Ernie, her Aunt E.'s oldest son. Anna said nothing to her mother at the time, but her mother was nonetheless suspicious, and confronted his mother. As an adult, Anna learned that Ernie had molested a number of young cousins, and neighbors' children. She recalls with disgust that her Aunt E., even after learning of these instances, did not prohibit Ernie from babysitting for young girls in the neighborhood. When Anna was 15, Ernie's younger brother Max, then also 15 years old, attempted to seduce her. Anna experienced this as being the same kind of abuse as the earlier molestation by his brother. However, this time she resisted, hit Max hard, and raised such a ruckus that all the relatives knew what had happened.

When Anna became old enough to play outside with friends or her numerous cousins, she managed to leave her mother as long as she knew her mother was securely at home. Even as an adolescent, she might call home from parties to check on her mother. Likewise, when she began to work, she called home from the job daily. Anna could manage the separation if she took the active role of leaving. If, on the other hand, her mother even went out to the store while she was home, she fretted until her return. She recalls her mother going out with a man only once during her childhood, and on that occasion Anna grew hysterical.

Anna's difficulty with partings was manifest with inanimate objects as well. She could not throw out toys, or even pencil stubs, imagining their

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hurt if she were to discard them. When her pet bird died, she kept his corpse in the freezer for many months.

She felt the need of an adult to control the impulses—hers and other children's—that would run rampant without supervision. She loved babies, and began babysitting when she was quite young. However, she would never let the children be alone together. For instance, two toddlers, brother and sister, were under her watchful eye even after bedtime. She planted her chair between their two beds. Not only the children's sexual impulses needed to be contained, but also their aggressive ones. Though this watchfulness became a credo after her daughter's sexual abuse, she had adopted it early in life, since suffering the consequences of the inadequacy of the supervision she received and the weakness of her own ego. As proof of this need, she recites a story of a five-year-old girl who was left alone with her newborn brother. When the mother returned, the baby was dead. Anna avers her mother saw the sight and told her of it in latency, but cannot recall whether the little girl had tried to cut off the remains of the baby's umbilical cord, or his penis.

When Anna was 11, her grandfather became seriously ill—tuberculosis was suspected—and he was hospitalized. She experienced her therapist, Dr. V., as trying to keep her away from him, much as she felt Dr. V. was trying to come between her and her mother. Dr. V. cautioned her mother not to allow Anna to visit, and certainly not to let Anna kiss him, because of the danger of infection. When Anna saw him next, she defiantly threw her arms around him and kissed him.

The diagnosis was incorrect: her grandfather had lung cancer, and died that year. In his final illness, she was not permitted to visit up on the ward because of her age, and he was not allowed down to see her. When the hospital called the family to say he was dying, her mother wanted to rush to

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his side. However, her sister E., who had a car, insisted on completing the frosting of a cake and by the time they arrived, he was dead. This incident is one of the "unforgivables" that Anna and Mrs. T. hold against Aunt E. and her family.

The death of her grandfather was the most painful loss in Anna's life. Already a believing Catholic at the time of his death, she tore a rosary apart and flung it across the room, in a rage with God for letting her grandfather die. After his death, she did not attend church for a year. She was also enraged with her aunt and cousins for being insufficiently distraught. Anna still becomes depressed every Thanksgiving, the anniversary of her grandfather's death. Her mourning is also rekindled monthly when she menstruates for reasons that have not been understood as yet, although there seems to be an unconscious wish to have his child.

Anna eventually did return to her religious beliefs. In seventh grade, she met a nun who took an interest in her. She discouraged Anna from becoming a nun, telling her she needed to experience more of life before she could make a sound decision to renounce the world, perhaps not realizing, Anna speculates, the extreme adversity she had already experienced. But in other respects she was empathic and encouraging, and had faith in Anna's intelligence. She tutored her so that she could enter a local Catholic school, where she was Anna's eighth grade teacher. She also arranged for the archdiocese to pay Anna's tuition, which was done on the condition of anonymity. For the first time, Anna liked school, and was able to concentrate and learn. Her grades shot up from the forties and fifties to an average in the eighties. She thought about becoming an accountant.

Unfortunately, the following year this sister—a Maryknoll nun—was transferred, on principle, as she explained to Anna. Her posting was rotated

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every few years so that she would not become too attached to the external world. Shortly thereafter, Anna lost her tuition scholarship, because someone revealed the secret of its source. She returned to public school, where she began to cut class with increasing frequency. By age 16, she dropped out. Later, in her twenties, she took and passed the G.E.D. exam.

When Anna was in her teens, her mother asked the parish priest to explain to Anna that she was illegitimate. This priest was a handsome young man, on whom many of the local girls had crushes. The priest supposedly overstepped his instructions, and also revealed to Anna that her mother's husband had physically abused her. He counselled Anna against becoming a nun, because her mother needed her. Anna reports that this advice created a rift between her and her mother "for the first time." The resentment she felt is one of the few signs of a developmentally healthy wish to be separate, and to renounce the parenting role she had assumed in reaction to her mother's heart ailment, and inability to work, and most of all, in reaction to her mother's own psychopathology and concommitant failures as a parent.

Be that as it may, this priest too betrayed Anna when she turned to him for help at age 18. At that time, she and her mother were on the verge of being evicted and close to starvation. Anna reports he made a pass at her. Once again, her dependency and state of need were reportedly exploited.

Anna developed dissociative mechanisms, as well as using denial, avoidance, projection and splitting, to manage the frequently overwhelming circumstances in which she was placed. In second grade, she found herself sitting in class without a clue as to who she was and where she lived. She looked in the books in her desk to find out her name. After several hours her memory returned.

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She had a similar episode of a fugue state when she was a young adult. She was walking in the street with her mother when a stranger accosted her. Wordlessly she took his arm and began to walk off with him, dazed. Her mother's intervention brought her back. These mechanisms were later to figure prominently in defending herself against the awareness of her husband abusing Hillary.

Perhaps the only aspect of Anna's development that demonstrated a thrust toward health was her involvement with peers. This was confined to after school, however, so that even here there was a marked constriction in functioning. She had no friends in school, but she and her mother now deride her teachers' observation of her "socialization difficulties" because she had a group of neighborhood kids with whom she played daily, as well as her cousins. However, Anna describes feeling secure only if she was sure her mother was home, and even then only if she checked in by phone. She was aware of how socially inappropriate her friends would find this, and always made up an excuse for calling home. The one time in her entire youth that she remembers her mother getting angry with her was when she did not come home until one or two in the morning, without giving her notice.

Anna also had boy friends, although she was not sexually active until the end of her teens or her early twenties. Her love choices clearly bore the imprint of her early experiences: she inevitably selected boy friends who mistreated her, or were not interested in her. She was very attracted to older boys, and later to older men. If a man did become wholeheartedly attached to her, she lost interest.

At 14, she had a boy friend several years older who left her for someone else. This abandonment prompted her first suicide attempt. In retrospect, she maintains that breaking up with her boy friend was not the real reason for

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her suicide attempt, that it was a convenient excuse to escape the misery she had always suffered. The thought of actually killing herself (as opposed to her lifelong, ego syntonic yearning for death) came to her on the spur of the moment one evening when she was out with her friends. They were at the local store, buying something to drink. She suddenly thought, "Why not do it now?" She bought a packet of razors, went behind the store, and slashed her wrist—horizontally, because she explains, she did not know the effective way to do it. Her friends called for her, and as she walked toward them, her blood flowed on the sidewalk. Her wrist was gaping apart at the wound. They called an ambulance. Anna insisted that she had fallen down and cut her wrist on a broken bottle, and begged to be taken home to her mother first. The ambulance attendant complied. Unconsciously, she wanted to show her mother, so that her mother would "know." She was not hospitalized, as at the emergency room, where her wrist was stitched together, her story of having had an accident was accepted.

Later on, this boy friend was sent to prison for murder. Upon release, he wanted to get back together with Anna and marry her. While Anna had felt she was in love with him up to this point, she now lost interest.

Anna recalls not knowing the "facts of life" until she was 15 or 16. A male friend told her about intercourse and conception, despite her protestations that she already knew. Anna had started to menstruate at age 12, and knew that this meant she could have children, as it indicated as much on the Kotex box. But she still did not know how children were conceived. She had welcomed the onset of menses, however, as she loved babies and imagined a large family of 10 children for herself.

Anna, like her mother, went through periods when she was fearful of leaving the house. At 19, she had a clerical/secretarial job in Manhattan.

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(Until she went to work, the family had subsisted on public assistance.) Her employers valued her, and wished to give her a raise and promotion. However, she could not tolerate the commute to Manhattan, where she felt disturbingly alien, as if she was not good enough to be there, and eventually gave up the job. For months she only left the house to walk her dog, usually late at night, and to go to the store. She gained a good deal of weight, until she weighed over 200 pounds. Her bulk clearly served as a protection against being looked at, which she found increasingly difficult to tolerate. Around this time she began to respond to what she thought were the stares of others with aggressive challenges—"What do you think you're looking at?"—quite different from her usual passive acceptance of actual encroachments. In addition to feeling out of place on the street, she began from time to time to experience macroscopy and microscopy, i.e., things appeared larger than life size or smaller than life size when she was out of doors.

Anna also attempted to join a convent. The first one she approached rejected her because she was illegitimate, which for her was confirmation that she was scarred, not good enough. Subsequently she applied to a second convent, but she could barely conceal her dismay when she met a nun from this order and saw her dressed in a short modern habit. Anna had an old photo of a member of the order, dressed in the old-fashioned, concealing habit. In revulsion, she told the sister she could not join the order.

It was following this decision that she became sexually active, for until now, in accordance with Catholic teaching, she had been keeping herself pure for her marriage to the Church.

In her early twenties, Anna became pregnant. During this pregnancy, she went to the hospital for an examination, only to be informed by the doctor that she was not pregnant. She had entered the room with a rounded

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belly. By the time she got home, she reports, she was "as flat as a pancake." Initially, Anna accepted the doctor's diagnosis of a phantom pregnancy. Subsequently, she recovered a memory of a spontaneous miscarriage: of going to the bathroom late one night and seeing a bloody mess in the toilet. Following this miscarriage, she became depressed, and sought treatment with a psychiatrist. She describes the treatment as very circumscribed, focusing on the miscarriage, as she refused to discuss her childhood. However, she experienced the therapy as helping her get over the loss of her child. The psychiatrist prescribed medication. The hospital had given her Valium, which she had thrown away. She only found Stelazine useful, a medication her G.P. had also prescribed for her over the years.

The confusion in her own mind—as to whether she had a real or phantom pregnancy—was typical of her experience of her body, and the insufficient differentiation between the somatic and the affective. Dating back to her childhood, physicians had been hard put to differentiate between the physical and psychogenic sources of her ailments. Caretakers had inadequately understood her bodily and emotional cues and failed to protect her. As a child of six she complained to her beloved pediatrician that she had headaches, only to be told "young kids don't have headaches." Yet frequently, her body did express her emotions—e.g., a readiness to vomit when she experienced disgust.

She went through a period of months when she made herself subsist on coffee and cigarettes, forcing herself to vomit anything she ate so that she would lose weight. She eventually became dehydrated, and narrowly avoided hospitalization.

On another occasion, she suffered severe toothache for months on end, until it reached a point that she could barely move her jaws. She recalls the

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infection was so widespread, the dentist feared for her life. Thus in adulthood she too ignored the signs from her body, and even actively abused it.

In her twenties, Anna found a job at a local manufacturing plant. Then began what she recalls as the happiest period of her life. Though she called her mother every day from work, she enjoyed working, and became friendly with numerous colleagues. Among her friendships was a close one with a supervisor that stirred unconscious homosexual longings and fears. This supervisor introduced her to shoplifting, which was an ego syntonic, thrilling activity that persisted for many months. Anna loved the satisfaction of "getting something for nothing" and always picked items she really wanted. The pleasure was spoiled when her friend was caught shoplifting, while in Anna's company, and narrowly avoided arrest. Anna gave it up thereafter.

Anna was successful at her work during her eight years at the plant. She was picked for promotion to supervisor several times but each time rejected the promotion. She did fill in when a supervisor was absent, but preferred being out on the floor, packing goods with her friends, despite the hard physical labor.

While working at the manufacturing plant, Anna had a number of boy friends. Her description of her relations with men in general suggests an unconscious sexualized aggressive component which emerged in sarcastic but flirtatious banter.

The boy friend who played a dominant role in these years, and whom Anna describes as the one man she has ever really loved, was a widower 30 years older than she. The parallel between her intense feelings for this man, Vince (then in his early sixties), and her love for her grandfather is

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immediately evident—so much so that Anna herself feels called upon to deny it, asserting that the link people make between a woman's relationship with her boy friend or husband and her father is "disgusting."

Vince had daughters who were Anna's age and older, and grandchildren as well. He was a man of Italian extraction, who ran a small business which was fairly successful. He also had links to small time gangsters. Their relationship was kept secret from his children because of their age difference. Although Vince felt that Anna broke off with him because he could not marry her, Anna asserts this is not so. What she could not tolerate was his children coming first. She had an unbearable fear that he would die and abandon her, like her grandfather. If he were ill, she would not be allowed to be with him in the hospital; if he died, to come to the funeral, for that was his children's place. Thus even in death they would be divided. This was her central fantasy.

There was one other intolerable aspect to the relationship with Vince, which Anna was able to articulate only after several years of treatment: Vince would never say that he loved her. He would show he loved her, but he never put his feelings into words, whereas Anna was both very affectionate and very expressive of her love.

Anna's sexual relationship with Vince was the only one she ever found satisfying. She states he taught her everything about sex; previously, she had pretended to be experienced, but really was ignorant.

Anna met her husband-to-be, Peter A., while he was making deliveries to the plant where she worked. When they met, Mr. A. was 23 and Anna 32. She began to date Peter when Vince was in Europe on a combined business trip and vacation.

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Everyone at work disliked Peter A., whom they called "creepy," and warned Anna against him. She refused his first several invitations, but eventually agreed to a date, during which Peter asked her to marry him. Anna at the time thought this peculiar, and when she learned of the age difference between them, refused to go out with him again. She finally succumbed to his importunities. Over the next weeks, Peter overwhelmed her with attention: he sent her flowers at work, called her daily, proclaimed his love for her, and besieged her with marriage proposals. During one of their first dates he told her he had been sexually molested by his parents (with whom he still lived). The thought crossed Anna's mind that he could be a child molester, but she buried it. In retrospect, Anna realizes how peculiar her husband is, and cannot understand how she agreed to marry him. Nonetheless, after four months of dating, she consented to do just that, and they planned a church wedding for the following April. Anna says that sex with Peter was unsatisfying, unless she had something to drink, as she did the night she became pregnant.

Anna as Mother

Anna insists that she knows the precise date that she became pregnant with Hillary because she "felt it" as soon as she and Peter had sex. Shortly afterwards a missed menstruation confirmed her belief. However, she soon repressed awareness of her pregnancy, and by the time she gave in to Peter's urgings, and secretly married him at City Hall at the end of December, it was forgotten. A doctor informed her of her pregnancy in February, after she sought an examination because of her persistently swollen belly. She was pleased and Mr. A. was reportedly relieved that his wife did not have a tumor.

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Neither Anna nor Peter initially told their parents of their marriage, and for a time the couple continued to live separately. When Peter finally broke the news to his parents, they were furious and banished him from their house. Peter now took up residence with Anna and Mrs. T., sleeping on the couch until Anna too told her mother of the marriage.

Mrs. T. had also opposed their marrying, as she disliked Peter A. from the outset. However, Anna dismissed her mother's warnings as possessiveness, and similarly dismissed her friends' shock at her marriage as envy or jealousy.

Anna enjoyed Peter's adulation, which contrasted sharply with Vince's reticence. Yet she also felt smothered by Peter's possessiveness. She thinks he wanted to marry her to feel he possessed her exclusively, but marvels that she married him, particularly in that, as a Catholic, she does not believe in divorce. Anna says she was adamant that her child would have a father and stated often that nothing—not alcoholism, unfaithfulness nor physical abuse—could have caused her to leave Peter except his abuse of Hillary.

These protestations bely the depth of her ambivalence that was evident from the beginning of their relationship. Several times before their marriage she broke off their relationship, and when she returned home from the hospital after Hillary's birth she asked Peter for a separation, but gave in to his pleas. She also experienced some fear of him that she believes may have tempered her demands for a separation.

Anna describes her pregnancy as easy, but notes that she did gain 67 pounds and twice was hospitalized for toxemia—once for two weeks, and then following five days at home, for the last four weeks of her pregnancy.

Anna's labor was long and difficult. After 30 hours, Hillary was finally delivered by caesarean section.

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For the first few days, Anna did not want to hold or feed Hillary. She found Hillary's gaze direct and peculiarly piercing. She felt guilty about her lack of maternal feeling, and was temporarily relieved when a nurse explained to her that it was not an uncommon reaction. Though Anna had always wanted a boy, she described herself as content with a girl.

Hillary was bottle fed from birth, as Anna found breast feeding "disgusting." She also recalls with disgust that one of her roommates' breasts became huge overnight, from being engorged with milk, when she stopped breast feeding. Anna began to wear a bra day and night to "prevent" this happening and continues to do so to this day. Yet, simultaneous with Anna's lack of bonding and even revulsion to her baby, and the baby's neediness, she experienced a sense of protectiveness and suspicion. Although consigned to bed rest, she dragged herself down to the nursery to see Hillary.

Hillary was allowed home after five days, whereas Anna remained in the hospital for two weeks longer because of infected stitches and high fever. She ultimately got the hospital to discharge her by putting ice under her tongue to mask her fever, a ploy suggested by a nurse. Anna believes she could easily have died in the hospital if she hadn't taken matters into her own hands, as the medical care was so inadequate, and the conditions poor; her G.P. seems to concur in her opinion.

Even before Anna came home from the hospital, her mother found blood in Hillary's diaper. Mrs. T. also noticed that Peter locked himself in the bedroom with the baby during these first weeks, and that Hillary screamed endlessly. As she tells it now, Mrs. T. even then suspected her son-in-law of sexually abusing Hillary. She supposedly tried to warn Anna (exactly when she first did this remains unclear), but Anna dismissed her warnings as part of the ongoing enmity and rivalry between her mother and her husband.

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The family lore contains several stories, all subsequent to Hillary's birth, of this enmity: Mrs. T. kicking Peter in the behind when he was leaning into the refrigerator; Peter mixing an antiseptic into Mrs. T.'s shampoo; and so forth.

As noted above, when Anna returned home from the hospital, she attempted to separate from her husband, but gave in to his pleas. She now slept on the couch, leaving her husband the bedroom. In fact, soon after her pregnancy was confirmed, Anna and Peter had virtually stopped having sexual relations. On those occasions when they had attempted intercourse, Peter had proved impotent.

Although Hillary had her own room, very soon Anna took her to sleep on the couch with her, ostensibly because she cried so much. In retrospect, Anna thinks that on some level she did not want to leave Hillary alone because she mistrusted her husband. Much of the abuse seems, from Hillary's later reports, to have occurred at night when Anna was asleep.

Anna says she knew yet did not know that her husband was abusing Hillary. Certainly, she kept full recognition out of consciousness, often through dissociative mechanisms. For instance, on one occasion, Anna walked out of the kitchen into the living room, only to "see something" that drove her back into the kitchen without knowing what she had seen. To this day she cannot remember, but thinks she must have seen Peter abusing Hillary. On another occasion, she recalls finding Hillary's diaper undone, and on still another instance she recalls finding semen on Hillary's night gown. On that occasion, she immediately washed out the horrifying evidence, and quickly forgot or denied the significance of what she had seen.

Anna never experienced herself as a competent mother. This feeling was intensified by her discovery of Hillary's abuse, which may color her

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reporting of this earlier period, but it undoubtedly predated her discovery: Anna has never felt competent in any regard. Her primary conscious maternal feeling appears to have been a failed vigilance. The unconscious conflict over protecting Hillary was of course evident in these failures. Although she was unwilling to leave Hillary alone with Peter for one moment, at night she fell into a sleep so deep—"as if I was drugged"—that nothing could wake her. The expectable maternal watchfulness and responsiveness—which wakes the mother when her baby cries—was overridden by her denial, her shutting out even in sleep, which enabled her unconscious compliance in Hillary's abuse.

Her compliance speaks to the core of her relationship with Hillary: that Hillary embodied her negative self-representation, of a damaged, vulnerable, unlovable girl. Hillary was never fully differentiated from Anna, but remained a self-object, on whom Anna's past trauma had to be repeated.

Anna's vacillating feelings toward her child had been evident in her pregnancy, in her "knowing" she was pregnant, and then "forgetting" it. Throughout Anna's life, her devaluation of women and preference for men had been conscious: in her denigration of women, e.g., of women doctors; and in her own sense of being vulnerable and worthless, in part because she was female. This represented a convergence of her self-experience and representation (that she was abused because she was a girl and hence damaged and abandoned by her father) and her negative object representations (her ill mother, incapable of protecting her from want, loss, and abuse). Hence she had longed to have a male child. Though consciously she had experienced no disappointment when Hillary was born, her initial revulsion may well have been in response to her being a girl.

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Throughout this period, there were increased threats, hostility and violent tension between Anna and her husband. There were, as well, interchanges in which Anna accused her husband of harming Hillary and threatened him with physical injury in return. When Anna left Hillary alone with her father for a few minutes, the baby would begin to cry. Anna contends that very soon she ceased to leave Hillary alone with him, but says there were moments—when she was in the bathroom or kitchen or asleep—that Hillary was unprotected. In short, Anna walked a tightrope between suspicion and denial during Hillary's first two years of life.

Anna's relationship with her husband was highly ambivalent. As described above, she felt stifled by his attentions and possessiveness; his numerous, daily phone calls; his insatiable demands for demonstrations of love; his jealous whining and sadistic envy of the care and attention lavished on Hillary. Yet she seems to have enjoyed provoking his jealousy by flirtation or banter with delivery men or shopkeepers—and by exaggerating the significance of these interchanges. When she first returned from the hospital subsequent to Hillary's birth, she felt like she wanted to run away—from him, their home, their baby. This is an impulse Anna had frequently had during her life. At first she contained it by going out early in the morning, leaving Hillary with her mother, and walking and shopping. Later, she began to take Hillary with her. As throughout her life, she vacillated between a longing for a perfect union, and a fear of engulfment.

From Anna's return home, Peter was consumed with jealousy over Hillary. He demanded attention and whined if she attended to Hillary. He complained that Anna preferred Hillary, and ignored him. When Anna bought Hillary a present, he demanded one as well.

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Peter also threatened Hillary verbally: he said he would beat her, or put her in the garbage. He teased her sadistically, proffering her a toy or interesting object, only to snatch it away when she responded. He also teased and physically abused the family dog, which Anna had had for several years before her marriage. From early on, Hillary pushed her father away.

Hillary's Story

With respect to Hillary's developmental history, events and their reporting are both overshadowed and recast by her abuse. Anna's response to many aspects of Hillary's functioning have been obscured. Some sparse facts are recalled from Hillary's first years. Until her father was thrown out, she reportedly never slept the night through. Similarly, she reportedly was a poor eater, who basically subsisted on a bottle and baby food, eschewing solids until her father left. However, this report is contradicted by stories of her father's envy of the special foods bought for her. For instance, Anna recalls Peter guzzling Hillary's chocolate milk. Eventually, Anna took to hiding special candies and cookies for Hillary in the back of a closet, but these too Peter found and devoured. These incidents reveal Peter's intense oral envy and greed, but also suggest that Hillary did in fact consume some solid foods.

Hillary spoke her first words early, but had few phrases or sentences until her father left the house. She was not toilet trained, and in fact was afraid of having her diaper changed and of going into the bathroom.

However, Hillary's motor development is described as precocious—Anna insists that Hillary could hold her head up the week following her birth. Turning over and sitting up were also achieved early. From mother's description, Hillary appears to have differentiated early, and to have been prematurely alert and even vigilant toward the external world. Photographs

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of Hillary in infancy do portray an alert, attentive and developed baby, supporting the notion of her premature ego development and lending some credence to the descriptions of her phenomenal memory. Anna has repeatedly reported Hillary recalling events or objects from her ninth or tenth month that Anna herself had forgotten until Hillary recalled them: for instance, shoes with butterflies that Hillary wore but had been discarded by her first birthday.

Her memory also encompasses actions of her father's, which she began to relate in increasing detail after one-and-one-half years of treatment. She has described him luring her, and the dog, into his room and then the attic crawl space by tempting her with special toys, only to torment or abuse her. The expectation and excitement in being lured is the only "positive" feeling Hillary has ever uttered in relation to her father, though it is a source of guilt as well.

Anna reports that Hillary as an infant was frequently in distress, often inexplicable distress. She began showing a pronounced aversion to her father around the age of one year—crying if he approached her, wanting her mother to take her in her arms—or at least this is when the aversion was remarked on. It must be borne in mind that some of the haziness regarding events, dates and milestones of Hillary's first two years speaks to the semi-dissociated state that her mother was in, by which Anna obscured her own awareness and denied her mother's hints.

Anna recalls Hillary's second birthday as a particularly stressful day. Hillary was in constant fear of her father, and wanted to be held by her mother without cease. It was less than two months later that Anna's pediatrician directly confronted her with the fact of Hillary's sexual abuse.

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Mrs. T. persuaded Anna to take Hillary to the pediatrician because of her terrified state. Dr. E. was in fact their family doctor of long standing, idealized by both Anna and Mrs. T. When Hillary was brought to his office, she cried and screamed, "No more men," alternately covering her mouth, crotch and behind. Anna initially responded to Dr. E.'s statement that Hillary had been sexually abused with disbelief, asking how it was possible. He asked simply what male was in the home. This breached Anna's denial, and she was flooded with awareness of her husband's actions. Because of Hillary's terrified state, Dr. E. did not examine her.

This was the last time Anna saw Dr. E. She could not forgive that he said about Hillary, "She'll get over it," though quite possibly she could also not forgive his breaching her denial. Dr. E. did not report the abuse to Special Services for Children; possibly, as Anna believes, he was afraid of Mr. A.

It took Anna a week before she told her husband to get out of the house. She called him at work, and told him not to come back; packed up his things, and left them with the landlady. At first, Peter called her frequently, begging her to take him back, but never denying or commenting on her accusation. He wrote her letters asking for a reconciliation. Anna is at a loss to explain why she was often in tears during this time, crying over Peter, when he called or she thought of him.

It was Anna who called Special Services for Children to report her husband, and it was she who contacted the police. To press criminal charges, Hillary would have had to undergo an internal gynecological examination, and Anna was unwilling to subject her to this, as Hillary was in an ongoing state of panic. Hillary had already been terrified by a Special Services worker, who abruptly confronted her with anatomically correct dolls and demanded that she show her what Daddy had done.

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This was a period of turmoil and chaos for the family. The landlady raised their rent. Anna attempted to return to work, to support the family, but after several days quit, because Hillary was hysterical when she was away. Though Hillary wanted to be carried by her mother, she would also lash out and try to scratch her face and hit her. Words began to pour out of her. Anna went on Public Assistance, but had to find another place to live, which she sought without success. She joined a parents' support group, but found the other parents' stories agitating rather than helpful. She entered individual therapy, obtaining a referral through the archdiocese, but quit when her male therapist reportedly tried to seduce or date her. (It has never been completely clear whether he actually did so, or was making transference interpretations, albeit prematurely.)

As eviction loomed, Anna secretly planned to kill herself, Hillary, her mother, and their dog. At the last minute, a friend, Annie, who lived with her mother, offered to take them in. At this same time, Anna obtained a referral to the clinic from SSC, and Hillary began treatment.

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Chapter V
Course of Treatment

The First Year of Therapy

The history of the first 4 1/2 years of the treatment of Anna and Hillary A. illustrate the dramatic impact of early trauma on character formation, on psychic functioning and on the course of life generally. In this family, the trauma of sexual abuse—and its consequent function as an organizing principle—was linked to separation, so that separation itself, and the process of separation-individuation, came to be experienced as traumatic. The fear of being overwhelmed; the intolerance of, and predisposition to, anxiety; the heightened significance of the positions of passivity and activity; and the tendency to repetition are illuminated by the case of Anna and Hillary A. In the pages which follow, the simultaneous treatment of this mother-daughter dyad is detailed. An analysis of the theoretical implications of the case is more fully presented in the final chapter.

The case of Anna and Hillary A. was transferred to me when their previous therapist, Mrs. N., left on completion of a one year training position. At that time, Hillary had been in therapy with Mrs. N. for six months. Anna A. had been seen by Mrs. N. collaterally, for parent guidance.

The family's functioning was characterized by the unsuccessful completion of the separation-individuation process by succeeding generations. At the outset of treatment, grandmother, mother, and child needed to be seen together in sessions, for they functioned as one unit whose members could not be parted from one another. To separate them would have been akin to sundering a single integrated organism. It would very

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likely have induced a sense of panic and helplessness in mother and daughter, and destroyed the possibility of treatment.

Rather than attempting to enforce an immediate physical separation, when there was as yet no true intrapsychic separation, I initially saw grandmother, mother and daughter together on a once weekly basis, as Mrs. N. had done. The goal of the weekly therapy session was to enable the family, and mother and daughter in particular, to have first a satisfying experience of symbiosis. In this respect, the treatment was arranged along the lines of the tripartite treatment design devised by Elkisch (1953, 1971); Mahler and Elkisch (1953); and Mahler and Furer (1960/1979); and implemented and elaborated by Bergman (1971). This experience is achieved via the therapist, who, by becoming a good object with whom the mother can identify, enables the mother to meet the child's needs and experience satisfaction in mothering.

I also saw Anna weekly, for individual parent guidance sessions. Though Anna was the one family member permitted physical separation, her individual sessions were characterized by the same lack of intrapsychic differentiation. She plunged into her work with me as if she had always known me—as if there were no break in the continuity of her sessions with Mrs. N. Although she treated me as if I were indistinguishable from Mrs. N., actually she experienced me as not completely differentiated from herself. Thus she expected me to understand all the allusions and names mentioned in her rambling discourse; likewise, I must have the same feelings as she did. She latched onto me immediately as an idealized object, and very quickly began to denigrate Mrs. N. Her good experiences with Mrs. N. were quickly expunged from memory by her bad feelings.

Anna's idealization of me began even before we were introduced. According to Anna, prior to our first meeting, she spotted me in the corridor,

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and was filled with hopes that I was Hillary's new therapist. She told me later she had inwardly prayed, "God, let her be the one." She could not elaborate on this wish when asked, beyond repeating that something about my appearance made her feel "she's the one for me." (Even here she did not distinguish between her needs and Hillary's.)

Borderline aspects of Anna's personality organization were thus quite evident from the onset of treatment. In particular, her reliance on primitive defense mechanisms, such as splitting, primitive idealization, and early forms of denial, Kernberg has formulated as typical of borderline disorders (1975). As work progressed, other characteristics of the borderline personality organization as delineated by Kernberg became evident in Anna's functioning: manifestations of ego weakness, as seen in her lack of anxiety tolerance; lack of impulse control, and lack of developed sublimatory channels; and the pathology of her internalized object relations, with the concomitant failure to synthesize good and bad introjections and identifications. The link between borderline pathology and failures to achieve separation-individuation is evident in Kernberg's writings (1967; 1975) and has also been discussed by others, e.g., Mahler (1971/1979). This link is observable in Anna's case, in part by reconstruction; and in Hillary's case, in *status nascendi.*

First Impressions of Hillary. Hillary's behavior at the outset of her treatment with me was characteristic of her pattern of relationships, and of her manner of managing new experiences. She needed to be in control, and to be able to titrate the physical and emotional proximity and involvement. Allowed to assume an active position, to manage the passive experience of being left by her old therapist and assigned to a new one, she could mobilize

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her ego to orient herself to the outside world, and express curiosity and a readiness to form a new attachment.

I did not challenge Hillary's initial refusal to come into the office when she and her grandmother accompanied Anna to her meeting with me. Her presence was itself a statement of interest. I left the office door ajar so that she could peek in at will from the safe distance of the hallway, where she remained under her grandmother's care. Anna's use of Hillary as a container for her disowned feelings—in this case her doubts and mistrust—was evident in the note of triumph in her voice when she stated, "I didn't think she would come in." Hillary made full use of this opportunity to observe me. After I had met with her mother several times, she announced that she was ready to come to her own session. Certainly, Anna's rapidly emerging idealized transference contributed to enabling—and allowing—Hillary to come, as much as did my unpressured attitude toward both mother and child as to when Hillary would begin.

At the outset of treatment, Hillary was a small three-year-one-month-old girl, physically and visually tense and hyper-vigilant. She had a noticeable strabismus of the left eye, but otherwise she appeared intact, pretty and alert. Her diapers suggested a younger child, as did the frequent unintelligibility of her communications. Their complexity and sophistication when deciphered, however, suggested an older child, with a somewhat pseudo-adult quality. This very quality curried approval with her mother and grandmother. Hillary gloried in learning sophisticated words, such as "epidermis," and in her family's delighted laughter when she used them. It is noteworthy that the ego capacities which could be active (e.g., perceptual alertness, both visual and auditory, and verbal comprehension) when she was physically helpless as an infant apparently developed prematurely and

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were hypercathected. Other abilities—motility, fine motor dexterity—lagged behind, in part inhibited by their later association with aggression.

When Hillary initiated ball play in the very first session, her limbs became tense and rigid, practically to the point of trembling, with excitation and barely inhibited aggression. The border between the excitation being pleasurable and it being overwhelming was tenuous. To this day, ball play and other physical games remain highly charged with aggression.

Much of Hillary's play during the first half year was highly repetitive and rigid (the ball game in the first session being an exception). She played with me on the rug, at her mother's feet; or on the desk, while she sat on her mother's lap and I sat kitty-cornered to them. Grandmother sat more on the periphery, at the side of the office. (It should be remarked that the office itself was divided in two by a partition with a door in it, which did not quite reach the ceiling. My desk and the toys were on one side, and in the first phase of treatment we all sat and played exclusively in this area.) Hillary's activity consisted of constructing, with my aid, a "house" out of blocks. The "house" consisted of four walls, and on these walls she then placed all the toy animals, dolls, and puppets. All faced inward. I came to realize that she was creating the protective circle of the maternal eye (Riess, 1978, 1988), as a circle encompassing and safekeeping her, and that this circle referred to the treatment sessions themselves: the creation of a secure, holding environment. The three maternal figures—mother, grandmother, and myself—watched Hillary in the sessions, just as at home she demanded that there always be the protective eye of an adult on her. Thus what Hillary was attempting to create in therapy, and at home, was the watchful maternal presence that had been absent in her infancy, exposing her to abuse.

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Once I interpreted the play to Hillary, her activities became less rigid and repetitive. Anna then told me that Hillary engaged in similar play at home: piling all her dolls and stuffed animals on the bed and retreating under them, especially when highly anxious.

Now another aspect of Hillary's concern with eyes emerged: her experiencing eyes as filled with malicious intent, as "evil eyes." During numerous sessions, Hillary had to turn all the dolls and animals to the wall because their eyes frightened her. Consciously, she recalled her father's threatening glances. However, her interpretation of her mother's failed protective watch as active hostility, as well as the projection of her own rage, were condensed in the formation of this phobic-like phenomenon.

<u>Fostering the Symbiotic Tie</u>. Hillary also experienced the eyes as intruding eyes, and hence they were symbols of the therapeutic, investigative or probing eye as well as the disapproving maternal gaze (Riess, 1978, 1988). But by and large, she experienced the therapy as a holding environment (Winnicott, 1960b/1965). This resulted in part from my efforts to enable Anna to mother Hillary, and make her an ally in Hillary's treatment. Hillary at this point experienced my joint efforts with Anna to understand her, our talking about her, and her mother reporting on the week's events, as calming and enveloping. Our voices themselves became part of the soothing background to Hillary, perhaps because of their aim and content, but also in the way that mother's voice serves as a soothing container, a flexible connection that allows physical distance and differentiation. Very soon, she was asking her mother to "tell" me things.

Before Anna found her voice, Hillary's grandmother, or "Nanny" as Hillary calls her, had more often been the one to speak, to comment on

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Hillary's play or on home events. In a subtle way, Mrs. T. dominated Anna, and assumed basic maternal functions.

As Anna began to feel more able to "mother" in the sessions, and responded to my fostering her relationship with Hillary, it was to her and not Mrs. T. to whom Hillary turned. It was Anna on whose lap Hillary sat; it was Anna whom Hillary wanted to help her wash her hands. If I asked Hillary a question, she began to respond, "Ma, you tell her." She wanted her mother to speak for her, as she had not been able to do during Hillary's infancy.

During Hillary's treatment with Mrs. N., Nanny had been the dominant parental figure: she held Hillary on her lap during sessions, she narrated pieces of family history, weekly events, or remarked on Hillary's activities.

Hillary was beginning to use her mother in a new way, and to turn from grandmother to mother; and Anna was allowing her to do so, whereas previously she had felt incapable of mothering and of adequate maternal responsiveness. However, her mother asserted that she could only do so in my presence.

Hillary had missed the experience in the preverbal period of her mother functioning effectively as stimulus barrier and an auxiliary ego to understand and meet her needs without words, and titrate the stimulation she received. She was now, in effect, attempting to experience this in the therapy sessions.

The strengthening of Anna and Hillary's relationship was not without repercussions on Anna's relationship with her mother, Mrs. T. In Hillary's sessions she seemingly accepted her less active role with good grace, sitting to the side. However, she had even less tolerance for aggression than Anna, and was likely to issue unnecessary warnings when aggressive impulses, hers or

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Hillary's, were stirred: e.g., for Hillary not to throw a ball so hard; or for Hillary not to bump her head when retrieving a toy from under a table. She urged a Pollyanaish politeness, telling Hillary to "thank your friend" at the end of each session. She felt thrust aside by Anna's taking over the mothering of Hillary, as Anna already managed the finances and most details of daily life. Due to her less focal role in Hillary's sessions, she began to feel increasing pressure to divulge her recollections of the period of Anna's marriage and the abuse of Hillary, according to Anna's reports. These memories she could not review with Anna, because both agreed Anna could not tolerate hearing them. She began to consider going to a therapist herself. After one-and-a-half years of Hillary's therapy with me, Mrs. T. expressed her resentment in a phone conversation during a holiday break. Anna was in a bad state, unable to talk and retreating into sleep. Mrs. T.'s tirade began with her saying, "I'm tired of being pushed into a corner." She reported on the fighting between Hillary and Anna, in which she frequently intervened to protect Hillary from Anna's unmodulated, and at times unprovoked, outbursts. She also spoke of Anna's resistance to her attempts, during Hillary's infancy, to make her aware of Mr. A.'s actions. Anna then dismissed her words as coming from jealousy, but Mrs. T. was aware that Anna had been in an altered state. Following her outburst over the phone, when a therapist was found for her she did not follow up: in part, she too had wanted to be more included in the therapy with me, and to blame Anna. Anna herself, not unlike Hillary, never spoke of disagreements with her mother, except to say her mother was right.

The reparative and developmentally positive aspects of Anna's increasing ability to verbalize for Hillary aside, there also emerged a more pathological aspect to her assumption of the role of "reporter" in our sessions.

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Anna desperately wanted Hillary to tell what "had happened": to detail the specifics of the abuse she had suffered, and to verbalize memories or thoughts that arose and triggered regressions or outbursts. She wanted Hillary to do what she had been incapable of in her own childhood, and thereby vicariously—but passively—enact it now: to "speak up." Once again, her need—her self-experience—was undifferentiated from Hillary's. In this drive to purge herself and Hillary, which she justified by a cathartic notion of therapeutic cure, but which overlaid an infantile notion of regurgitating, or expelling, the bad experience and thereby ridding themselves of it forever, she did not respect Hillary's timetable, but pressured her relentlessly to tell.

The wish to "tell" simultaneously served to punish Anna and to assuage her guilt. By wanting Hillary to "tell" or to "tell" for her, regardless of Hillary's ability to tolerate such disclosures, she implied that she could not have known, without Hillary's "telling," that her father was abusing her, thus obviating herself from the responsibility of failing to protect her. Yet hearing or seeing enactments of the abuse—e.g., Hillary moving her crotch up and down over a candlestick—were intolerable to Anna, and frequently resulted in her vomiting from disgust.

The Beginning of Anna's Individual Treatment. Five months after treatment began, I suggested to Anna that her sessions shift from parent guidance to therapy and that we increase the frequency to twice a week. The justification for mother and child being treated individually by the same therapist has been discussed by Burlingham (1951). Elkisch (1953) shifted to treating mother and child individually after a period of simultaneous treatment sessions. I did this in response to the manner in which Anna used her own sessions, and in recognition of her intense neediness and competitiveness with Hillary over me. The latter had been manifest in her

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bringing Hillary erratically to sessions, and at times arriving for Hillary's sessions without her. The format of psychotherapy—in which the sessions and hence the treatment were determined by themes of her material, conflicts and character—differed from parent guidance, in which the material is deliberately referred back to the child (Pine, personal communication, February 1987), and was clearly more congenial to Anna's needs and wishes. Nor would she have accepted a referral to another therapist: she and Hillary were still too undifferentiated.

In response to this change, there was an intensification in the transference attachment of both Anna and Hillary, who was now brought to therapy more regularly.

Parallel progression of this kind has been typical of the treatment and indeed of Anna and Hillary's life together. Through mechanisms of projection, identification, and projective identification Hillary frequently takes on her mother's affects and ideas, or acts out for her, so that issues in their treatments are often parallel. This is another aspect of the insufficient individuation between mother and daughter, as is Anna's use of Hillary, from birth on, as a repository for unwanted, displaced feelings and conflicts, and her experience of her as a bad self-object—the abused and damaged child.

Anna now reported that Hillary kissed someone on the TV screen whom she thought resembled me. Anna herself spoke of her trust in me, stating that she had never trusted anyone before me. She confided that she had at times lied to Mrs. N.: she had occasionally kept Hillary home because she could not tolerate her terrified screaming en route to the clinic, but had told Mrs. N. that Hillary was ill. She had believed that Hillary would be forcibly taken from her if she did not comply with treatment. In part her trust in me was a trust that I would not sunder them. Hillary clearly responded to

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this "reunification" with her mother. Whenever she left the office with me to get water, she asked her mother to accompany her; whereas with Mrs. N., she had gone unaccompanied.

Anna's Resistance to Hillary's Differentiation. Yet this trust was fragile. Mrs. A. feared that I would supplant her in Hillary's affections, and hence undo their newly strengthened unity. This fear was evident when she spoke of the importance to her of the newly found intimacy between her and Hillary. Her statement that she would allow nothing to disrupt this was clearly a warning. Hillary's progress—which inevitably involved pressures toward separation-individuation—was experienced as a threat to this symbiotic intimacy, and frequently resulted in regression on Hillary's part and disruption in the treatment by mother.

Even small steps could be experienced as a threat. For instance, after several months of therapy, Hillary for the first time walked into my office, an event her mother noted in the session with pride (previously her mother had to carry her from the waiting area). However, Anna than failed to bring Hillary to her next appointment, and when Hillary came the following week she refused to get off her mother's lap. The importance of upright locomotion in moving the infant from symbiosis to the practicing subphase, and its impact on the mother-child relationship has been noted by Mahler (1965/1979) and Mahler, Pine and Bergman (1975).

Hillary was able to represent the issue in play—ordering me to make the dolls walk, and both she and Anna were able to take in my interpretations of their conflicting feelings about Hillary walking and the separation it implied. By the end of the next month, Hillary walked from the bus stop to the clinic (as well as into my office) for the first time since she had begun to come for therapy.

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In this session, Hillary's diminished anxiety was evident in the loosening of the constriction in her play, which paralleled her increased mobility. She represented, in muted fashion, a condensation of her abuse, her fear of her father's return, and its effect on her struggles to achieve developmental milestones. She placed the baby doll in bed with the mother doll and made the father doll walk on the roof of the house, while the baby cried. Subsequently she played at toileting the dolls. Equally significant was that she sustained play with me the entire session, without refueling with her mother.

This remarkable session was followed by Hillary missing her therapy sessions for a month. Anna reported that Hillary was ill with the flu, and then, that she was recovering slowly. But Hillary's absence must also be understood as their recoiling from Hillary's progress and involvement with me. Immediately following this session—as Anna had reported during her appointments, which she continued to meet—Anna reproached Hillary for not talking more. Hillary replied, with veracity, "But I showed her." Anna's clearly conveyed ambivalence about Hillary's showing me was evident in her "not seeing," much as she had denied and not seen the actual abuse of Hillary. It fueled Hillary's own anxiety and fear of retribution for having shown me. This resulted in a serious regression during the month at home: Hillary had frequent, intense panic attacks, stated her father was coming back, and refused to be called Hillary. This fear of her father's return is often aroused when Hillary undergoes marked psychic stress—whether from developmental progress or reversals or her mother's psychopathology. This recurring fear is one indicator of how Hillary's life experiences are organized by the abuse by her father, and in particular her experience of—and lack of

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tolerance for—anxiety, much as Greenacre has suggested that trauma becomes an organizer (1967).

That Anna feared that I would choose Hillary and rid myself of her, and hence had to keep Hillary away from me, was evident in her statements as well as her actions. For instance, she brought up that a year earlier Mrs. N. had suggested she have a therapist of her own, only to go on to disavow any such wish. However, it was not yet possible to interpret this rivalry.

During her month-long absence I communicated with Hillary by letter, in response to messages she sent via her mother. When Hillary finally returned to therapy, she announced on entering my office, "I'm Hillary." Her resiliency was evident in her rapid reacclimatization. She began the session sitting on her mother's lap, but after I commented on things feeling unfamiliar to her because she had not come in so long, and suggested that she show her doll the toys, she was able to play off her mother's lap, without refueling. She played out in the session the issue of her bad self-image, using her doll, whom she call Hillary, and telling me she was going to throw her in the garbage. However, this important theme gave way, in subsequent sessions, to her usual, rigid play pattern.

There was a parallel development in Anna's sessions; her material centered on her childhood traumas and the origins of her negative self representation. She spoke for the first time of having been in foster care, of her abuse by her uncle, her disappointments in love and especially the loss of her grandfather.

Several months after the inception of Anna's therapy, Hillary began to introduce current developmental issues and family struggles into her play material, and increasingly to direct her mother to report on these to me, as well as snippets of her past history. For example, she had her mother tell me

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about a fight they had when she refused to take a bath, and about other instances of oppositional behavior. By the summer, she was making clear her wish to have a potty and enacting it in play. This freeing up of her ability to symbolize, her increased desire to disclose events and affects, and a greater ability to take in my verbalizations, led to an amelioration in Hillary's symptoms. She took her first bath since infancy. She was able to leave the office alone with me. Nor did these events, or other progress, precipitate regressions or withdrawals on her or her mother's part. Yet despite the reports of battles at home, Hillary could not acknowledge ever feeling anger toward Anna. This affect was always displaced onto Nanny.

Hillary's Developing Symbolic Capacity. In this period of progress, variations in Hillary's play, in which she represented fresh aspects of her trauma, could still precipitate a panic. In one session, Hillary altered the usual pattern of her play, making the dolls recline, instead of stand in their watchful pose. When my phone rang toward the end of her session, Hillary panicked, and did so in several subsequent sessions whenever the phone rang. Eventually, Hillary's mother and I realized that Hillary believed it was her father calling. However, interpreting her belief that her father was phoning to retaliate for her disclosures of her abuse (which the dolls lying down had symbolized) did not calm her panic, even though Hillary confirmed the interpretation. Only when I actually answered the phone and told the caller I would phone back later did Hillary calm down.

Hillary's rigid, repetitive play—though a consequence of and representation of her trauma—served to ward off anxiety. Variation threatened this brittle equilibrium. She consciously feared retaliation by her father. In addition, her greater access to fantasy and its symbolization made her fear a loosening of her own impulses, and feel threatened that they would

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overwhelm her. Simultaneously, the symbol and the actual experience being symbolized were insufficiently differentiated (Beres, 1956), so that the former threatened to induce the state of overwhelming helplessness she had experienced on the latter occasion. Clearly, anxiety had not developed the function of a signal for Hillary, but still resulted in panic, or automatic anxiety. However, Anna's increasing trust in me, and use of me to strengthen her own functioning, enabled her to be more of an auxiliary ego to Hillary, and promoted greater flexibility in Hillary's play.

The fragility of Anna's increasing attachment (because of the primitive level of her object relations) was evident preceding a break for the Memorial Day holiday. On my last day of work, she told me she could not manage without medication. She consciously desired medication to manage the suicidal wishes that arose in anticipating a separation; but it was evident she also felt unable to modulate the murderous rage her disappointment in me aroused, yet wished to protect me from it. Anna told me subsequently that she felt in a dissociated state during the medication consult with a clinic psychiatrist. In response to the psychiatrist's questions regarding individual therapy for her, Anna did not say she was in treatment with me. She expressed anger toward me, which she fantasized she was directing toward Mrs. N., whom she imagined, or possibly hallucinated, sitting in the office with her and the psychiatrist. The failure of her attempt to split and shield me from her rage aroused such guilt feelings that she had to rush to my office to see me, ostensibly to explain the whole incident and thus repair the relationship, but more primitively and unconsciously to assure herself that I still existed. It was soon thereafter that she was able to articulate her recognition that when she did not see me over the weekends, she did not have confidence that I still existed.

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Just as Hillary's symbolic capacity had developed over the first year, so had Anna's. Her sessions had become more coherent, with recognizable themes; narratives were less rambling and disjointed. She had begun to reveal hitherto secret aspects of her life history, and of her feelings. Repetition and action—with both Anna and Hillary—could at times be circumvented or cut short by verbalization and interpretation. Anna's improved verbal symbolization bespoke an advancement in her object relations. She no longer assumed that I was symbiotically omniscient, but was using words to communicate—to bridge the separation between us. However, symbolization, for both mother and child, was still so linked to impulse discharge that there persisted the magical belief that articulated fantasies could be transformed to corporeal reality. Thus the process of symbolization was dangerous and could result in psychic regression or decompensation.

The Second Year

The specificity of Hillary's tie to her mother—turning to her mother as the prefered parent figure and protector—had been developed in the first phase of therapy. Anna was now able to take pleasure in their improved, symbiotic attachment, despite her continued untamed rage toward Hillary. Hillary, however, remained unable to acknowledge any anger toward her mother.

Toilet Training. Anna's satisfaction in the symbiotic aspects of her relationship with Hillary led her to experience any change in the status quo—such as Hillary's striving to achieve developmental milestones—as disruptive. Change carried with it the threat of loss. Thus, for example, Anna resisted toilet training Hillary, who was now four-years-old, long after

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Hillary had expressed a pronounced interest in obtaining and using a potty. Toileting Hillary was one of the few mothering activities that Anna felt competent to perform, and that gave her satisfaction. This was evident in derivative material related to the toileting and cleaning of their pets, a dog and a rabbit. Anna postponed buying a potty, ostensibly because of financial constraints, but never made it a priority when more money was available, despite the work on this issue in her sessions. Earlier in therapy Hillary had herself become irate with my possibly premature interpretations of play indicating her fears of the toilet. Now she chafed at her mother's delay, and resorted to a ruse to obtain the coveted potty. When a substantial Christmas check had been received from their aunt and cousin, the family went to a store to buy gifts. Hillary asked her mother, "Are we rich?" and when her mother assented she demanded that she be bought a potty. Anna complied and was able to report the incident with humor.

However, without Anna's active help, toilet training did not progress, and the potty languished in the closet. It was not until many months later, when Anna was able to find substitute gratification for herself (in the renewal of her former love affair with Vince) that she was able to permit Hillary to become toilet trained. It is noteworthy too that Hillary's fears of using the toilet centered on her father. Thus the whole issue was characteristic of Hillary and Anna's functioning: progress was experienced as a threat of forced separation, by one or the other, and hence resisted, and Hillary's experience of each step was organized around the abuse by her father. For instance, typical fears of possible loss of body parts or self or of active mutilation were fantasied in terms of her father being in the toilet, or of his spoken threats that she would fall in and disappear.

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Hillary's Self Hatred: Her Wish to be a Boy. Hillary now played out her wish to be a boy. She made dolls engage in physically daring acts; others were afraid, threatened, or injured. The daredevils were always boys, the victims, girls. Her underlying fantasy centered on a belief that if she had been a boy, she could have actively defended herself, that then she would not have been abused—in fact, her Daddy would have loved her. She expressed a loathing of baby girls, and denied that any baby girl she saw—whether on the street or on television—was, in fact, a girl, insisting that her mother collude with her by pronouncing the baby to be a boy. This her mother frequently did. The greater security in her relationship with me—that I liked her as a girl—had evidently been a necessary prerequisite to her revealing her hatred of her female self. One can speculate that being willing to give up the diaper—and the greater concealment and protection it provided—was also a part of revealing her feelings as a girl.

Assuming the Active Position in Reinterpreting the Abuse. The interpretation of her self loathing and its origins enabled Hillary to represent more explicitly in play the issues of blame and guilt. In one play sequence, she vacillated between representing the daddy and the baby as mean. First, the bad daddy doll chased the child dolls, who ran away; later, he in turn was chased, and Hillary blamed the kids for provoking the daddy. "The daddy was nice and the kid was mean. Then the daddy got mean." When I commented that she too blamed herself for what her daddy had done to her, she burst out passionately, "I like you, Miss Ziegellaub. I really like to play with you." Subsequently, she was able to play out the mother doll's collusion with the daddy. She had the children run from the monster (whom she substituted for the daddy doll), and then made the mommy doll put the baby in the monster's mouth. After interpretation of these issues, she was able to tell me

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for the first time that her mother had grabbed her and shaken her in a rage, and that she had been very frightened.

Parallel material in Anna's sessions revolved around her childhood wishes to be a boy, and her memories of the story of a five-year-old girl who murdered and castrated her infant brother. For Anna, the intensification of her tie to me aroused powerful symbiotic yearnings as well as homoerotic fantasies, evident in a spate of homophobic material and the revelation of her revulsion toward breastfeeding. In narrating the history of a close friendship with a supervisor at her former job, Anna recalled that colleagues had speculated the woman was homosexual, because of her intense and jealous attachments to women. (The friend broke off the friendship with Anna because of her involvement with her future husband.) This had inhibited Anna from being physically affectionate thereafter. Behind her homophobia lay a wish to embrace me. There was clearly an infantile origin to this wish which Anna was able to articulate: that if she hugged me when she said good-bye, I would be more present to her during the separations (be they weekends or vacations). This seemed a derivative of an unconscious fantasy—that if I fed her she would have a more lasting sensation of satiety; she could experience me inside her. At a more accessible level, her wish was for the protective maternal arms.

Concomitant with the strengthening of mother and child's ties to me was increased rivalry for my affection and attention. Anna's neediness and competitiveness had been evident from the onset of treatment She had taken Hillary's sessions for herself; asserted that my absence during vacations was worse for her than for Hillary; and she had quarreled bitterly with Hillary during these absences.

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The Abuse as Organizer of Experience. For Hillary, the rivalry coalesced in the second year of treatment in a phobia about playing in my office. After I acquired new shelves for the toys, she refused to come in, confiding to her mother, who in turn told me, that she was afraid of the shelves. As has been typical in her history, the conscious fear centered on her father: the shelves reminded her of shelves he had had, and she could not bear to see them. Mother's poor reality testing was evident in her concurring with Hillary on the similarity, despite the difference in size, shape and color. A number of sessions were spent with grandmother, mother, Hillary and me sitting and playing in the hall, to Anna's intense embarrassment. Anna felt she was "a spectacle," as she told me, and was even able to admit her anger that I did not simply restore the old shelves. She was able to understand, however, my explanation of why this would not be helpful to Hillary, and continued to bring her in this difficult period—signs of her strengthened ability to tolerate stress.

Hillary herself was quite amenable to continuing therapy, as long as I did not insist she go into my office. I was eventually able to show her that she had been angry with me, and had consequently felt I must be angry with her. Her projected anger had frightened her, but to protect her relationship with me, she displaced and condensed her fears onto the office shelves. It was the shelves that were scary, not me. Eventually, we were able to uncover the root of her anger: that I met with her mommy, and not with her, twice a week. However, interpretation was not sufficient to get Hillary to return to the playroom. She still experienced a return as being forced to submit. Given a chance to assume the active position in play, however, she readily suggested we take her doll into the office to pretend to look for Hillary. In playing this game of hide-and-seek she returned to the office unaccompanied by mother

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and grandmother, for the first time. Eventually, showing her doll the toys on the shelves became the vehicle by which we resumed playing in the playroom, and using the objects from the once dreaded shelves.

This juncture was one of a number in Hillary's treatment at which she seemed ready to take a developmental step that I felt I could not encourage because it was premature for her mother. At this point, Hillary seemed ready to continue coming into the office on her own, but her mother was not prepared for this separation. In this way, Anna often interfered with Hillary's developing autonomy because of her inability to tolerate a passive role in any separation. Hillary, like any toddler, needed the experience of actively leaving the mother and finding her again. However, Anna herself always needed to be the active one, much as in her childhood she could leave her house as long as she knew her mother was safely confined therein, but could not tolerate her mother's departures. Anna was the same in her therapy sessions. She kept an eye on the clock so that she could regulate her own departure. This was quite conscious: she articulated how intolerable she had found it when her previous therapist announced her time was up. Anna's persistence in assuming the active role interfered with Hillary's own phase appropriate need to assume an active role in practicing separation within the therapy sessions. Anna recoiled from, and disrupted, any of Hillary's steps toward individuation that proved too precipitous for Anna's own psychic development.

The emergence of Anna's yearnings for me to mother her, and the intense infantile and sexual impulses aroused, resulted in her feeling she was decompensating. In particular, she felt as if a memory was coming, a memory that if allowed to enter consciousness would cause her to lose her mind or have a heart attack. My hunch that the heartbreak she feared was losing me,

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much as she had lost objects in the past, was confirmed by her reporting the following dream. She had awakened during the night and recalled only that she was pounding someone in the dream. She was, she said, suffused with "rage and brokenheartedness, like when my grandfather died or when we moved out of my grandfather's."

The Turn to the Outside World. During a break in treatment over Christmas vacation, Anna had begun to think about calling Vince, her old boyfriend. This was a culmination of several strands of development: her increased adaptive orientation to the outer world; her reawakened sexual feelings; and the intensity of her transference to me, which she wished to dilute. Anna's experience of feeling nurtured by me (though not enough to meet her insatiable demands) and of her increased ability to nurture Hillary reawakened her longings to be a mother. She spoke of her life long fantasy of being a mother to ten children, and began to mourn the loss of the good children she would never have, and of the damaged child she did have. Yearnings for a good baby persisted, and this wish also contributed to her contacting Vince and their resuming their former love affair.

As Anna mourned her damaged baby, so Hillary in therapy also worked on her sense of being damaged: damaged because she was a girl, and hence unlovable and subject to abuse; and damaged by the abuse itself. It was evident that both Anna and Hillary felt castrated by their abuse. That Hillary recoiled from female babies she saw in the street was also a response to her mother's nascent wish to replace her with a good baby. Anna's rage toward Hillary found expression in fantasies of abandoning Hillary: simply walking out on her or getting a live-in job somewhere. Yet despite the continued cycles of rage oscillating with desperate clinging, both Hillary and Anna were clearly progressing. Mother and daughter were both increasingly interested in

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the outside work, and increasingly ready to seek out new attachments outside the orbit of their enmeshed relationship.

Previously their yearnings—positive or negative—had centered on the same objects: grandmother, therapist, or the elderly mother of their landlady, whom both idealized. Now Anna turned to Vince, and Hillary was freed to become interested in nursery school. Although the process was mutual, it was clear that it was Anna's shift of cathexis that enabled Hillary to move successfully outside the confines of the maternal circle. Simultaneously, Hillary's newly developed ability to play in a separate room at home had clearly played a part in Anna's reawakened interest in Vince. They were both experimenting: could they have separate objects of love or interest without losing each other? Did they have to maintain the primary maternal preoccupation (Winnicott, 1956/1958) by which both had been consumed, or was their connection now solid, substantial, and flexible enough to permit this enlargement in their circle?

The turn toward the outer world was evident in other ways as well: the family obtained a phone and Anna obtained an alarm clock and began to wear a watch. Hillary at first did not respond to Anna's love affair (it was ostensibly kept secret) but she did react to her mother's wish to have a baby, as was manifested in her therapy by a consuming wish to know if I had any children. She spent sessions pleading with me to tell her—or to whisper the answer to Mommy while she crouched, half-hidden, trembling in suspense in the corner between my desk and the window. My comments regarding Hillary's wish to be my only child, as she wished to be Mommy's only baby, led to Anna's revealing in her session that she too wished I would answer the question, and, regardless of the truth, tell them both I had no children. She too could not bear the thought of sharing me.

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In this period, Hillary stated she never wanted to get married or have children, though sometimes when home she would tell her mother she wanted a husband so she could step on him.

Anna's renewal of her affair with Vince bespoke a new relationship to her body, her willingness to admit its impulses and desires, and to recognize its signals. Perhaps because I had been attuned to her and her body's needs, and had interpreted them and validated them for her, she had become able to speak of its past disappointments and humiliations, and to take better care of it herself. For the first time since giving birth to Hillary, she went to a physician, and eventually had a gynecological exam. She began to seriously consider bringing Hillary to the doctor, which was a prerequisite to Hillary joining a group in the therapeutic nursery, and medically indicated for completion of her immunizations. Much work in both mother's and daughter's sessions resulted in a visit to the doctor. For Anna, this meant having the strength to bear Hillary's frightened tears. Although Hillary's play had depicted her conviction that a checkup was the equivalent of a sexual assault, and although I had interpreted her fear that the doctor would damage her, just as she feared Daddy had done, she was nonetheless resistant and terrified. One corollary to Hillary's feeling that she had been damaged by Daddy and hence was unlovable emerged in this period. She said, "Nanny doesn't like me because Daddy didn't."

On the day of the checkup, both mother and daughter needed me present as an auxiliary ego. Though Hillary cried throughout the exam, she seemed to calm somewhat in response to my saying several times, that although she was scared, the doctor was not Daddy, and was not doing what Daddy had done.

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In this period, Anna spoke of her wish to be a therapist, indicating it was of long standing. The obvious element of identification with me, as well as with her childhood therapist, denoted progress in Anna's attempts at internalization.

Toward the end of her second year of treatment, Hillary expressed her curiosity about the therapeutic nursery in asking to peek through the one-way mirror dividing the nursery class room from my office, and ultimately by asking to explore the room itself, when there were no children in it. This I arranged for her to do. She declared herself ready to begin in July. This step in individuation she felt must threaten her tie to me, much as such steps threatened the tie to her mother (though the latter, and her grandmother, were to be present in the nursery). She felt divided between her wish to be in the classroom and her attachment to me. She could not bear the teacher's arranging her admission to group for September. The delay between her wish and its fulfillment was intolerable, and she accused me of not wanting her to begin school. Like her mother, she could not believe I could bear—let alone foster—her increased autonomy. She thought that I, like her mother, must want to hold her back. She herself was not sure she could be attached to two people at once outside her home sphere, much as she thought I must wish for her exclusive love, because she wished to be loved exclusively. This was the major issue in her therapy when she began the group.

The Third Year

Turning Passive into Active in Response to Separation. The issue was intensified by her mother's rage over my summer vacation. As usual, once Anna had seen me in the fall and was assured of my continued existence, her anger over my "abandoning" her was acted out, and she told Hillary she

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would never bring her to therapy again. Her feeling of betrayal was sharpened because of two life crises that arose during my vacation: one was the threatened loss of her home; the other, the death of the family's pet rabbit. Anna felt bitter over Vince's inadequate response to the prospect of homelessness. He did not offer shelter or money, and Anna broke off contact with him. This she attempted to do with me as well. The death of the rabbit, with whom she sat while it died, aroused memories of previous losses. But it was also experienced as a partially displaced enactment of her unfulfilled wish to be with her grandfather when he died. However, it made her again aware of the impossibility of enacting this wish with Vince. She had a nightmare that he called and said, "I'm dying," and she became frantic as she did not know where he was and could not go to him. However, she also feared that she had worn him out (sexually) because she was too demanding, and was enraged that he, and I—who needed to be replenished by a vacation—could not give enough.

When Anna's rage abated and she did return Hillary to therapy a few days later, Hillary announced that she was not coming to therapy anymore, and refused to talk. I interpreted her need to turn passive into active, following the threat of a precipitous break by Anna, which eased her initial resistance. At home, she cried in remorse over having been unkind to me. However, she remained torn between her new fascination with the group and her teacher, and her former adoration of me. It was not clear that she could sustain both, just as she was not convinced I could tolerate her new attachments and the developmental gains she was making. However, it was possible to interpret these conflicts. What was harder was to enable Anna to allow Hillary's world to widen. The battle seemed to be displaced onto therapy.

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Hillary and Anna's relationship at home had the flavor of a parent and toddler in rapprochement. Fierce oppositionalism alternated with clinging dependency and regression. At this stage of therapy the issue of sharing the love object became a primary one. For Hillary, now five-years-old, being part of a group of children for the first time necessitated sharing the ministrations of the teacher. For both Hillary and Anna participation in the nursery group heightened their awareness of my having other patients, which, in turn, intensified feelings of rivalry. In the group, in fact, Hillary demanded quite a bit of individual attention, and found participating in activities with other children anxiety inducing. Prior to this, she had had little contact with children her age.

Hillary's anxiety was aroused by her rivalry and resentment, and by her projection of these feelings. However, a new issue arose as well: she began to fear other children. In her play with dolls she repeatedly acted out groups of children becoming wild and out of control, whenever they were without supervision, or the teacher's attention wandered. It was evident that Hillary's underlying, unconscious fantasy was that she herself would become overly stimulated and lose control. At home, Hillary would sadistically and impulsively attack the dog. Whereas she had for some time been playing in a room alone at home, mother and grandmother now would not let her be with the dog unsupervised.

The Emergence of Oedipal Wishes. Gradually, the dog became the object of her Oedipal fantasies, and Hillary used him in play as her husband. Thus the dog, her fellow victim, came to be the object of her displaced sadistic impulses toward her father, and her positive libidinal and Oedipal strivings. Hillary confided in me, "Sometimes I hurt the dog, and I don't feel sorry afterwards." Yet in the same period, Hillary developed a wish to become a

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veterinarian. This goal embodied her reparative wishes and her attempts to sublimate her aggression while maintaining an active position. As such, it represented an adaptive identification with the aggressor, a striving for a transformed, creative repetition (Leowald, 1971/1980).

In the nursery, Hillary's conscious fears reinforced her insistence that her mother at least remain in the room with her, though grandmother was eventually allowed to leave. Some steps at allowing mother to go to the parents' room (which Anna came to desire, through developing contact with some of the other parents before and after group) were renounced, and Hillary condensed her fears into a near-phobic response to one child, who became the repository of all of Hillary's fears and impulses. This classmate was chosen as a phobic object because her history resonated with Hillary's deepest fears: she had been found, motherless, abandoned, in the subway and was now in foster care; and she was highly impulsive, prone to sudden outbursts of aggression. Thus Hillary consciously feared being her victim, and doubted that the presence of two teachers was sufficient control or protection. After I helped Hillary articulate her worries, I went on to explore her own fears of loss of control, and her need to have her mother there to help *her* remain in control. Although the issue was clearly represented in play, Hillary denied all such interpretations. Her mother, who had begun to spend some time out of the nursery, now had to return full-time.

The Response to Helplessness as a Threat of Trauma. The resolution of this dilemma was to be facilitated by another crisis in which Hillary and her mother both felt themselves to be helpless victims. In this case, as in several others, a new experience of passivity pushed Hillary to take an active step forward in development, and hence in separation-individuation. The crisis in this instance was the A. family's forced move from their house to an

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apartment in a different neighborhood, after many months of living under the specter of homelessness.

This experience of relative helplessness, because of the serious difficulty of finding any affordable, inhabitable housing, stirred memories for both mother and child of previous life experiences of helplessness. Over Christmas, as the threat of homelessness grew more imminent and converged with Anna's annual holiday feelings of deprivation and depression, Hillary became convinced her father was coming back. Anna discovered Hillary masturbating with the instruments from her toy doctor's kit, and hid the needle. Hillary's father, it emerged, had possessed doctor's instruments, and had used them on Hillary and the dog.

In addition, Hillary began to masturbate openly again, and to demonstrate masturbation on her doll Buddy. In a frantic phone call, Anna demanded that I sanction her wish to take Buddy away from Hillary. Instead, I was able to help Anna tolerate Hillary's play, and her attempts at disclosure. Hillary at times accompanied her gestures with such words as "This is what Daddy did to me."

Following the Christmas vacation, Hillary brought Buddy to her session and repeated the scene with me. She asked her mother to stimulate Buddy's genital area, but I intervened, suggesting that this was too highly charged for either Anna or Hillary to bear. Hillary was then able to show me herself. It is worth noting the shifts between the active role and passive voyeurism in Hillary's attempts to represent and master this aspect of her experience, including her use of masturbation in these shifts.

Hillary was increasingly able to express anger toward me within her play, as she did her anger over my upcoming Christmas vacation in this third year of treatment. First, her dolls were angry toward me; then she played they

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had a tantrum that escalated out of control. Then Hillary in turn behaved sadistically toward the dolls. I was able to show Hillary that she feared her anger toward me would get out of control, and that I would retaliate; that she in fact felt I was retaliating by taking a vacation in the first place.

Anna, too, was more able to acknowledge her feelings about my Christmas vacation. She recollected that Dr. V. had cried when she said good-bye to her. When I interpreted Anna's wish that I feel as sad as Dr. V.—as Anna herself—about the separation, she was able to verbalize her sadness.

The threat of losing their home had hung over Anna and Hillary since the previous summer. It had been a factor in Anna's breaking off her affair with Vince, and had similarly resulted in disillusionment with and devaluation of, her landlady's mother. In both cases, the idealized love object had failed to adequately protect or rescue Anna. The ongoing threat of homelessness was a precipitant for recurring feelings of helplessness, which in turn stirred recollections of similar—i.e., unconsciously interpreted as psychically equivalent—experiences in childhood. In particular, the threat of homelessness aroused recollections of what may be considered Anna's central childhood trauma: her molestation by her uncle and the consequent need to move out of her grandfather's home because of her uncle's presence, which resulted in her feeling that her uncle had been chosen as the preferred child, and that she had lost both her home and her grandfather's preference. Just how deeply disturbing was the current threat of homelessness only became evident gradually, as Anna's material revealed that, for her, the experiences of separation, loss of home, and sexual abuse were condensed.

<u>Anna's Suicidality as a Defense Against Helplessness</u>. What was clear, time and again, was the tendency for Anna and Hillary to experience untoward events, whether major or minor, as a repetition of their original

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traumas. They lived from crisis to crisis. In particular, the feeling of helplessness precipitated this experience of repetition. Such stress could catalyze progress in their individual development toward autonomous functioning, or it could result in regression. In Anna it now provoked a suicidal crisis the outcome of which hung in the balance for six months. In instance after instance during this period, the propulsion to act out or experience a repetition was evident—as was the opportunity to work on these earlier experiences in therapy and hence contain the tendency to action in the here and now.

There were two reasons for the family's dislocation: their house was eventually to become part of a co-op, and hence would become unaffordable; and their landlady's son was to build a second story and move in upstairs. This young man, who was known to abuse drugs, Anna and Hillary now called a "pig," the term ordinarily reserved for Hillary's father. Like Hillary's father, this man was now experienced and spoken of as a potential child molester: i.e., the present threat was interpreted and experienced as the potential repetition of a past trauma.

Under the press of stirred memories, Anna began to reveal more details of childhood privation and deprivation, and of her relations with her uncle, although she has to this day been unable to verbalize the specifics of her molestation. Nonetheless, to one session she even brought a photo album, which included several snapshots of her uncle. The momento, which at one time would have proven overwhelming, could now be tolerated, in part because of Anna's improved symbolic capacity.

At this point Anna's wish to be loved exclusively by me surfaced anew, in part centered on her contact with other patients of mine during her hours at the clinic. It was now reworked in the light of the genetic material

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regarding her uncle. I interpreted her childhood conviction that her grandfather had not been able to adequately protect her because he did not love her exclusively, and that this had resulted in the molestation by her uncle, and the choice of her uncle over her as a living companion. Because of this experience, she now believed I could adequately protect her in the therapy only if I loved her exclusively.

Anna's feelings of helplessness, and need to assure herself of my protective presence while she took a relatively passive-dependent position in regard to the life crisis confronting her, were in the forefront during this period. Her enraged conviction that I didn't really care—like Vince—that it was just a job for me, vacillated with her wish to show her love for me, to give me presents because she, intrinsically, was not worth loving. Earlier in the year she had wanted me to witness a donor card leaving her body parts to the hospital affiliated with my clinic. Now she made me a scarf. In her childhood, as we were able to reconstruct, this feeling alternated with the belief that if she was lovable or attractive, she would be molested—she would indeed be asking for molestation. She spoke of the priest who had betrayed the secret source of her high school scholarship, hence resulting in its loss, and had in her late adolescence made a pass at her. Thus, to Anna dependence was a source of danger, a provocation of abuse.

Anna's somatic symptoms abounded. Over Christmas, she had worn a halter heart monitor to record her heartbeat for 48 hours, because her physician had suspected heart disease. Hillary had then played out dying with her doll, Buddy, graphically depicting her concerns over her mother. An arrythmia was subsequently diagnosed, and Anna was placed on several heart medications. She was also tested extensively for ulcers. The proliferation of her somatic complaints was one indicator that she might be decompensating,

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of a regression to a somatic experience and expression of affect, which in her development had been insufficiently differentiated (Krystal, 1978).

However, Anna's willingness to "listen" to her body had initially been a sign of progress, and no doubt contributed to her willingness to bear Hillary's panic and now take her to a needed doctor's visit. The recognition of body boundaries and body pain seemed a step forward in individuation from Hillary. Following this doctor's visit Hillary played that the baby doll was tricked and hurt, and that no grown up protected it. The baby then became enraged and sadistic toward the other dolls; then the baby subsided into self-punitive actions. I was able to explain to Hillary that this was how the doctor's visit had made her feel, and that these feelings recalled to her how she had felt as a helpless baby, and how she thus worried that the same things would happen to her again. Following this, she was able to tell her mother at home, "I'm afraid you're going to do what Daddy did." At other times she seemed to attempt to provoke actively a repetition. One wished for aspect in the repetition had been evident when, months before, she had asked her mother to scratch her vagina, "Only don't put anything in": i.e., a wished for benign repetition that was not overwhelming, but bearably exciting and hence pleasurable.

I knew that the possibility of homelessness might make Anna homicidal and suicidal, from revelations that she had almost killed herself and her whole family when previously they had lost their home (around the time they first began therapy). Hillary too picked up on her mother's state. In a most poignant session, Hillary played with me on the other side of the office divider. Using a dolls' house, she played her usual story of children being unsupervised by adults and losing control. The added twist was that these "children" had just moved to a new house, and the danger involved falling

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down the stairs—being pushed by another doll and being killed. Hillary made the doll whisper, "I don't want to die." It was impossible not to feel that she was responding to her mother's periodic—and current—homicidal wishes toward her, yet simultaneously reorganizing her experience of this, her experience in the group, and the need to move, around her abuse. Part of the story of Hillary's abuse was a warning given Anna by the investigating detectives that if she had not realized her husband was abusing Hillary, he would ultimately have killed her by pushing her down the stairs. Undoubtedly Hillary had been exposed to this piece of speculation—if not to actual threats by her father.

Though Anna was moved by Hillary's utterance, it did not completely alter her sense that she had the right to kill Hillary if she chose: i.e., that Hillary was not a separate being, but a part of herself—albeit a hated part—whom she could protect from ultimate adversity (homelessness) by the same method she had always known she could protect herself—death. Yet it jarred her somewhat, by forcing into consciousness the recognition that Hillary might cling to life and have hopes from life quite different and independent from Anna's death longing. This was jarring in that it implied that Hillary could indeed be autonomous, just as her playing on the other side of the divider with me suggested a separateness that was intolerable.

Rupture in Anna's Experience of the Holding Environment. As the time neared when Anna and Hillary had to move, Anna began to miss numerous appointments. She kept in touch by phone but the disappointment she felt because I had not prevented or averted this crisis was not allayed by interpretation. To her, I was repeating her infantile experiences of failures in the maternal holding environment that had resulted in traumatic impingements (Winnicott, 1955/1958). Ostensibly, she did not

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come because I could not give her what she needed; and the incontrovertible fact was that I could not give her an apartment, and apartment hunting was the most frequent reason she gave for not coming.

By phone and when she did come, I had been able to help her mobilize her ego somewhat so that she was not completely paralyzed. For instance, she saved $100 from her once-yearly heating check; she asked people for leads, and followed some up. Following up on my question about obtaining a security deposit from welfare, Anna asked me to call a welfare rights worker who had been helpful to her in the past to ascertain what financial help was available. She was afraid she would be too devastated or paralyzed by the response to do so herself. She still experienced me as titrating stress for her, despite her anger over my limitations. At this point, when I suggested she might be suicidal, she became tearful but did not respond. However, my being able to assess her state was helpful to her. After I ascertained that she was eligible for a security deposit, she was able to admit she was getting "scary thoughts." When I pointed out the incongruity of planning to pay the last month's rent for their old house—her feeling morally obligated, despite the lack of services for the past months (heat, gas, etc.)—yet feeling no qualms about killing herself, her mother, and Hillary because there would then be insufficient money to move, Anna was able to acknowledge that her thinking was awry. She described having gone into a "weird state . . . like I had this thick protective shield around me," similar to when she had had to go to Housing Court to prevent immediate eviction after her husband had left the home. Now when she was in this state, she explained, she could not recognize the irrationality or absurdity of her thinking. Only when she was in a better state, i.e., in a session with me, was her judgment improved. By recognizing her state, I had helped her reorganize, and enabled her to be less

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secretive about her wishes and fantasies, and to describe the previous suicidal periods generated by losing a home. However, she had not sufficiently internalized my presence to reliably manage this higher level of ego function in my absence.

Material now became accessible and interpretable regarding her role reversal with her mother, her attempts to protect herself from disappointment by not asking for help; and how her search for a sanctuary had found expression in her childhood wish to become a nun. For the first time, Anna could acknowledge being angry with her mother in the here and now over a remark her mother made. This enabled her to admit that she had been angry with her mother when she had been urged to renounce her wishes to be a nun in order to care for her mother.

In the midst of this work on Anna's inability to separate from her mother, on her inability to use aggression in the service of differentiation because of her belief it would destroy the love object, and her refinding her strivings for autonomy, Anna found an apartment. It was a very small two room apartment, ten minutes walk from the clinic. (Her previous home was a 45 minute bus ride away.) Anna immediately formed an idealizing, but apparently mutual, attachment to her elderly immigrant landlady.

In the months preceding locating the apartment, Anna had been coping with the crisis by retreats into dissociation or paralysis, in which she became passively demanding or overtly angry toward me. These retreats had alternated with attempts at understanding and reorganizing. Hillary had been quite open about her state: she was angry. When their former landlady told them she was closing their house, Hillary said "I don't care" and told me that they were packing in garbage bags. She agreed when I suggested that she felt as if they were being disposed of like garbage. She had also been worried,

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but I had with some success enlisted Anna in emphasizing to Hillary that finding a home was a grownup problem, and that Mommy would take care of it. This highlighted for Anna a clear difference between her and Hillary, and an area of success for her, as I pointed out. She was successfully able to manage, and Hillary, unlike Anna in her own childhood, did not feel like it was her responsibility to solve the crisis.

Hillary did attempt to master actively another derivative of her abuse, which was stirred by this crisis. She asked her mother to draw eyes for her. Eventually the drawing frightened her, and she crumpled it up and threw it out. When she was younger, she had in therapy (besides turning around the puppets and dolls whose eyes frightened her) drawn these pictures herself, often confiding they were of Daddy. Now she put herself in a more passive role, of spectator, much as she was helpless in terms of having to move—but as such she was *actively* creating an experience of passively receiving a potentially frightening perceptual stimulus, in an attempt to master the fear. This attempt seemed in reaction to her more helpless position vis-a-vis the recrudescence of her old fears—of her father's return—which reappeared at this time as they did in every period of additional stress.

Nevertheless, despite Anna's progress, in March of the third year of treatment Anna went into an altered state and almost killed herself, Hillary, and her mother. Anna had called her Public Assistance worker to ask for the month's security deposit for the new apartment, and her worker had denied that such payments were made. Desperate, but not yet overwhelmed, she attempted to call a welfare rights worker with whom I had previously spoken on her behalf. When this second worker's line was busy, Anna, clutching the receiver as if still expecting her to answer, went into an altered state that she described as unlike any other she had ever been in. Everything felt and

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looked far, far away and a calm voice kept telling her to go to the kitchen, get the knife and "do it." She felt "life draining out of me." She began to pace up and down, thinking only to get the knife. However, her mother was between her and the kitchen, shouting repeatedly, "We can do it, we can do it, look, we figured it out," and waving a piece of paper at her. Somehow her mother's words eventually penetrated, and she recalled that the night before they had calculated with paper and pencil that even without the security deposit from Public Assistance, by putting all their money toward the rent and basically starving for two weeks, they could just manage. This more hopeful appraisal of the situation had flown out of Anna's head when the welfare worker's line was busy.

In reconstructing the incident with Anna, who was shaken by how close she had come to actually terminating all their lives, I was able to help her see that it was the disappointment and anger at the Welfare Worker—for not being immediately available and protective—that had precipitated her murderous and self-destructive state. She was also able to acknowledge that she might have displaced these feelings of anger and disappointment from me.

Anna continued to feel, in the months to come, a deep sadness and sense of loss over the move: a sadness that resonated with the moving she had done in childhood. These losses were now recalled and examined: the losses because of separations from loved ones; the sense of being unprotected that these moves generated, because they were experienced as a repeated failure in the maternal function of titrating experiences; the anger these moves provoked, but that was unexpressed because it was so dangerous. In relation to Hillary, Anna struggled to protect her more successfully than she had been protected: e.g., from starvation, and other basic physical necessities;

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and she had in fact been successful in her endeavor to provide physical necessities, once Hillary's father left the home. This was the more adaptive aspect of her functioning. She was able to ask at times for help for Hillary—e.g., for food from their local church—that she could not ask for herself, but felt justified because it was "for the baby." (Of course, this issue is highly complex, as Anna was also asking for her undifferentiated baby self.) At other times—e.g., when a neighbor was too intrusive with Hillary—Anna was paralyzed and unable to intervene.

Within the treatment relationship, Anna was very slowly becoming able to ask for herself—directly, consciously, as distinguished from her unconscious, ongoing demandingness. Putting her demands into words implied a separateness between us—I was not, symbiotically, like an omniscient mother just reading her mind, or her nonverbal cues, and magically fulfilling her. It also meant a recognition of my failures, and for Anna the question was whether her experience of my failures would represent an intolerable repetition of her infantile experiences, or instead would prove manageable and hence promote ego development, and enable her to recognize her need for immediate satisfaction as a residue of an infantile state. A sign of her progress was that she was now able to articulate for the first time the deeply shameful memory, dating from age 7, of wanting to ask Dr. V. for $2 to feed her mother and being rebuffed for her inarticulate tears.

However, this trust and dependence made her all the more fiercely possessive, while simultaneously stirring anxiety that I would exploit her dependency to abuse her. This was evident in her recollection that Dr. V. ostensibly insisted her mother have a gynecological exam in order to prove she was not a prostitute. The fear of being passively abused by me seemed the

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more dominant fantasy in this period, rather than the fear that I would act out with her her homoerotic wishes, which had been evident earlier in treatment.

Hillary's Attempts at Active Mastery. After the enraged altered state, Anna's affect in her sessions was predominantly sad. Hillary's, however, was one of anger—much as at home Anna described great anger between the two of them, anger that she viewed as an expression of intense hatred. (Anna denied there ever being hatred between her and her mother—only anger.) Hillary protested, "They're not giving us enough time (to prepare for moving). We need 100 more weeks." Hillary was difficult at home, more even than usual, and flew into panics over objects that reminded her of her father. As always in periods of stress, she regressed and feared her father's return.

Yet immediately following their move, Hillary took a step forward and began to participate in the nursery group without either her mother or grandmother's presence. One precipitant was the need to assume an active role, following the passive one of having to move. As such, the crisis catalyzed a step forward in development.

Perhaps there was also an attempt to separate from Anna because of her murderous intentions, or, as seemed to be the case in the months to follow, because Anna was increasingly depressed and withdrawn. Anna's depression seemed to increase with Hillary's step forward in separation-individuation, and with the knowledge of an even greater separation to come in September when Hillary would, at age 6, have to enter first grade. To fill the void thus created, Anna talked about getting a foster child. Hillary wanted to know if I would permit her mother to follow through on her plan,

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clearly wanting me to forbid her. With interpretation of its origins, Anna's wish subsided.

This episode illustrated an aspect of the rivalry between Anna and Hillary: whose side would I take? For Hillary, the issue of her mother getting more of me was also dominant, and accentuated by the progress in separation-individuation. Some tentative progress in taming her aggression, or fusing the aggressive with the libidinal, seemed to have contributed to this progress. In one session, Hillary played kickball with me with little aggression or overstimulation. She herself remarked, "We're just playing ball." (She also played hide and seek and told me about a fight with her mother dramatizing the link between her separation anxiety and her untamed aggression.)

In another session, she moved from treating her doll, Buddy, with aggression to tenderness, after I interpreted the reason for her anger. She then said, embracing him, "I love him," and overcome with her projected emotion asked, "Is he real?" She sat in a grownup chair, talked in a grownup way, telling me Buddy's fears, which interwove issues of aggression and separation: that she would leave him behind when she moved; that she would put him in the garbage; that she would hurt him; that he would have to lie down alone; and that he was angry with me, because he wanted to know why he could not come again after school on Thursday. In subsequent sessions, when I interpreted Buddy's wish to come twice a week and talk, like her mommy, Hillary asked me to see her mother just once a week. She demanded the same from Anna at home.

Anna's Deepening Depression. It was more than two months after Anna had the experience of being in an altered state that she was able to talk about her ongoing suicidality for the past three months, during which she

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had repeatedly touched electrical switches with wet hands in the hope of being electrocuted, and been tempted daily to throw herself in front of a truck. She felt her state was worsening and she went from bouts of melancholy to not caring. There were numerous fantasies about me linked to her suicidal ideation. Once, following a failed attempt at electrocution, she regretted not having left me a note, as she imagined I would blame myself. In a session I commented on her notion that if she killed herself it would mean I had missed something, some clue, and failed to protect her; she acknowledged the impossibility of my protecting her, as she needed me 24 hours a day.

At the same time that Anna was becoming increasingly suicidal, and increasingly aware of her need of me, she was—or had—been making noticeable progress. This progress, including her increased ability to formulate and articulate insights and recollections, contributed to her depression, as it heightened her awareness of her separateness—from Hillary, from me—and left her with a feeling of loss. Speaking of her suicidality while she was experiencing it was part of an attempt to give it up; yet it had been a primary defense against feeling helpless since early childhood, and she had organized her secret self around it. Exposing it left her feeling "empty," barren, as if she had lost something of value. It was striking that she felt her suicidality to be a precious possession, a true self, much as it has been described in literature. For instance, Virginia Woolf, who was herself suicidal, described a suicide victim thus in her novel, *Mrs. Dalloway*: "And had he plunged, holding his treasure?" (1925/1953, p. 228).

Over the next three months, Anna described herself as engaged in a fierce battle between her "good part," which wanted to live, and her "bad part," which urged her to kill herself. She experienced the good part as gradually shrinking, while the bad part erupted in impulsive self-destructive

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acts—e.g., suddenly stepping out into ongoing traffic. Though she agreed to a medication consult, the anti-depressant prescribed, Sinequan, had no discernible effect in mitigating her suicidal wishes, or her other numerous symptoms of depression: insomnia; loss of appetite; loss of energy; and feelings of hopelessness.

Anna now felt no attachment to her mother and Hillary. I was the only person to whom she felt bound, and that tie became ever more tenuous. Occasionally, she felt that a comment of mine "went into" her good part and made it grow. She was emotionally aloof from Hillary and her mother. As the weeks passed, and my summer vacation approached, she became increasingly silent in her sessions, or spoke in telegraphic phrases. It seemed easier for her to talk on the phone, during the nightly phone calls, than during her sessions, which had, in view of her precarious state, been increased to four a week. The sessions reminded her of my insufficiency, whereas the phone calls were probably experienced as something special, just for her. Nonetheless, there continued to be productive sessions, in which we were able to understand the dynamics and origins of her state, and she was able to articulate her experience.

Eventually, I deemed it necessary to discuss hospitalization with Anna. She considered it, but decided to try to manage without. She felt there was enough of a "good part" left to let me know if she needed hospitalization. At times, e.g., when she would make what sounded like farewell testimonials ("I want you to know, if anything happens, you're the friend I always wanted"), she revealed that this might not be so.

Her dependency on me was the major issue in this period. She oscillated between wishing to be special, and recoiling from this wish; between feeling like I would disappoint her and enrage her, that she would

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murder me, and feeling that she could not live without me. She reported a dream: she received a telephone call that I had been in an accident. "I took a knife, and I did it. Then, when I was dying, a voice said to me, 'You don't know, she may be OK.' But it was too late." Despite these signs that it was a calculated risk to not do so, forced hospitalization seemed inadvisable and probably unfeasible at this time.

Hillary's Increased Autonomous Functioning. Hillary reacted in part adaptively to her mother's withdrawal, and the open talk about a possible medical hospitalization. Anna's physician was considering hospitalizing her for tests of a pre-ulcerous condition, and this hospitalization Anna longed for, as for a haven. Hillary actively tried to prepare for this eventuality. She played with me and her grandmother, taking us on the other side of the office divider while her mother remained behind. She practiced going for walks in the neighborhood with just her grandmother, for the first time. In some sessions, she would interrupt our play to return to her mother and report on her activities. She responded to my comment that she would indeed be able to tell Mommy about her day—by phone, if she were in the hospital, and after school when she began school—by asserting that she would not go to school. She actively planned with Nanny how to take care of things if Mommy had to go to the hospital; but, she told me defiantly, she would not come to therapy during her mother's hospitalization: i.e., she too could be the one to abandon and turn passive into active.

Hillary was acutely aware of her mother's depression and decathexis of her. At home, she attempted to hypnotize Anna, so that she could make her sing and dance. At times, her attitude was protective and maternal: when they walked in the street, Hillary told Anna to lean on her, as Anna had developed sensations of dizziness and often listed to one side. She helped put

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away the groceries. Hillary's solicitude could give way to rage. During angry fights, she yelled, "I'm glad you're going to the hospital." Or she provocatively announced, "I love my Daddy," or rubbed her vagina, an action sure to get a reaction from her mother. In part, she wished to animate her mother, with *any* affect—be it anger or tenderness—rather than have her be so lifeless. I had a similar experience in Anna's session—that Anna's depression was a dead weight, that I was trying to lift by cathecting her with my words.

Hillary spent much of her sessions playing ball. Working with her on her fluctuating feelings about her mother's state she confided to me her fears concerning her mother dying. She was afraid, when her mother slept, that she was dead and hence had to wake her. She was afraid, when her mother went out, that she would be hit by a car, but she added "only a bad mommy" would let that happen. Her awareness of her mother's suicidal state was thus interwoven with, and a contributor to her own anger toward her, and to her anxiety over her angry wishes. Yet Hillary was able in this period to lend her ego to attempts at mastery.

As Anna's state deteriorated, Mrs. T. took on more of the caretaking and maternal functions in relation to Hillary, Anna, and the household. Anna spoke for the first time of her mother's earlier breakdowns and of periodic episodes during her childhood and adolescence when her mother was afraid to go out of the house. In the last weeks before my vacation, Anna appeared to have already left, emotionally. However, once, after my talking for the entire session, she cried. In the last days she was able to say, "I'll miss you," though the following session she told me contemptuously, "Give up, Ms. Ziegellaub."

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Anna continued to deteriorate while I was on vacation. We spoke daily by phone, and she had weekly appointments with Hillary's teacher, by pre-arrangement. She came close to killing herself several times. Each time, the act was averted by fortuitous occurrences. She told me on the phone that a terrible calmness had descended on her. She reported a repetitive nightmare that seemed a condensation of her feeling of emptiness, her fantasy of annihilation, and her abuse by her uncle: of a hole in a wall.

The Fourth Year

When I returned from my summer holiday, Anna continued to report on her ongoing sensation of slipping away: "Like I'm way inside, and what is outside isn't me." Yet she was able to tell me in the first session that she couldn't talk because she felt like she hated me: the first time she had directly expressed her anger, while she felt it, instead of defending by denial and displacement. During the following several sessions, she was freed to talk, and was preoccupied anew with memories of her uncle, the feelings of "terrible fright" when she insisted on being allowed to go out with him, which I connected to her current feelings of fright, that if I did not watch over her, she would harm herself. She spoke at length of having felt, since childhood, that she was not worth listening to, which I linked to the disastrous consequences of her molestation being suspected, and her subsequent unwillingness to divulge her true feelings.

Hillary and Anna had had some bitter fights during my vacation. Hillary confessed to me her transgressions, and her mother's: she had insisted that Anna buy her the cookies she wanted, not those Anna craved, when there was only sufficient money for one box; that her mother hit her for getting after their dog, Pepe. Hillary's aggressive urges were the theme in

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her play. Subsequently, for the rest of August, her sessions focused on preparing for school and helping her cope with her mother's state. She played with me alone several times, enacting with dolls her fear that the kids in school would hurt her, alternating with the fear that she would be left out, excluded by them. She began to counter my interpretations of these fears with a dismissive "yes," except when I commented on her wish to have an undisturbed peaceful time in therapy because of the anger and upset at home.

Because Anna was so unavailable, Hillary's possessiveness of her was intensified. When Anna helped a woman who stumbled in the street, Hillary, enraged, shouted, "Don't ever help anybody again!" Her sadism had clearly been intensified by the experience of her mother's depression, and its sadistic and homicidal components. Although in her play with her dolls—Kid Sister and Buddy—she had long taken on the role of mother, her attitude to marriage had been negative. She had spoken of adopting kids. Now her hatred of babies, by which she turned passive into active, and displaced her self-hatred, resurged. She said she could hardly wait to have a baby so she could pinch it.

Therapeutic Intervention Experienced as Abuse. The turning point came the weekend before Hillary was to start school. Anna confided to me, on the phone, that she was killing herself, slowly, undetectably, but inevitably; and that before she died, she would kill her husband. I conferred with the medical director of the clinic as I thought Anna needed to be hospitalized, and his cooperation was necessary. He disagreed, doubting her suicidality, but agreed to see her to make his own assessment. By the time Anna came to this appointment two days later, she reported having been brought out of her suicidal state by Hillary's dramatic, terrified reaction to starting school, which had breached her denial of Hillary's need of her.

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Heretofore, pointing out Hillary's need of her had not stimulated any maternal feeling, as she herself had repeatedly stated. Perhaps, because Hillary reacted to this separation, when she returned home from the first day of school, with such intensity—sobbing and clinging—it mirrored the intensity of Anna's own denied need and pierced her withdrawal. She felt she had a reason to live—before she had felt worthless to one and all, that Hillary would be better off with her mother, when she concerned herself with Hillary's well-being at all.

Anna reacted dramatically as well to my having spoken to the Medical Director, and to her meeting with him. She felt acutely betrayed by me, and that her trust in me was irrevocably shattered. She tried to protect me from the full brunt of her rage by displacing it onto the Medical Director. She was successful inasmuch as it enabled her to continue bringing Hillary to therapy, but she began to miss most of her sessions, and after three months decided she would only come once a week—not for therapy but to discuss Hillary.

My attempts to help her understand and work through these events were not successful at the time. It seemed that the depression had in part related to reenacting her experiences of early loss—aroused by the housing crisis—in the context of her relationship with me. The illusion of me as the all-gratifying, protecting, need-fulling symbiotic object had been shattered. This had been an opportunity for a developmental gain, during which she had vacillated between her regressive longings for symbiosis and her terror of it. My hunch was that she had been sustaining herself with the fantasy of dying in my protective arms, as she wished her grandfather had died in hers—i.e., a union in death. Once again the symbiotic fantasy was shattered—but she now had the substitute of Hillary, who for many months had been

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valueless. Of course, my not protecting her would have meant I was taking on the role of her childhood parent who permitted her abuse.

Increased Separation and Increased Regression. The daily physical separation that came of Hillary's attending school led Anna and her mother to cling to each other more than ever. Anna, when she did come to her appointments, was accompanied by her mother who sat in the waiting area. However, Hillary made a dramatic stride—she came to her appointments with Anna only. It was "too much" for Nanny, they reported, after the trips to and from school.

In Hillary's sessions, there were also clear signs of regression: Hillary began smelling all the toys, which she explained she did because "Pepe does it," another instance of her identification with her dog. Her play became repetitive and anxious, as in the beginning of therapy. The theme was unbridled aggression: she played out endlessly recurring aggressive acts by children in groups, who lost control because of lack of supervision or indifference on the part of the teacher figure.

Hillary also dropped out of the afterschool therapeutic group at the clinic which several members of her nursery group attended. Anna and she could not tolerate any additional separation, nor could Hillary's ego bear any more stimulation from other children. The day in school was already testing her capacities to the limit. My interpretations continued to be warded off by hasty agreement. She frequently brought toys to show me, as if to fill up the sessions, and soothe herself with this benign show-and-tell. Now that her mother was restored to her, the combined stress of the previous six months and attending school became evident. She could not tolerate any interference with her already strained attempts to control her anxiety, and became largely inaccessible to therapy. Her mother's withdrawal from me was an additional

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factor. Hillary began to succumb to illnesses with increasing frequency, and missed many days of school. After each illness, it was harder for her to return to school.

Anna too was beset with innumerable somatic complaints, and began an endless process of medical appointments and tests. This retreat into somatization seemed to serve the function of reorganizing her body ego, and thus reconnecting her with the world, as she recathected and cared for each part of her body which a few months before she had been bent on destroying. Hillary's internal fears were, however, reinforced by her mother's outward ill health.

I worked with Hillary's school to provide her with additional supports to ease her anxiety and enable her to manage: the teacher arranged for Hillary to be physically close to her; when possible, a para-professional worked one-to-one with Hillary; her mother came into the classroom for brief amounts of time. Nonetheless, Hillary's anxiety when in school began to mount to panic proportions.

Anna was manifestly ambivalent about Hillary going to school. Her conflict emerged in an obsessive indecisiveness over whether or not Hillary was well enough to attend. She found Hillary's anxiety unbearable, as it stimulated her own. She fantasized that if she kept Hillary home from school for illness that was not sufficiently serious, some malignant authority would force Hillary to go, much as a truant officer had come to her house and marched her off to high school in adolescence. Again both mother and daughter experienced this separation as an act of violence, for which they were unprepared. By Christmas it became evident that Hillary could not manage the regular first grade class, and a referral to the Committee on

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Special Education for a change of placement was made. It was not until May that the evaluation was completed, and an individualized plan implemented.

Discontinuing school did not appreciably lessen Hillary's high level of tension and the rigidity in her functioning. Anna had not been bringing her regularly to therapy, and when Hillary had come she had often wanted to avoid the treatment room. She would ask to go to her former classroom or the waiting room to borrow toys. An old symptom recurred: difficulty in swallowing. Anna traced this symptom to the period of Hillary's abuse, and her father's attempts to choke her. Since then, at times of heightened anxiety, Hillary might have difficulty swallowing, which then frightened her into thinking she was choking, and interfered with her eating. The line of regression went from the anal sniffing to this oral refusal. Anna requested medication, and proclaimed herself willing to take Hillary to the hated medical director for a consultation. However, after some discussion with me, Anna agreed to bring Hillary to therapy twice a week instead. She understood my explanation that it would be best to see first if I could help Hillary understand the symptom and its recurrence. I had proposed increasing Hillary's sessions in the fall, when it was clear she was under serious stress, but Anna had been unresponsive. No longer having to share Hillary with school contributed to her willingness to bring her more frequently. So did a shift in her attitude toward me, though she still proclaimed herself unwilling to resume therapy with me—or anyone else. Increasing Hillary's sessions thus enabled her to have greater contact with me, without acknowledging her need. (She had similarly used Hillary in the first years of therapy to ask me to telephone her—ostensibly at Hillary's request, but often as a projection of her own desire for contact.)

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Though Hillary had in the previous year longed for an additional weekly session, she now responded to this increase with suspicion, and was reluctant, for the first time, to come to therapy.

The symptom of difficulty swallowing, however, did disappear almost immediately. It emerged that Anna had increasingly been threatening Hillary that she would tell me things, largely about violent fights between them, about which Hillary did not want me to know. In part Hillary feared that I too would think she was bad, and side with her mother. But even more she feared that Anna's verbalizing the rage between them would destroy their relationship, because her denial would be overcome. She resisted Anna's attempts to report to me on her heightened phobic state, and her constant demands for attention, by averting her eyes, though she did contribute that she was afraid that Daddy was coming back. When Anna spoke of the all-consuming hatred she and Hillary felt during their fights, Hillary was overwhelmed with anxiety. She demanded to leave the office, and refused to reenter. She continued to be resistant and fearful over a number of sessions. I came to realize not only that we had reached a therapeutic impasse, but that I had been bludgeoning Hillary with my interpretations in hopes of getting through her resistance, much as her mother had assaulted her with her revelations. Without pressuring Hillary to enter the office—though she eventually did, insisting that we not go to "my" side—I discussed anew what had been going on in therapy. I told her I had noticed that my words, as well as Mommy's, were often too much for her, frightened her, and that she tried to shut them out. I reminded her that she could always tell me when my words became too much, but that in any case I would talk less. I reaffirmed the importance of playing. Since Hillary was relieved but inhibited in resuming play, I encouraged her idea of bringing her doll, whom she had not

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brought in a while. Hillary waltzed into her next session with her doll and played a game in which she bought all the toys for her, and thus repossessed them.

Hillary's sessions now took on a different tone. Anna, no longer an angry observer or withdrawn figure, was often enlisted in the play by Hillary, and Anna herself chatted more. Hillary no longer asked to leave the office several times a session. Her play became freer, and Oedipal themes became more noticeable (she was now six-and-one-half years old). She took on the role of Mrs. Le Meko, the family dog being her husband; the dolls, and Anna, were her children. In this maternal role, she played out issues regarding her fear of her mother's illness and hospital was a frequent game. Anna was, in fact, now diagnosed as having a spastic esophagus, but no heart condition, and medication for her esophagus and stomach replaced the heart pills.

Hillary's envy of all the toys in my office now increasingly became a focus of treatment, as did her sense of deprivation and her insatiability. Hillary wished to steal my toys. Every day she made her mother buy her a toy, but the pleasure of possession was shortlived, and a new one was longed for. Interpretation of how Hillary used these toys to make herself feel better did not slake her thirst for them. In part Hillary's longing for my toys was a displacement of her longing for me—that perhaps I could be her perfect mother. But it also represented a regression from the Oedipal to the position of anal hoarding, as the threat of the Oedipal issues was heightened by her conflicts and fantasies about Anna's illness.

The Continued Function of Trauma as an Organizer of Experience. Hillary had regained some ability to titrate anxiety, as was evident in how she handled a frightening accident, in which she ran full steam into a phone booth and cut her scalp which bled profusely, although her wound was

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superficial. Despite Hillary's usual panic at the sight of blood, she, not Anna, who was paralyzed by the injury, suggested—or rather screamed—that Anna take her to the Health Station housed in the same building as the clinic. A physician there helped Anna staunch the flow of blood. Hillary then had Anna call me before her session to tell me that she did not want to talk about the accident and I should not mention it to her. Thus fortified, she came to her session and symbolized the injury in play. As usual, her experience of this frightening event revived the issue of her abuse, and was recast in its light. In her play, her doll hated babies. These babies were then subjected to scary attacks. Keeping my comments within the play, I talked to Hillary's doll about how when scary things happened to her now, they reminded her of scary things that happened to her when she was a baby. I told the doll that she hated babies now because they reminded her of her baby self from long ago. I also explained to Hillary—still via her doll—that her doll thought it was her fault these scary things had happened to her long ago, and happened to her now. She thought if she were lovable, she would not be hurt.

Hillary's doll was also useful in preparing Hillary, and, indirectly, her mother, for my next summer vacation, by commenting on the feelings of her doll in response to my going away. Hillary was then able to tell me that she was afraid I was not coming back. Anna was able to acknowledge the need for someone to be available during my absence, and after I left, she did indeed see the administrative director of my unit four times. She used the sessions largely to discuss her anger toward me and the medical director.

The Fifth Year

My vacation again escalated the hostility between Hillary and Anna. Anna, as during each of my previous summer vacations, felt she could not

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bear the hatred toward Hillary. She felt smothered by Hillary's clinging, which often followed rageful outbursts, and talked of going to work. In this way she threatened to leave Hillary, as she felt I had left her, and thus put herself in the active position again. Even though—or more likely because—she had renounced therapy, she called this the worst vacation ever. Hillary had also talked a good deal of her fears of her father, and during fights with Anna, adopted his mannerisms and curses, or rubbed her vaginal area suggestively. Anna, enraged, denounced Hillary as being "just like him," and experienced a hatred that did not distinguish Hillary from her father. She was frightened several times when she shook or hit Hillary, and once when she almost choked her.

This barely bridled, mutual aggression intensified Hillary's separation anxiety and her fear of resuming school. She told me on the phone that their couch had broken down, and in her first session she proceeded to draw for me their "all broken down" couch. I interpreted this as her wanting me to know that things between her and Mommy had "all broken down" while I was away.

The Ongoing "Hostile-Dependent" Relationship. When she was three, Hillary had dominated the family with her phobic and panic reactions, which dictated where they could go, who could enter the house, what mother and grandmother could do (mostly play with Hillary or watch), what possessions could be in the house; and even what they could eat. Increasingly, as she became older, and some of her phobic symptoms subsided, Hillary attempted to dominate at home in a more active, direct way. She demanded that what she wanted be done, and in the way she wanted. She flew into tantrums or terrors at a "no" or the least delay. She often refused to comply with requests, and was particularly adamant about regulating family members' comings and

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goings. She was highly oppositional and controlling, sometimes out of panic, but often in an attempted assertion of omnipotence, which erupted in rage when frustrated, and resulted in angry fights with her mother. Her relationship with Anna oscillated between these fierce battles over autonomy and calmer—albeit briefer—periods of mutual cooperation and greater intimacy and dependency.

Anna was as reluctant as Hillary for Hillary to start school. Anna asserted she could not handle it, physically or emotionally. The new plan called for her to be present and a para-professional to be assigned to Hillary, while Hillary, now seven-years-old, became acclimated to a small class with eight other children. Being present in school generated massive anxiety for Anna: a terror that she would not know how to help Hillary manage, and that her performance as a mother would be scrutinized and criticized. Could she allow—and promote—separation from Hillary? The particular dilemma she imagined always involved Hillary demanding to leave the class when she became frightened: would Anna recognize the point at which Hillary's supportable fear gave way to panic? Should she insist Hillary stay, as ultimately one day she would have to insist Hillary stay while she leave? This was far different from the aggressive wish to abandon Hillary, when she, Anna, had the urge, but felt again like a threat of coerced separation from without.

Anna had formed an idealizing transference to her general internist at the new hospital where her varied symptoms were being investigated. Numerous times he had served as a voice of reason, an auxiliary ego. Now he recommended she resume therapy, and attempt to work out her anger toward me—warning her she would otherwise simply repeat the process with someone else. He advised her to try to compromise between her needs and

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Hillary's, and take Hillary to school twice a week. Anna was able to listen to him, in a way that she could not to me, and attempted to resume therapy.

As Hillary's return to school approached, Hillary withdrew from the therapeutic process, fending off all my words. She was angry at me for promoting her school attendance, which she believed to be a "trick"—she meant by this a plot to abandon her in school—and thus viewed me in the role of aggressor, i.e., of abuser.

The Negative Oedipal Wishes and Separation Anxiety. In her play Hillary revealed another meaning of her separation anxiety. She had two babies attempt, to no avail, to catch up with their big sister and aunt who went on an exciting, fun-filled boat ride. When I suggested that Hillary felt the same way as those babies, that her mother goes out and has a good time without her, and that she so longs to be part of that good time, she agreed with a heartfelt yes. There was an Oedipal element to this fantasy of exclusion. When the school arrangements were finalized, Hillary confided in her Nanny that she thought her mother wanted to get rid of her. I was then able to make the link for Hillary with her school phobia that she was scared to go to school because it felt like a way of Mommy getting rid of her. This helped Hillary to actively rehearse leaving her mother. While her mother waited outside she twice went into the local store alone to purchase a few items. Her play—of unsupervised kids going wild—took a new and interesting turn, reflective of her struggle to internalize the object, to mute the aggressive impulses within her as the precursor to achieving object constancy and separation. In her play, when the babies were wishing for their mother to protect them, they "imagined" her there. Later, Hillary seemed to have them hallucinate her presence. In subsequent sessions she elaborated the play so that the mother ignored the babies' pleas for help. Not minding

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where she was walking, the mother then fell off a cliff. Hillary thus summed up her conflicts over her aggressive impulses, and her belief in the omnipotence of her fantasies when she spoke about the dolls: "Thoughts come to them that they don't want, and then they come true." Subsequently, she played that some zoo animals tried to eat the babies—in particular, the hippo whom she called a rhino. The kangaroo then came to the babies' defense, chased the "rhino," and stuck its tail up the "rhino's" heiny. After pronouncing this feat, she turned to her mother and said, "Did you see that, Ma?" wanting to be sure her mother had observed this act, in which the mother animal became an effective phallic protector, thus revenging the abuse of the babies.

Hillary's Castration Anxiety. Following this session, Hillary began to work on the sense of damage she felt she had sustained from her father's abuse. First she represented in play her sense that something was missing. She had me play a shopping game with her. In this variant, she would get all the good toys and I, in displaced envy, would try to steal them from her. In the midst of this she told me that her doll, Buddy, had come home from military school naked. This introduced the theme of peeking and wondering how bodies are made. In the following session, it was her doll, Kid Sister, who pined enviously for a toy, and cried when her mother (Hillary's role) would not get it for her, saying, "I'm a failure." As a first step, I commented that Kid Sister felt like something was missing, and thought a toy would make her feel better; but that Hillary and I knew it wouldn't (a transparent recounting of what repeatedly happened with Hillary). The equation of the missing external object she craved with the missing, injured part of her body became evident when I made a comment about the *hat* Kid Sister was longing for and Hillary misheard it as that Kid Sister *hurt* her *head*. When I

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interpreted this slip to her mother and her, Hillary immediately introduced doctor's play, and fear of the doctor. Now it was timely to interpret again her fear that the doctor, far from curing her, was going to repeat the injury she thought her father had done to her.

Hillary's play in this period thus symbolized the three basic anxieties of childhood—fear of object loss; fear of loss of the object's love; and castration anxiety—which Mahler has pointed out (1971/1974a) frequently coincide in the rapprochement subphase. In Hillary's case, each anxiety is recast by her trauma.

Hillary's entry to school, though one month late, had gone relatively smoothly. Her displacement upward in play of the injury to the head was paralleled in school in her preoccupation over whether she was normal, and the tremendous importance to her of being smart and being able to do the work perfectly. Her school attendance was abruptly cut short, as were Anna's attempts to resume therapy, by Anna's deteriorating physical condition. Her numerous symptoms included a feeling of muscular weakness and tiredness. Her physician ordered her to spend six weeks in bed, since she refused to be hospitalized. In the middle of January he would reevaluate whether she needed further bed-rest, hospitalization, or could resume some physical activity.

The Uncertain Therapeutic Outcome. Phone contact with Anna began to consist of a litany of physical sensations. No interpretive work was possible. The bed rest came after a flood of memories of her molestation by her 15-year-old cousin when she was aged nine. Her anger over being neglected by her aunt at holidays—the Thanksgiving past and the approaching Christmas—stirred memories of the neglect that had resulted in her molestation. She had learned, when she was older, that the cousin who

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had molested her had molested several other children as well, and that her aunt had repeatedly failed to intervene.

Since her mother was ordered bed rest, Hillary began to come to sessions with her grandmother, who after a period of house-bound withdrawal became more active. It seemed that only one person at a time could be a functional parent. Hillary had been working on her feelings that her mother blamed her for what had happened with her father, a reworking from a beginning Oedipal position of rivalry. In part, this material had been precipitated by an incident in which Anna blamed Hillary for being overly friendly with an acquaintance whom Anna now deemed a pervert. It remained unclear whether there was an element of attempted repetition on Hillary's part, or the incident was more a fantasied repetition by her mother and included inadequate protection of Hillary.

Now Hillary's play shifted back to working on her mother's illness. Themes of inadequate mothering and jealousy were woven into hospital play, in which the dolls were the patients—each one suffering from a combination of her mother's innumerable complaints. Hillary was the nurse/mother and I was the doctor. Issues of death and suicidality began to be represented. At home, Hillary began to tell Anna more explicitly things that her father had done to her. She said he had tricked her into the bedroom, showed her pictures of naked women, and talked lasciviously of their breasts. He had wrapped Ace bandages tightly around her and the dog; he had used rubber gloves. Hillary repeated these things to me on the phone. She told her mother that he rubbed her vaginal area and said, "This is love." Anna told me she had indeed found pornographic magazines when she had cleaned out her husband's things years ago, but that she had forgotten them and not mentioned them since. She believed Hillary's memories to be

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authentic. Her reworking them at different levels in her development is evident.

Hillary's ability to symbolize in words the abuse by her father, without displacing it into the dog, and without regression, marked significant progress in her psychic function, the process of separation, and the beginning mastery of her trauma. However, Hillary's progress has always been tied to Anna's; additionally, she has needed her mother's availability to recover from her regular setbacks and regressions. It is clear that Hillary will not have the strength to develop autonomously without her mother's support, and that Anna can only permit this as much as she is psychically prepared. Thus Anna's emergence from her current withdrawal is a prerequisite for their joint development, in which the impact of trauma and borderline pathology have seriously derailed and delayed the process of separation-individuation. Hillary, at age seven years five months, struggles between the developmental press to activity and mastery, and the pull to repeat evermore, passively and actively, the experience of her original trauma, a pull that is evident in her mother's life story as well.

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Chapter VI
Discussion

The Nature of Anna and Hillary's Traumas

I would like to begin by discussing the nature of Anna and Hillary's traumas, and how well the psychoanalytic conceptualizations of such events are useful in their cases. It seems to me that both Hillary and Anna suffered from two kinds of adverse events or circumstances. The first were ongoing failures in the mothering they received; the second were the specific instances of sexual assaults, which in Anna's case were more circumscribed and occurred later in life. Furthermore, there is a reciprocal relationship between the two kinds of adversities. The mother's failure to titrate stimulation and provide a good-enough holding environment allowed the sexual abuse to occur. But it is precisely Anna's own experience of trauma that left her unable to fulfill adequately the maternal functions necessary to protect her own child from abuse. Consequently, Hillary suffered the double traumas of failures in mothering and sexual abuse, much as her mother had before her.

The failure to receive adequate maternal care, which I will describe further below, is best subsumed under "strain trauma" (Kris, 1956) or "cumulative trauma" (Khan, 1963). This was an experience of ongoing stress. The actual sexual assaults are better described by the narrower definition of trauma: a sudden experience of helplessness on the part of the ego in the face of overwhelming stimulation (Freud, 1920/1961; 1926/1959) as seen in subsequent regression of ego functions (A. Freud, 1967). Kris has termed this "shock trauma" (1956). Since this can only be presumed to occur once there is some degree of structuralization of and differentiation between ego and id,

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only Hillary's later experiences of sexual assaults by her father could be considered "shock trauma." These two types of trauma speak to differing—yet overlapping or interconnected—aspects of Anna and Hillary's experience, and contributed to their particular outcomes.

The most dramatic of Anna's failures in mothering Hillary was obviously her failure to protect her from her father's abuse. However, their relationship was faulty in other respects as well. Anna was herself precipitately separate from Hillary. Her initial response to her baby was to recoil from her, from her weird gaze. One wonders if this was a displacement from Hillary's weird genitals: that Hillary was a "damaged" girl, like herself, instead of the boy she had hoped for. Then followed an actual separation of several days, when Hillary was released from the hospital before Anna, further interfering with their bonding. When reunited, Anna wished to escape. Eventually, she settled into alternating states of hyper-vigilance and denial. Since by all reports, Anna spent much of the time in dissociated or semi-dissociated state (including a drugged-like sleep at night from which nothing could wake her), she must have been emotionally unavailable. Early processes of attunement and mutual regulation, important precursors of verbal communication and awareness of the object, were evidently awry (Stern, 1971, 1974; Beebe and Stern, 1977; Brazelton, Koslowski, and Main, 1974; Pine, 1977). (This had also been the case in Anna's infancy.) The "good enough mothering" (Winnicott, 1960b/1965), deemed crucial to healthy infant development, was faulty, though Hillary's grandmother did provide some of what was lacking.

Winnicott (1955/1958) hypothesizes that the holding environment provides the infant with the experience of "going-on-being." If this continuity is prematurely disrupted, it may result in precocious ego

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development (Winnicott, 1949/1958; Kramer, 1955), and, in extreme cases, in the development of a false self that exists only in responses to impingements and recovery (Winnicott, 1960a/1965). Greenacre (1941/1952) also describes the outcome of early trauma as a personality prone to overly facile identifications and intense but shallow relatedness.

Hillary's abuse in the first months of life may be understood phenomenologically as an experience of overwhelming stimulation and build up of tension without discharge. These impingements may be understood in Winnicott's terms as interruptions in a state of going-on-being. A premature sense of separateness and helpless dependence on the object developed in conjunction with precocious ego functions, which I would view as an early attempt at active mastery of this organismic distress, by taking over the object's failed functions.

The dimension of physical pain also cannot be ignored in considering Hillary's phenomenological experience of the abuse: bodily intrusions that included vaginal and/or anal and/or oral penetration; the tight binding of her wrists that resulted in bleeding and bruising; the covering of her mouth so that she felt like she was choking. One can imagine in infancy her body becoming rigid and stiff in these states, much as Tustin (1981) has described:

> Unbearable bodily tension which is not understood, empathized and relieved by the mother quickly enough is experienced as a disturbing "overflow." It disturbs the illusion of "flowing-over-at-oneness" (Tustin's term for the process by which the illusion of symbiosis is maintained). Unbearable bodily tension is uncomfortable. It feels turgid and hard. It is projected as "not-me." Thus, the sense of "oneness" is disturbed and "twoness" results, but in a way that is unduly painful and sudden and causes a precipitate coming together as

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a "self" which is not genuine—a "false self" as Winnicott (1958) has termed it (p. 92).

Indeed, I have observed in Hillary just such a body stiffening, as well as a mild trembling in her entire body when she becomes excited and tension mounts, from the very first session when she initiated ball play with me.

The precipitous and premature awareness of separateness that Hillary experienced as a result of the unbearable bodily tension and intrusions interfered with the development of object relations as well as creating a premature but rigid and fragile ego formation, which will be discussed below.

As Hillary developed some ability in infancy to connect the proximity of her father with her previous bodily experience of him, and hence to anticipate his approach (an ability that seems to have developed prematurely), his approach must have in itself aroused a particular excitement, which was to become linked with the affect of fear. This repeated fear, indeed this terrified anxiety which induced psychic helplessness, was an integral part of Hillary's pain—of her abuse. Edmund Burke, writing in the 18th century, lucidly described the workings of fear: "No passion so effectively robs the mind of all its powers of acting and reasoning as fear. For fear being an apprehension of pain or death, it operates in a manner that resembles actual pain" (1757/1815; p. 158). Her father's abuse induced repeated states of annihilation anxiety.

The feeling of deadness Anna experiences in her suicidal depressions may be a recurrence of the "deadness" she experienced during the first 10 months when her foster mother picked her up only to feed her, and otherwise left her lying in the crib. (Subsequently, this deadness came to be used defensively.) Pine (1985) has described how the child develops "feelings of efficacy," which grow into more general feelings of competence, from the

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functioning of motor, perceptual and cognitive apparatuses in exploration and play. These in turn aid in the development of attunement to reality and enhancement of self-esteem. The opportunities to exercise these functions were severely limited in Anna's infancy. So was the opportunity to exercise the precursors of communication (aside from the cry of hunger) within the context of a developing relationship with the object: to have a satisfactory symbiotic experience out of which the ego and the gradual awareness of the object could develop, and the beginnings of differentiation unfold.

I have mentioned that Anna's infancy was marked by a lack of attunement and mutual regulation with caregiver (her foster mother) much like Anna's relationship with Hillary. Anna also suffered two dramatic losses in early life. The first occurred at 10 months, when she was returned to her mother. It appears that her grandfather, even more than her mother, was able to help her recover from this separation at 10 months, and bring her out of the apathetic, withdrawn state in which she had existed in the foster home, spending most of her time sleeping. By being constantly available, stimulating her and responding to her, he brought her back to life. (Her lessened reactivity was most likely also a consequence of delayed development secondary to prematurity.)

Around the age of three, she suffered her second dramatic loss: she was forced to move out of her grandfather's home. However, before this traumatic physical separation from her grandfather, she had been sexually abused by her alcoholic uncle. The move confirmed Anna's sense of helplessness and worthlessness, and her self-blame: i.e., the move was a punishment for the sexual abuse. Her inner experience that her rage could destroy the positive object image seemed borne out in external reality. Her mother's heart ailment served as another confirmation of the danger of

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expressing her rage. Thus she continued to turn her anger against herself, to protect her grandfather and mother.

The Formative Impact of Trauma on the Separation-Individuation Process and the Psycho-Sexual Stages of Development

The treatment of Hillary and Anna A. was presented, in the preceding chapter, within the framework of the separation-individuation process, because their respective childhood traumas had become dynamically linked to the fear of object loss; and because the increasing physical and intrapsychic individuation and distancing of this developmental process had come to be experienced as a threat of trauma by this mother-daughter dyad. As progress within the treatment fostered differentiation, the attendant anxiety precipitated regressions and crystallized resistances. As Mahler (1972a/1979) has phrased it, "Inherent in every new step of independent functioning is a minimal threat of object loss" (p. 120). This threat of loss was experienced differently at succeeding stages of development. However, it commonly led to regression—e.g., in Hillary, early on, from separation anxiety to annihilation anxiety—and was hence interpreted anew as a threat of traumatic impingement. As Freud has noted (1926/1959), the situations of danger that precipitate anxiety at succeeding stages of infant development "can persist side by side and cause them to react to them with anxiety at a period later than the appropriate one; or again, several of them can come into operation at the same time" (p. 68). Both the trauma of sexual abuse and the trauma of actual or threatened object loss had to be worked through anew at each successive step in development and treatment.

Anna's life story dramatizes her difficulty mastering the tasks of each developmental stage with its implied increased distancing from mother.

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Latency age tasks of attending school, learning from teachers, and forming peer relations; or the adult achievement of marriage and motherhood, had only been accomplished in a distorted fashion that did not disturb the primary affective and physical tie to her mother.

In this section I will first address how it came about that the process of separation-individuation in Anna and Hillary was compromised by their respective traumas and review the significant instances of this experience within the treatment. Then I will discuss how for Hillary the focal issues of each developmental phase became organized around her early traumas, and in turn how her memory and understanding of these traumas were redefined in the new light of phase specific conflicts. Freud observed this process long ago when he wrote of trauma by deferred action in the case of the Wolf Man (1919a/1954).

For Hillary and Anna sexual abuse and the threat of object loss were dynamically linked and associated in memory. There also existed a structural link between trauma and the threat of object loss, in that the experience of trauma contributed to the failures in the development of object relations and of the intrapsychic structures that are conceptualized as its derivatives (Kernberg, 1966).

Anna's absence—from the household, but more frequently by withdrawal into sleep—has been blamed in family history as the circumstance allowing Hillary's father to abuse her. Anna's denial and withdrawal into dissociated states were the underlying causes. In any case, she was unavailable to Hillary, in terms of providing a holding environment (Winnicott, 1960a/1965) that protected Hillary from extreme impingements and provided sufficient appropriate libidinal gratification. Thus when Hillary first entered treatment she feared physical separation from mother and

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intrapsychic separation as leaving her vulnerable to a repetition of abuse by her father, whose return she feared daily. Later on, she came to fear abandonment by her mother for being a bad, damaged child, and hence being exposed to repeated abuse by her father. At either stage—and in succeeding ones—she readily regressed to a state of traumatic, annihilation anxiety.

The early trauma to which Hillary was subject—trauma in the sense of Kris' (1956) strain or Khan's (1963) cumulative trauma—left her with a heightened predisposition to anxiety which readily becomes overwhelming, traumatic anxiety. Greenacre (1941/1952) has similarly noted such a consequence of trauma in the preverbal period, a consequence which she calls an indelible "genuine physiological sensitivity" that continues to give "greater resonance to the anxieties of later life" (p. 54).

Hillary's early trauma also precipitated precocious ego development, as will be further discussed below. A precocious ego development operates at the expense of adequate object relations (Bach, 1985; James, 1960). Hillary's aggressive drive appears to have been heightened by her abuse, as has been noted in the treatment of other patients sexually abused in childhood (Katan, 1973). The integration of negative (aggressively cathected) and positive (libidinally cathected) self and object images and introjects is thought to be impeded by an intensified aggressive drive and consequent preponderance of negative introjects (Kernberg, 1966). The resultant reliance on splitting and projection to protect the "good object," and the subsequent failure to fuse the aggressive with the libidinal drive, prevent the attainment of an intrapsychic representation of the object that is relatively impervious to affective shifts (Kernberg, 1966; Mahler, 1966/1979; Pine, 1985). In Hillary, this was evident in her insistent clinging to mother. As Guntrip (1969) succinctly put it, "The more unable a growing child is to leave mother in outer reality, the more

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certain it is that she has no basic ego relatedness to mother in inner reality" (pp. 228-9).

These presumed failures in Hillary's structural development meant that the signal function of anxiety was not achieved (Freud, 1926/1959). Hence she remained prone to experiencing automatic or traumatic anxiety when any anxiety was aroused. Hillary's heightened predisposition to anxiety left her more vulnerable to these repeated occurrences of traumatic anxiety; and these occurrences came to be interpreted by her as a consequence of maternal failure. However, her frequent anger at Anna for such past and present failures threatened her intrapsychic tie to her, i.e., threatened to obliterate the positive image which she had to vigorously defend by splitting and displacement (she frequently became enraged at her grandmother instead), and increased clinging to her in the external world. If there was no good object, if her mother was "absent," psychically or physically, she feared she could be abused again. Thus the consequence of her anger at Anna resulted in a fear of the repetition of trauma.

Anna presented with the ego functioning and object relations typical of a borderline personality organization. Anna experiences the precipitous intrapsychic object loss typical of borderline personalities when anger obliterates the positive internal object representation (Kernberg, 1975). Beyond this, I have come to realize that she interprets intrapsychic loss as a repetition of betrayal and disappointment verging on traumatic abuse. In fact, whenever Anna feels hopeful of a good object relationship she also feels unprepared—i.e., for her own rageful devaluation of the object—and hence vulnerable to the unexpected, which for her is equated with trauma, i.e., the assaults by her uncle.

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The subsequent trauma of "losing" her grandfather when she had to move from his home served a screening function for the preceding sexual abuse by her uncle, which for most of her life remained unconscious. Glover (1929/1956) has similarly described a patient whose memory of being severely burned between the ages of three-and-one-half and four served as a screening function for the earlier trauma of circumcision. For Anna the dread of separation carried the unconscious dread of the previous abuse. At the time she interpreted the move as a punishment for being abused by her uncle; it signified to her that she was indeed damaged, not good enough to be her grandfather's chosen child. Later she recast this belief in more Oedipal terms, that she was not good enough to be her grandfather's Oedipal partner. Her understanding of attachment thus came to equate love and hope with being exposed to traumatic abuse, while simultaneously she harbored the conviction that any attachment must end in disappointment and loss as a consequence of being damaged by abuse.

It is no wonder that progress in treatment, which implied increasing differentiation, aroused heightened resistance in Anna, and often in Hillary—at times in response to mother's withdrawal, at other times in direct consequence of her own fantasies and feelings—because of the genetic, dynamic and structural link between being abused and losing the good object, physically and intrapsychically.

Once treatment had enabled Anna and Hillary to experience some measure of symbiotic satisfaction, it was hard for mother in particular to renounce this. She resisted Hillary's resumption of motility, e.g., Hillary walking to my office from the waiting area, and did not bring her to her next session. It was hard for Anna to tolerate that upright locomotion occurs "not *toward* but *away from* mother" (Mahler, 1974/1979, p. 158). Other signs of

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increasing differentiation, associated in infancy with the emergence of the practicing phase, were also resisted by Anna: e.g., Hillary playing with me without refueling. The first of these developments was less threatening to Hillary, I believe, because of the gratification involved in exercising these newly restored functions and in the escape from mother (Mahler and Kaplan, 1977/1979), as is typical in practicing. However, Hillary did not experience the elated mood characteristic of that phase. As Mahler (1966/1979) has noted, the mood is typically more subdued if there is a deficit of libidinal supplies.

However, Hillary reacted strongly, with regression and intensified clinging, to Anna's great resistance to her playing with me without refueling, manifest in Anna's not bringing her to therapy for one month and Hillary falling ill. Hillary feared she would lose her mother because of her own growing attachment to me and her mother's intolerance of this attachment being separate from their tie. This fear generated the fantasy she would be traumatized again, because of losing her mother's protection (during this month she was panicked by the conviction that her father was returning). This regression from separation to traumatic anxiety was simultaneously reinforced by Hillary and Anna's lack of differentiation between the symbol and the thing signified: hence Hillary's symbolization in play of her abuse was also overwhelming to her—i.e., felt too much like it was actually happening—especially because Anna, in response to feeling overwhelmed, resorted to the denial she had exercised in Hillary's infancy (she accused Hillary of not telling me anything).

This first representation in play by Hillary of the failed but needed watchful maternal eye cast responsibility for the abuse on the absence of the object—the closing of the protective eye. Following my interpretation she enacted this failure more specifically: she made the daddy doll walk around

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on the roof of the doll's house while the baby doll cried in the crib and the mommy doll slept in the bed. There was another reason this specificity and directness proved too much for Anna: Hillary was communicating with me without her mediation. Previously, in the more symbiotic position, Anna had been speaking for Hillary, and I had encouraged her ability to do so, asking her for her understanding of Hillary's actions and feelings.

Anna was experiencing two rivalries: one was with me, over who would be Hillary's mother; the other was with Hillary, over whose mother I would be. This rivalry was partially alleviated by the change in the treatment arrangement: increasing Anna's sessions to twice a week, and shifting to psychotherapy, we were able to address these issues in her sessions.

As conflicts and concerns characteristic of the anal stage of psychosexual development began to emerge in Hillary's sessions, these were also interpreted by Hillary in the light of her abuse by her father; and mastery of these conflicts was also resisted by her and her mother because of the increased independence such mastery would engender. Hillary's fears of the toilet were recast in terms of fearing her father was in the toilet. Stage-appropriate conflicts between activity and passivity, between good and bad, made their appearance in her interpretation of the abuse by her father. She blamed herself for actively provoking his abuse: on the one hand, by being bad and dirty; on the other, by her own anal-sadistic attacks on him which she represented as the precipitant of his actions. This reworking of her abuse now cast herself in an active, as opposed to passive, role. She equated herself with garbage (i.e., shit), as was evident when she threatened to throw her doll named Hillary into the garbage. At this time, Hillary believed her mother colluded with her father in letting him abuse her, for the same reason he did so: because she was a bad, dirty "shit" baby and not a beautiful blond clean

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baby. Hillary retained her belief in a magical thought-action: symbolizing an aspect of her abuse in play could cause it to occur, just as angry wishes could result in injury or talion punishment.

At first, Hillary resisted giving up her diapers: they represented security, both as a tie to her mother, necessitating her close physical ministrations, and as an active barrier to assault. But once Hillary was ready to renounce them, Anna resisted for many months. It was hard for her to give up the libidinally gratifying activity, one of the few mothering acts which gave her satisfaction and in which she felt competent; and hard for her to allow Hillary the autonomy of active sphincter control.

Another patient of mine, five-year-old Marie, also experienced diapers as a protection. She had been sexually abused during the first three years of her life by her aunt and uncle, who had been acting as foster parents during her mother's psychiatric hospitalization. She repeatedly played doctor with the baby dolls in her sessions, but spent the most time swaddling them in diapers which were tightly secured with innumerable lengths of tape. Outer layers of clothing were then also secured with tape. Thus she symbolized her concern with protecting her body against the physical intrusions of sexual assault.

The affect of envy, and the feeling of possessiveness—hallmarks of the anal phase—the greater awareness of other children, and the wish to have or do what they do, which develops in the rapprochement phase (Mahler, 1974/1979), were also recast by Hillary in terms of her abuse. She wished she could be the good child—either the blond undamaged baby or the active, phallic boy—and hated other children who had these attributes, that she simultaneously envied. Baby girls—especially black-haired ones—she despised, as embodying of her bad self.

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Hillary's wish to be a boy, the emergence of penis envy, was also organized by the abuse by her father. She believed that had she been a boy she would have been active, strong and unafraid, and hence able to resist; and had she had a penis, she would also have been loved, and hence not subject to abuse.

Her early awareness of the anatomical differences between the sexes (she appears to have been exposed to her father's genitals, possibly as early as the first weeks of life, and through her second year) contributed to an early sense of being damaged and castrated, and to her low self-esteem and depressed mood (Mahler, 1966/1979; Galenson and Roiphe, 1971). Hillary interpreted her sense of castration in two ways: as a consequence of her abuse, and as a precipitant of it.

What Mahler (1966/1979) has called the "pillars of early infantile well-being and self-esteem" (p. 70) were certainly missing for Hillary: a belief in her own omnipotence, and a belief in her parents' omnipotence, in which she could partake. Or rather, there was an early belief in her father's malevolent omnipotence as directed against her; and even a belief in her mother's omnipotence, as deliberately not used in the service of protecting her, and hence, in this sense, as malevolent.

In the initial phase of treatment of a restored or restitutive symbiosis, my role was that of a maternal good object facilitating the tie between mother and child. Gradually, as both Hillary and Anna moved toward differentiation I took on in some respects the role of the father, as Abelin (1971) has described it, in the separation-individuation process. In differentiation and practicing, the father represents the "non-mother" (p. 246), the exciting, outer world. In rapprochement, he is the "other one," aligned to reality as a supporter of adaptive mastery and exploration, promoter of mastery of the process of

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intrapsychic separation for both mother and child, in helping them turn to the outer world. Similarly, I enabled Anna to allow Hillary to become toilet trained; to play alone in a room at home, and on the other side of the divider in the therapy sessions; and ultimately to begin a therapeutic nursery group; and enabled Anna herself to do occasional cleaning work outside the home, and resume her love affair with her former boyfriend.

Another element, typical of rapprochement, that fostered differentiation was the emergence of and tolerance of Hillary's directed aggression within the transference. Simultaneously she became able to listen to my interpretation of the affect of anger in sessions and at home, and then to relate herself instances of anger or aggressive outbursts between her and her mother. This she had long resisted as threatening her tie to her mother: because disclosure to her mother would result in her mother abandoning her; and because if she did not use displacement and splitting to protect her internal image of the good object, but acknowledged her aggression toward it, it would be obliterated. On either level of experience, it meant losing the maternal protector, and being vulnerable to trauma. The condensation of these fears was evident in the formation of her phobia about my office shelves, as a consequence of her anger toward me and her mother, in which the phobic object was allegedly feared as a reminder of her father.

In the phallic-narcissistic (Edgcumbe and Burgner, 1975) phase as opposed to phallic-oedipal, Hillary much wanted to be admired. She wanted her mother's eyes on her to ensure her admiration when she showed off, e.g., when she sang or danced, or rode a newly acquired scooter. But the wish for her mother's admiring eye, if not met, easily regressed to the anxiety that she did not have the mother's protective eye necessary to ward off trauma. Her anxiety that she had been damaged—castrated—by her father's abuse was

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with increasing frequency displaced upward into a worry that her intellectual faculties had been damaged, or that she was emotionally abnormal. She feared that her mother would abandon her for a normal, better, perfect child. She could not bear to see her mother admire another child or help anyone else.

Hillary in this phase demonstrated her conviction that her mother did have a secret phallus: e.g., when she played that the phallic mother kangaroo anally penetrated the attacking rhino father in retaliation. The subsequent official declaration of her mother's illness (i.e., heart disease) by the physician deflated Hillary's belief in the omnipotent phallic mother. In Hillary's play, medical procedures were often equated with attempts to restore the damaged or missing phallus as opposed to being a castrating attack. Hillary would strap what she called a "heart monitor" to a doll. For this device, she used a blood pressure instrument from the toy medical kit, which she taped across the girl doll's chest, invariably arranging the bulb so that it dangled down between the doll's legs. Usually physical abuse of the doll preceded—and precipitated—the need for a heart monitor. Thus she demonstrated her belief that her mother, like her, had been castrated by abuse. At the same time, the abuser in her play was a bad, phallic mother.

Hallmarks of the anal phase continued to pervade, thematically—as in the anal penetration symbolized in Hillary's play—and characteriologically, in Hillary's demanding acquisitiveness. Hillary daily demanded to be bought new toys, which served multiple functions: as narcissistic supplies; anal hoarding; and reparation of castration.

Hillary's movement into a "negative" (Lampl-de Groot, 1927/1948) or "active" (Nagera, 1975) Oedipal position and subsequently into a "positive," or "passive," Oedipal position (Nagera, 1975) did not mean that the

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rapprochement crisis had been successfully resolved. Oppositionalism, controlling behavior, and heightened sadism continued to stamp Hillary's character. Her relationship to Anna, even during the Oedipal phases, bore the stamp of a typical "hostile-dependent" relationship (Mahler, 1966/1979). She continued to vacillate between attempted restorations of grandiose omnipotence and clinging. As noted above, failures to integrate positive and negative self and object images, the persistence of large amounts of un-neutralized aggression, prevent the achievement of libidinal object constancy (Kernberg, 1966; Mahler, 1966/1979). Hillary's attempts at restitution of parental and self-omnipotence, that has been shattered too early by trauma and severe maternal failures, were thus especially intense, as Greenacre has similarly reported (1941/1952).

In the initial active Oedipal phase Hillary represented in play triadic relationships in which the rivalry was for the mother figure, and this advance resulted in a reinterpretation of her abuse by her father, and a new meaning to her fear of separation from her mother. She played that the mommy or aunt dolls went out for wonderful fun-filled boat rides, while the little girl doll, despite her longing and begging to be included, is left behind. At this time, Hillary was resisting her mother leaving the house without her, even for medical appointments, and I interpreted her conviction that Mommy went out at these times to have a good time without her. Hillary responded by telling me how her mother put on makeup and got dressed up when she went to the doctor, confirming my conviction. Subsequently, it became evident that she now believed her mother had preferred her father to her, and hence had left her to his abuse, just as she now feared that when her mother went on a date with these rivals her father would return and abuse her.

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When Hillary moved into a passive or positive Oedipal position her rivalry with her mother centered largely on a local doctor on whom Hillary developed a crush. She spoke of marrying him when she grew up. At the same time she voiced fears that her mother would take him away from her. (In fact, Anna was quite flirtatious with him, and he apparently was attracted to her, thus adding to the Oedipal rivalry.) In the work with Hillary, it emerged that she now believed her mother blamed her for taking her father away, and that this was why she had allowed her to be abused; and that now she believed her mother would steal the doctor from her in retaliation, and consequently she would lose both him and her mother. (This was in sharp contrast to Hillary's reaction to Vince; when her mother resumed their affair, Hillary liked him and demonstrated no jealousy.)

Hillary's changing understanding of her abuse at each developmental phase was strikingly evident, as was her reworking of her fear of losing her mother at each step. Hillary continued to be prone to regression—e.g., from castration anxiety to separation anxiety to annihilation or traumatic anxiety. Anna, too, reacted to the different stages, and her resistance was shaped by the issues of each: e.g., her actively flirting with the doctor (even though she told me she did not find him attractive), thus acting out the Oedipal rivalry with Hillary, because of her reluctance to let Hillary have this new object tie that did not include her.

Other of Hillary's phase expectable behaviors—e.g., her masturbation—remained intimately connected for both to the abuse by Hillary's father. Hillary began to openly masturbate, to say she was doing what Daddy did to her, and later to use his words when she did so. Anna's attempts to prohibit Hillary's masturbation were experienced by Hillary as an attempt by Anna to reinstitute her denial of the abuse, and an expression of disgust with Hillary

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for her activity in the abuse. Anna even threatened Hillary with abandonment, which came to have Oedipal overtones: "If you like him and act like him, go live with him." Satisfactory resolution of the Oedipal phase eluded both mother and daughter, who continued to feel threatened by their increasingly autonomous functioning, and to equate such anxieties with the possibility of further trauma. To understand this more completely, it is necessary to examine the development of precocious ego functioning in Hillary, which I shall do in the next section.

Precocious Ego Development

Hillary's precocious ego development can be inferred from her mother's description of her behavior in early infancy, from photos of Hillary during that period, and from the visual and auditory hyperalertness and advanced verbal and reasoning functions already observed between the ages of two-and-one-half and three when she first began therapy. Hillary's visual alertness, and auditory acuity, her ability to focus on and track objects, appear to have developed prematurely, as did her internal understanding of language. (As soon as her father was removed from the home, Hillary began to speak in full, complex sentences—as if she had felt there was no point to communication until she saw her communications would be responded to.)

I believe Hillary's precocious ego development represented an early attempt at mastering the repeated, massive impingements to which she was subject by her father. Specifically, Hillary's hypercathexis of auditory and visual alertness were attempts to anticipate the assaults of her father—the only way she could prepare for them in that early period of development. The subsequent development of receptive language appears to have also been used in the service of vigilance. When Hillary entered therapy, these sensory

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channels were still in a state of hyperalertness, attempting to ward off the unexpected (equated for her with the traumatic). She was acutely sensitive to sights and sounds, to any changes in her surroundings, and suspicious of the nuances of verbal communication.

Several other child patients who were traumatized also presented with such hypervigilance. One five-year-old boy, Carlos, who had been severely physically abused, neglected, and left tethered to furniture for long periods in early childhood was hyperalert aurally and visually; most especially he was acutely sensitive to any shifts in facial expression. This was an attempt to compensate for a serious language delay, which made Carlos reliant on reading of other cues as to the intentions of people.

Another child, a five-year-old girl named Kameisha, also physically abused and neglected (until found at the age of three in a crack house, half starved, with burns, her hair pulled out) had developed a similar hyper-vigilance. Additionally, she developed a heightened reactivity to music, and a strong sense of rhythm. When she made music in her sessions—using sticks and a tin container as a drum—her facial expression was transformed: it became contented and relaxed; her whole being appeared better integrated, the way a fretful baby responds when calmed by its mother. In this way, she appears to have developed and taken on the maternal soothing function—perhaps even used the loud cacophony of the surround to which she was subject in early life for such a purpose. Giovacchini (1980) has similarly reported on primitive patients who find the disharmonious to be soothing, in that it is reminiscent of the disjunct parenting they received in early life.

I view the ego precocity in these patients to be a taking on of the active functions of the mother, which the maternal figure has obviated, for the purpose of mastering the traumatic impingements. In Hillary's case, her

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precocious alertness, verbal ability and memory subsequently became a means for winning narcissistic gratifications from mother and grandmother. She continues to imitate the speech and action of figures from life and television and by these shallow identifications she assumes an adult coloration with which she hopes to achieve approval, from her mother, and security, from a repetition of abuse.

James (1960) has also noted that the precocious ego functions at the expense of phase-adequate object relations. He discussed a case in which the patient was in a state of tension due to chronic hunger for the first three months of life. At 14 days she already gave the impression of a much older baby. The mother's failures to mediate stimulus—i.e., the state of need to act as an instinct barrier—precipitated the infant's precocious development. "Premature ego development would imply that the infant, during the phase of primary narcissism, took over functions from the mother in actuality, or started as though to do so" (p. 107). In this case, the infant was forced to anticipate and to tolerate delay. Later in infancy and then childhood, she showed a marked reactivity to the environment and a facility for shallow identification, quickly taking on mannerisms and interests of those around her. James suggests "this infant cathected and developed a narcissistic 'thought action' which also fulfilled a need satisfaction, but in a different way" (p. 109). Similarly, Hillary developed a precocious visual alertness, memory and latent verbal facility, with which she now attempts to assume adult coloration.

Another patient, David, who had been left unattended for long periods of time and exposed to the physical abuse of his older brother by his mother, during his first year and a half; and later was exposed to her sexual activity; developed an extreme self-control. Initially, this appears to have been a

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precocious ability to delay, like James' patient; as well as an attempt to be unobtrusive, and hence not call down on himself the violent attacks to which his brother was subject. He developed an extreme stoicism in regard to pain. Later, however, the ability to delay broke down and he became intolerant of the least frustration, but he continued to be elusive in his communication and facially impassive. He needed me and his foster mother to decipher his wants from the least hint or cue, because of the dangers in early life of expressing needs, of communicating his presence at all.

Bergman and Escalona (1949) have written of children with innate "unusual sensitivities," i.e., insufficiencies in the stimulus barrier, which resulted in a premature ego organization that was similarly brittle and prone to breakdown. "The idea of an optimal time for the development of each function is not strange to present psychological thinking. Precocious organization of the ego may therefore be considered equally as deleterious a development as its delayed organization" (p. 349).

Mahler has described how the maturation of the mental apparatus, whose paradigm is the sensory-motor process, brings with it increasing awareness of separateness from mother. This enhances the sense of dependency upon mother, which arises out of helplessness and the threat of object loss (1965/1979, p. 157). However, physiologically based maturation (of autonomous ego functions such as locomotion and perception) can outstrip the developmental readiness for awareness, which can come as a shock, and result in high anxiety, or attempts at denial of separateness and struggles against re-engulfment (Mahler 1961/1979).

The forced development that results from a disjuncture in the physiologically based rate of maturation is in contrast to the healthy development of the ego and awareness of the object that arises from

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modulated, phase tolerable maternal failures (Winnicott, 1955/1958). This disjuncture may have pathological consequences, of which one may be the repeated attempts to restore the lost omnipotence, and insistence on being in an omnipotently "active" position.

Activity and Passivity

The "balance of activity and passivity" (Rapaport, 1961/1967) is a concept particularly germane to a discussion of trauma. The hallmark of trauma, as defined in the narrow sense, is that the ego is put out of action. This the victim experiences as a state of helpless passivity. Efforts to master the trauma are attempts to reinstitute activity. Initially, these efforts are seen in regression of the ego to more primitive modes of functioning, i.e., a reactivation of more primitive defenses in place of the high level defenses that have been overwhelmed. Later efforts include repetitions or recreations of the trauma in attempt at belated mastery (Fenichel, 1945/1972). Even trauma of the "strain" or "cumulative" kind, in the pre-ego phase of development, appears to promote attempts at activity, i.e., the premature development of ego functions, as occurred with Hillary.

Rapaport viewed activity and passivity as dualistic, but relative concepts. In a paper in which he attempts to formulate a metapsychology of activity and passivity (1961/1967), Rapaport presented a clinical case illustrative of "the manifold layering of passivity and activity as defenses against each other" (p. 534). In this case, passivity appeared "as a state in which the ego's controls of or defenses against drives are not used or are in abeyance, and a state in which no or ineffective use is made of the ego apparatus to seek out and to perform the detour activity leading to the drive object in reality" (p. 337). Activity appeared "as a state in which the controls

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against drives are used, as well as a state in which the available ego apparatus is used to seek by detour the drive object and thus find gratification in reality" (pp. 537-538). This patient turned activity dynamically into a state of passivity; she experienced her defensive activity as dystonic, an enforcement by a strict superego. Subjectively, she then experienced herself as being dishonest and psychopathically phony, as this state of activity obscured her underlying illness and prevented her from getting help. Conversely, she experienced passivity dynamically as activity, i.e., the only goal permitted her ego, and experienced as "honest," was to "demobilize its defenses against and controls of impulses" (p. 538).

"So in a sense—in this illustrative case as well as in general—all activity is also passivity and all passivity is also activity, and only the study of the dynamics of any given situation reveals which is the prevailing or dominant trend, or rather—and more correctly—what the balance of activity and passivity is at any given point" (p. 539).

As happened with Hillary, and to a certain extent with Anna, a largely passive experience of trauma is reworked in subsequent phases of development so that the victim is recast in an active position consonant with the issues of the later phase. This can also represent a defensive regression to the omnipotent position. Two other young girls whom I have treated, who were sexually abused before the age of five, had developed harsh superegos which were turned against themselves as well as onto the world at large. In the one girl, Kameisha, who had also suffered severe physical abuse and privation, the responsibility was cast in oral terms, of her intense greediness and insatiability. In the other child, Donna, whose environment was chaotic and unpredictable, and whose adolescent mother was poorly differentiated from her, yet was highly involved despite the neglect, the responsibility was

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cast in anal terms, of being bad—messy, angry, uncompliant; as opposed to good—clean, neat, and obedient. Both girls were intensely controlling, as is Hillary, and vigilant. In all these patients, the controlling behavior, characteristic of the rapprochement phase and anal stage, an attempt at restoration of symbiotic omnipotence, also served to control the object and the environment so that nothing unexpected could happen again: i.e., represented a vigilant warding off of trauma, which is equated with unexpectedness (the correlate of the ego's lack of preparedness). Simultaneously, it vitiated against the feeling of helplessness which follows trauma and the awareness of separateness.

Precisely in such patients (of the nine cases I have treated) who have suffered the severest abuse, and early "trauma" little mitigated by other factors in the maternal function, the propensity to extreme anxiety is most heightened; and the active vigilance against it most intense; and simultaneously the structural failure to achieve signal anxiety exposes these patients to repeated flooding with traumatic anxiety—an experience of passive helplessness. In such patients one sees dramatic shifts in ego state from activity to passivity and strenuous attempts at shifting the balance.

Fenichel (1945/1972) has noted how a passive attitude can become characteriological in certain traumatic neurotics.

> Helpless persons usually tend to regress to the times of their childhood, because as children they actually were helped by "omnipotent" grownups. Traumatic neurotics sometimes develop a kind of demonstrative attitude of helplessness and passive dependence and show certain oral trends; this is a regression to the more primitive passive-receptive type of mastery of the outer world following their failure to succeed in an active way (p. 119).

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Anna in part has such an attitude of helplessness, no more so than when she is deeply suicidal. At such times, she begins to experience therapeutic interventions, aimed at keeping her connected to treatment and alive, as intrusions—as molestations. She renounces all activity, retreating more and more into sleep: a symptom of her depression, but more importantly, the only acceptable defense against her suicidality—complete passivity (and blocking out) in sleep. Activity—even, or especially, the wish to live—become equated with abuse; only passivity is "good." Simultaneously, this passivity edges her ever closer to the ultimate identification with the aggressor—harming herself—so that she assumes the active role of abuser/murderer and the passive role of victim-suicide.

Analysts working with patients who have been traumatized have observed how in the process of working through the patient takes on at times an active position, at times a passive one. Erna Furman (1956) reported on an ego disturbance in a young child who had been seduced by her uncle and exposed to the parental primal scene. When the material concerning her molestation emerged in the treatment, the little girl ultimately enacted the intercourse with her uncle assuming both the roles: the passive one she represented physically (lying on the floor, etc.), the active one verbally (repeating her uncle's utterances).

Hillary has actively tried to repeat the passive position: asking her mother to caress her vagina. She has tried to repeat the experience symbolically as a passive voyeur (which she was to the dog's abuse): asking her mother to show me what her daddy had done to her, using her doll, Buddy, while she watched. At home, she has assumed both the active and passive roles, like Furman's patient: rubbing her own genital area while saying, "This is love," her father's words. (However, in Furman's patient,

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activity was presented exclusively by verbalization and passivity by reenactment.) Hillary's reenactments serve a number of functions: to force her mother to look; to provoke her mother to intervene; neither of which she did when the actual abuse took place. Hence it is a reenactment for a different outcome. (Hillary being prepared for and meting out the stimulation herself are other aspects of the attempted mastery.) However, her mother's belated intervention and emotional response, though provoked and wished for, now interfere with Hillary's activity and is experienced by her as an intrusion on her developing autonomy and her attempts to restore omnipotence. (They also serve to punish Hillary for her active complicity, and hence alleviate her sense of guilt.)

It seems to me that Hillary attempted to recapture the passive position not just in relation to her trauma, as in the instances cited above, but in relation to her development. Certain aspects of her passivity vis-à-vis her mother may be viewed as a result of ego regression consequent to trauma: e.g., the regression in motility—her refusal to walk when she was first referred for treatment (she demanded to be carried around for most of the day). Others appear to be an attempt to have a libidinally gratifying experience of passivity in relation to the object. She made her mother function as a titrator of experience, by using her as a verbal mediator; she reinstituted some of the physical care of earlier childhood; and in general used treatment to experience a holding environment: i.e., she regressed to the symbiotic state, of greater passivity but increased, fantasied omnipotent power.

In the discussion above, I have alluded to the ego's activity in exercising its function of mastery which is evident in the repetition of trauma. However, to simply deem such repetitions as activity is an

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oversimplification in part because, as seen in the examples above, the repetition can be in a predominantly active role, or in a passive one. Additionally, it is important to distinguish whether or not the ego experiences the repetition as syntonic or dystonic, active or passive, whether it is "automatic" or more consciously controlled. Hillary's entrenchment in the active position, her attempts to restore the omnipotence of early childhood, has a dynamic significance: by clinging to the fantasied state of omnipotent activity she attempts to maintain a magical control, she is ensuring that nothing unexpected—i.e., nothing traumatic—will ever happen to her again: that she (her ego) will never again be in a state of helpless passivity.

However, the consequences of such an attitude are mixed. Hillary experiences herself as the most powerful when she actively uses the defense of identification with the aggressor. Yet when she actively uses this defense, engaging in behavior, including the sadistic acts of her father in front of her mother, she is also permitting expression of the drives, at times mediated through play (when she physically abuses the dolls), at other times more directly (when she sadistically attacks the dog; or masturbates, saying her father's words and copying his gestures). Thus her active defenses allow the ego to be passive in respect to her impulses, and results in subsequent superego recriminations and attempts to restore controls at which time Hillary again feels weak, helpless, and passive.

In Anna's case, it became clear that her suicidal ideation was a form of secret activity, serving to protect her from future trauma, from suffering, and hence it gave her a feeling of control. Later her suicidality became a secret, phallic weapon. Similarly Krystal (1978) has suggested that some suicide attempts can be viewed as a means of interrupting a traumatic state: the

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person asserts mastery, interrupting a state of helplessness and psychological surrender.

I have come to see that suicide represented another form of activity for Anna: turning passive into active in an identification with the aggressor. She took on the role of the abuser, but kept herself as the victim, thus taking both the active and passive role at once (though this is also an expression of the lack of differentiation between self and object). Thus, in addition to the ego's achieving activity and mastery, she appeased her conscience, punishing herself for having been the victim ("no one will do it to be but me"); gave expression to her aggressive drive, turned against herself; and in fantasy, achieved a regressive symbiotic reunion. (This last, I believe, became particularly valent after her grandfather's death and her entrance into puberty. Her only serious suicide attempt followed two years after his death, a month or so after her boy friend left her, and reactivated her feelings of abandonment.)

Anna's wish, when she was highly suicidal, that I be with her when she died appeared to be a partial repetition of her grandfather's death, with her cast in the active role of the dying/departing one. Parenthetically, it is interesting to note that the very term "departed" attributes the role of active abandonment to the deceased. Anna was attempting to undo the separation by a fantasied fusion in death. My attempt to save her life, by notifying the medical director, she experienced as an assault, another trauma of betrayal and abandonment, similar to the consequences in childhood of her abuse being discovered. Here we have another example of Anna's tendency to experience activity on my part as abuse, even as she strove to provoke such activity.

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Repetition

In this section I will discuss certain aspects of the repetition of trauma, and its repetition within the treatment of patients who have been traumatized.

Repetition is a widely observable principle of human behavior in general (Loewald, 1971/1980; Pine, 1985). Freud observed this principle at work within the therapeutic session; that in analysis the patient reproduces what is repressed, "not as a memory, but as an action; he repeats it, without of course knowing that he repeats" (1914/1981, p. 150). This repetition forms the basis of the therapeutic work: it is the resistance to be analyzed.

The repetition compulsion operates as an outcome of psychoneurotic conflict, i.e., the return of the repressed (Fenichel, 1945/1972) and as an attempt to master trauma (Freud 1920/1961). Freud (1920) also posits it is an expression of the death instinct. Waelder (1936) postulates it as one dimension of the principle of multiple function. As such it is readily observed in people's life histories. For example, Jean-Jaques Rousseau (1781/1953) abandoned all his newborn children on the steps of orphanages. It seems to me this abandonment may be thought of as a repetition of his abandonment by his mother who died in childbirth. (One can imagine it served other functions as well: for instance as a displaced punishment of his infant self for the murder of his mother, for whose death his father repeatedly blamed him.)

This dramatic example from Rousseau's life is one of a number of types of repetition among which I think it is useful to distinguish. There is repetition over generations, as occurred in Rousseau's life. Likewise, Anna's history of being sexually abused in her childhood was repeated with Hillary. Anna herself may have served as a repetition of her mother's history. In

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each case, the mother was unable to protect her child, beginning with Mrs. T.'s mother, who left Mrs. T. to fend off the sexual attacks of her siblings. Such repetitions across generations seem to be facilitated by the lack of differentiation between the generations.

Searles (1982) uses the term "transgenerational transference" (p. 158) to describe the means by which this undifferentiated state between borderline patients and their parents is perpetuated. These patients are unconsciously perceived by the parent as the personification of the parent's own unintegrated past. The parents forms a symbiotic transference with their child, as a means of perpetuating the childhood symbiosis they had with their parents. Anna's use of Hillary in this way has been particularly evident in her more suicidal states.

Mahler (1963/1979) has described how in the normal course of development the infant's body in the presymbiotic and symbiotic phase are experienced by the mother as part of her unconscious representation of her "self." The baby's body is also experienced as phallic by the mother. In addition, each child has its own specific meaning to the mother. Hillary appears to have been fused to Anna's negative self-representation: initially as a worthless and vulnerable girl; subsequently, as an abused and hence doubly damaged girl. The dangers posed when the parent has pathologically split unintegrated self and object representations is that the lack of differentiation persists and is not simply part of an expected or even adaptive regression during the phase of early parenthood (Benedek, 1959; Blos, Jr., 1985).

There is another type of repetition in which the patient exposes him or herself again to the same experience. For instance, Anna repeatedly put herself in jeopardy with the uncle who had abused her by insisting she go out alone with him, and she later in life placed herself in dangerous situations

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with other men. It is not clear if Hillary, when she played with and became overexcited by a neighborhood man, whom Anna later claimed was a "pig," was participating in such a repetition or if it was her mother's fantasy.

Finally, there is repetition which shifts the balance of activity and passivity, as in turning passive into active. This type of repetition, which I view as especially important in both the etiology and treatment of pathology subsequent to trauma, was discussed in the section of passivity and activity.

The wish, conscious or unconscious, that this time it (the repetition) will turn out differently may be present in any of the types of repetitions delineated above. For example, when Anna in pre-puberty demanded from her mother that she be allowed to go out unaccompanied with the uncle who had abused her, she was consciously, silently wishing her mother would forbid her. In this attempted direct repetition, Anna participated actively but the activity was dystonic to her. It is also important to note that whereas the dread was conscious, the memory of her sexual abuse was under repression at the time. When Anna placed Hillary at risk for abuse by marrying a man she thought might be a child molester—an intergenerational repetition—Anna wished for a different outcome, i.e., she would protect her baby/self. The reparative wish in repetition may be foiled by environmental failures, by the patient's psychopathology, or by other aspects of the press for repetition. Anna's reliance on primitive defense mechanisms meant that when actually confronted with the recurrence of trauma with Hillary she was overwhelmed; when denial failed, she became paralyzed by the dissociated state to which she regressed, and hence was incapable of action. Thus the attempted shift to activity reverted to a state of passivity.

A. Katan (1973) has described her treatment of adult female patients who were raped in childhood, and who subsequently exposed their children

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to the same experience, largely by not protecting them when needed. Katan postulates they were prevented from doing so by their own overwhelming sexual excitement. I would add, in Anna's case, that this excitement had a sadistic cast, and in that regard she identified with the sadistic actor, her husband; yet she also identified with the victim, and as such experienced a punishment, terrifying excitement, intended to relieve her guilt. It is clear that the pathology of her intrapsychic functioning both contributes to the occurrence of repetition and shapes the outcome.

Freud observed a connection between the particular formative impact of trauma on personality functioning and two types of effects, which he called respectively "positive" and "negative."

> The former are attempts to bring the trauma into operation once again—that is, to remember the forgotten experience or, better still, to make it real, to experience a repetition of it anew, or, even if it was only an early emotional relationship, to revive it in an analogous relationship with someone else. We summarize these efforts under the name of "fixations" to the trauma and as a "compulsion to repeat." They may be taken up into what passes as a normal ego and, as permanent trends in it, may lend it unalterable character traits, although, or rather precisely because their true basis and historical origin are forgotten . . .
>
> The negative reactions follow the opposite aim: that nothing of the forgotten traumas shall be remembered and nothing repeated. We can summarize them as "defensive reactions." Their principal expressions are what are called "avoidances," which may be intensified into "inhibitions" and "phobias." These negative reactions too make the most powerful contributions to the stamping of character.

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> Fundamentally they are just as much fixations to the trauma as their opposites, except that they are fixations with a contrary purpose. The symptoms of neurosis in the narrower sense are compromises in which both the trends proceeding from traumas come together, so that the share, now of one and now of the other tendency, finds preponderant expression in them. This opposition between the reactions sets up conflicts which in the ordinary course of events can reach no conclusion (1939, pp. 95-96).

Freud's "positive" and "negative" effects are akin to different types of repetitions that are observable in Hillary and Anna. For instance, Freud speaks of an attempt to revive an early traumatic emotional relationship with someone else. Anna's choice of physically abusive boy friends in her adolescence and early twenties may be viewed as such an attempt. (The function in relation to the superego of this choice—of being punished for her badness, i.e., previous abuse—was of course prominent here as well.) However, I believe, Anna's primitive object relations, her reliance on projection and splitting insures repeated experiences of idealization followed by devaluation, which equals loss of or destruction of the good object. These cycles of idealization and devaluation are for Anna akin to small scale repetitions of her trauma: endlessly finding and losing the omnipotent object.

The negative effects of trauma—avoidances, inhibitions, and phobias—figure prominently in Hillary's defensive repertoire. Greenson (1959) has called a phobia "a defense against anxiety." In Hillary's case, since the trauma has remained conscious, it is conscious reminders of the trauma that ostensibly determine the choice of phobic object—as when she became phobic of the toy shelves in my office because they allegedly resembled her

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father's, precipitated by her anger toward me for giving her mother more frequent sessions. Hence "If you love me, you will get rid of him, or reminders of him" was a displacement from "If you love me, you will get rid of Mommy/your sessions with Mommy." Thus she protected me from her anger and her mother from her envy. My toys may have been experienced by Hillary as a seduction, a stimulus to envy, much as the toys her father proffered her were a seduction; which in both cases placed her in a situation of rivalry with her mother, thus threatening her tie to her. Hillary has clearly reinterpreted the abuse as an Oedipal triumph in later sessions.

Fenichel (1945/1972) described the striving to achieve belated mastery which results in repetition in economic terms as the need to relieve painful tension. His phenomenologically astute description is an accurate account of Anna's daily life experience.

> The ego's attitude toward the repetition is a very ambivalent one. The repetition is desired to relieve a painful tension; but because the repetition itself is also painful, the person is afraid of it and tends to avoid it. Usually, therefore, a compromise is sought: a repetition on a smaller scale or under more encouraging circumstances. The ambivalence toward this repetition shows itself in the phenomena of traumatophilia and traumatophobia and in the fact that whatever these persons undertake turns into a trauma; they fear this, and nevertheless they strive for it. There are many varieties of this mixture of fear of repetition and striving for it. When the striving is unconscious, the patients, in spite of a fear of upsetting experiences, experience very upsetting things every day; they run from catastrophe to catastrophe; everything is disturbing and filled with emotion; there is never time, distance, or relaxation enough for them to quiet down.

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> At other times, the wish for repetition is more conscious, and the patients long for one dramatic experience, to end their misfortunes once and for all. (p. 543)

I would add that the wish to repeat and achieve relief is defeated by the structural faults of the ego: in other words, Fenichel's economic explanation can be supplemented in terms of structural, ego functions and object relations: the failure to achieve signal anxiety, and inability to tolerate anxiety, which ensures the attempt will provoke traumatic anxiety; the fixation at the rapprochement phase, with its rapidly shifting, stormy mood states that are ill regulated. The press to repetition permeates character and habit. Anna is continually rearranging the furniture in her tiny apartment, repainting the walls: she is ensuring her environment is in an ongoing state of flux. But by expecting and controlling the change in this small arena, she is making it tolerable and robbing it of the suddenness which usually causes her to feel overwhelmed. (Anna, as are many fragile patients, is thrown off equilibrium by any change, whether it be in her therapy schedule, in her environment, or the departures of clinic staff she does not know.) Changing her home is a tolerable repetition of her sudden eviction from her grandfather's home in childhood. I believe it is also a titrated experience of the confusion and total disorientation of the infant when separated from the object—an experience that persists in later life when object constancy is not achieved. (Anna's feelings of "not belonging" or of the room or street looking different are a manifestation of this disorientation when the object tie feels threatened, whether by her anger or by external events.) The adaptive or progressive aspect of this habitual redecorating is her exercising control over the environment, measuring the change she can effect, as a toddler and even

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an infant does. However, it speaks to her enduring sense that something is wrong, and needs to be fixed, and the insufficiency of all her attempts to fix it.

Anna and Hillary's repetitions also function in regard to self-esteem regulation. (Pine [1985, p. 66] has suggested that all behaviors "have functions in the maintenance of self-esteem.") This can be seen with Hillary when she identifies with the aggressor, mimicking her father's words and gestures—at times to cause her mother to vomit; attacking the dog; or taking on the role of abuser of the dolls in her therapy sessions. She recasts herself in the active role, renouncing the position of helpless victim. Loewald has made the subtle distinction between the mere active doing and the participation in the adult's power which I believe serves to enhance the sense of self-esteem.

> For a child—and this is more so the younger the child—the important thing may not be that he is doing something now that he saw done by his parent, that he is repeating it himself. Frequently it is most important to him that what he is doing is the same as what his parent does or did, participating in this fashion in power and permanence, and more: in this way only he has any identity, any weight. At a later stage this may be attenuated to the importance of being watched by the parent while performing some action. (1971/1980, pp. 98-99)

This purpose is manifest in Hillary's repetition of her father's actions; although it is true in her imitation of her mother's as well—and in her attempts to act grown-up and disown all vestiges of babyhood and childhood. Hillary thinks of children as damaged and unlovable: "dumb," "weird," out of control, and frightened. Only by acting as the adult did, her abusive father, does she feel like she has any value, any hope of not being frightened. By repeating his actions, she attains his "power and permanence"; she is no longer a nothing, ineffectual.

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The aspect of self-esteem regulation is evident in attempted reparative repetitions, such as Anna's marrying a man she suspected to be a child molester. As discussed above, she imagined that she would actively protect her baby, which meant she would finally feel she had done something of value, that her life was worthwhile. She believed she could give her child a different life: her child would be loveable—would have a father; her child would not be abused.

Hillary, in participating in her father's power, and Anna, in becoming empowered by having a protected, undamaged baby, share a fantasy, I believe, of gaining the penis as a source of power. There has been much material in both Anna and Hillary's treatments, as I reported in the previous chapter, derivative not only of their penis envy and sense of castration as a result of being abused, but of their conviction that if they had been a boy they would not have been abused, and hence damaged; both because they would have been powerful and they would have been loved. Hillary symbolized her belief that a phallic weapon is needed to ward off sexual abuse—or perpetrate it—in the play sequence in which she had the plastic kangaroo/mother figure protect the babies from the attack by the rhino by threatening him with her tail, and ultimately attacking his anus with it.

A. Katan (1973) has reported similar recollections and fantasies from her treatment of women who were raped in childhood. One patient believed as a child, as Hillary does, that if she had a penis her father would love her and she would not get hurt. All her patients suffered from low self-esteem, a feeling of being "nothing," which they could only escape by identification with a man, and thus acquiring a penis in fantasy.

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Repetition in Treatment

Repetition, as has been stated above, is the essential vehicle for treatment. I would like here to turn to a particular type of repetition observed in the treatments of patients who have been traumatized: the trauma is repeated in the transference, with the therapist cast in the role of traumatizer (Winnicott, 1955/1958; Furman, 1986; Hopkins, 1986; Casement, 1986).

Greenacre (1963) noted that acting out in the transference "is most forceful and persistent when the child has suffered humiliation in the traumatic episode, being forced from a desired active position to a seemingly devalued passive one" (p. 699). The latter occurred to Anna when she was forcibly removed from her grandfather's home, and simultaneously thrust aside from the position of favorite.

With Anna, the instances of most forceful acting out in treatment have included a threat of termination if I did not participate with her in her attempts at repetition. Casement (1982/1986) reported a similar instance with an adult patient who had been severely burned in the tenth month of life, and had required corrective surgery in the seventeenth month. The specific attempt at repetition involved the patient's demand that the analyst take her hand. During the surgery at seventeen months, she had been under local anaesthesia when her mother, who was holding her hand, fainted. The patient felt she could not continue analysis if he did not hold her hand. Casement considered doing so and told her as much, but ultimately decided against it. This she experienced as his holding her hand and dropping it, like her mother, but ultimately was able to work through the experience of her original trauma with him. Similarly, upon seeing me speak to another mother in the waiting area, Anna flew into a rage and demanded that I tell

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her that I loved her best of all my patients. If I did not, she insisted she would not, could not, continue in therapy with me. My attempts to help her see she was trying to repeat something with me, and that it would be detrimental to her if I acted it out with her instead of helping her understand, initially fell on deaf ears. She seemed to get worse—more delusional in her insistence. Ultimately she was able to recognize her underlying need to continue therapy if she was to go on living, i.e., fend off her underlying suicidal ideation. She recognized she had wished to undo her need of me by making me need her as much as she needed me; thereby, undo her grandfather's rejection of her in childhood.

According to Winnicott (1956/1978) treatment provides the opportunity for the development of an ego and a repudiation of the false self that develops when repeated environmental failures have impinged on the infant's state of "going-on-being." Repetition in the treatment—repetition of failures—is experienced as a past failure which is now recalled.

> There builds up an ability of the patient to use the analyst's limited successes in adaptation, so that the ego of the patient becomes able to begin to recall the original failures, all of which were recorded, kept ready. These failures had a disruptive effect at the time, and a treatment of the kind I am describing has gone a long way when the patient is able to take an example of original failure and to be angry about it. Only when the patient reaches this point, however, can there be the beginning of reality testing. It seems that something like primary repression overtakes these recorded traumata once they have been used in the treatment.
>
> The way that this change comes about from the experience of being disrupted to the experience of anger is . . . *the patient makes use*

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> *of the analyst's failures* . . . The clue is that the analyst's failure is being used and must be treated as a *past* failure, one that the patient can perceive and encompass, and be angry about now. (p. 298)

Anna's false self—i.e., an existence in reaction to impingements—presumably developed in infancy when she was well fed by her foster mother but otherwise left completely to herself. No other needs were acknowledged or met. She slept all the time, until, taken to her grandfather's home, he became the primary maternal figure and brought her to life by his responsiveness, attunement, and stimulation. Before, she had been as a dead baby. This is one source of her depression—and the loss of the foster mother, inadequate though she was. "In its primordial beginnings, libidinal seeking is deeply intertwined with the desire to live, and it is the mother's task to 'seduce' her child to want to live" (McDougall, 1986, p. 218). This does not seem to have happened until Anna was cared for by her grandfather.

Her molestation by her uncle in her third year of life, and her consequent ejection from her grandfather's home, resulted in a secret self coalescing around the wish to die. Before her fifth year, she recalls the funeral of a great aunt, and her wish to lie down in the coffin and be at peace—as if her grandfather had brought her to life only to severely disappoint her, expose her to the trauma of molestation and object loss, and she longed to be the lifeless baby again.

Anna continues to equate the feeling of hope with a state of unpreparedness for the disappointments that she is convinced must inevitably follow, and which she equates with traumatic surprise. She often says, "Don't let me put my hopes on it. If I expect it, it won't happen. This way I won't be surprised. You know me—no surprises." Thus the hope that treatment, and I as a therapist, hold out to her (an ongoing "protective"

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relationship, an amelioration in her condition) becomes experienced, in her depressions particularly, as an attempt to traumatize her by putting her off guard. Yet it is evident that it is precisely in these episodes of intense acting out, in her intense depression, that the opportunity exists as Winnicott has described for using developing ego strength in the service of further therapeutic progress.

Ferenczi (1932/1955) cautioned that analysis of trauma is not possible if current conditions are not more favorable than the situation at the time of the original trauma. The conditions may be in the external world or mainly offered by the analysis, but this runs the risk of a life-long fixation to the analyst.

Another five-year-old boy, Robert, whom I treated, had serious separation anxiety that often prevented him from cooperating in school. He had suffered a real separation from his father at the beginning of his second year, when his mother permanently left his father and their country of origin. He was molested by his male baby sitter when he was five. This molestation intensified his already existing separation anxiety, but seemed to have otherwise had little adverse effect on his functioning, illustrating the notion that trauma will impinge upon the preexisting conflicts (Brenner, 1986). Interestingly, the actual loss (a four month separation) and restitution of his therapist during treatment—the real repetition of separation—appeared to facilitate his working through his separation anxiety vis-à-vis his mother. His relatively healthy endowment, and his recathexis as a good child by his mother as a result of therapeutic intervention, were factors mitigating against greater pathological sequelae to his abuse.

I believe the primary way Hillary has experienced me as traumatizing her is with my words. This has been so in periods when she has strenuously

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fended off my interpretations, but particularly in the fourth year of treatment when I suggested she come twice a week to therapy, and she reacted by not wanting to come at all. My words had become assaults on her—indeed I experienced them as such—as trying to force something into her, despite her resistance. Thus the offer of two sessions a week, previously so coveted, but now following a period of her mother's extreme hostility, resistance, and ill health, and consequently her own erratic attendance, was experienced as a seduction, a seduction preparatory to abuse. My words were traumatic in that I was forcing on her consciousness things she wished to avoid, and hence exposing her to being overwhelmed anew. Hopkins (1986) described her treatment of two traumatized children. One experienced her as traumatizing him because the treatment addressed his congenital illness, the source of his traumatic experiences. The other child blamed Hopkins for the traumas because she put her in touch with the past experiences. She accused her, in poignant words, "You broke me. You tore me apart" (p. 67). Hillary also experienced me as an abuser—a trickster—in my efforts to get her to attend school and go to the doctor.

I will close by mentioning a distinction Loewald (1980) has made between passive, "automatic" repetition and an active "recreation" which is adaptive and creative.

> Repetition on the psychological level cannot be defined simply in terms of reiteration or replica in a mechanical sense, although more or less stereotyped and automatic repetitions of prior experiences, prior behavior, thoughts, feelings and actions play an important role in normal and pathological processes. It is, in fact, one of the most important issues confronting us in a psychoanalytic consideration of repetition to make a distinction between such relatively passive or

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automatic repetitions and active repeating, and to study the conditions under which transitions from one to the other take place . . . Any consideration of the relations between id, ego, and superego has to deal with the passivity-activity issue in terms of repetition, and so does any consideration of psychoanalysis as a therapeutic process. (p. 87)

This creative repetition, it seems to me, is the possible adaptive outcome of successful treatment, in which the press for repetition—for mastery, for shifting the balance of activity and passivity, to enhance self-esteem—finds a more satisfactory sublimated outcome. Anna's wish to be a nurse and Hillary's to be a vet represent longings for such "recreations." Whether Hillary will ever be able to achieve such an outcome is uncertain. It is also possible that she will, like her mother, be confined to the disorganizing automatic repetitions to which her ego weaknesses and her experience of trauma leave her vulnerable.

Summary of Principle Findings

The first principle hypothesis of the present study posited that serious trauma will impair the development of self and object representations and will consequently disrupt the process of separation-individuation and impede the development of adequate object relations. The clinical data was consistent with this formulation. As expected, Hillary and the other children studied manifested these disturbances in some of the following ways: difficulty in actual, physical separation from the primary maternal figure; intolerance of being alone; extreme efforts to deny the experience of anger toward the primary maternal figure, and to shield that person from anger, by displacement, splitting, etc.

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The prominent symptoms varied from case to case. The disruption of the separation-individuation process was most evident in Hillary and Anna. Robert, the child whose presenting problem, even preceding his sexual molestation by his babysitter, was separation anxiety, in fact had the most successful outcome; precisely because his, and his mother's, object relations were on a higher level. His separation-anxiety was more in the realm of intrapsychic conflict, as opposed to a more chronic state of lack of, or poor, object constancy. Hillary represented the most intense, dramatic intolerance of actual physical separation. In others, such as Marie and Kameisha, there was a shallow, if intensely needy, relatedness; and with Marie in particular, as with Hillary, a facile imitation of behaviors and gestures.

The more severely traumatized children, like Anna, were highly susceptible to and intolerant of heightened anxiety. The precipitants of anxiety varied, however: e.g., for Kameisha, interpersonal stimulation and affective arousal tended to flood her with anxiety; for Carlos it was any change or lack of familiarity; some, like Hillary and Josie, existed in a chronic state of high anxiety. I agree with Greenacre (1941/1952) that these children are left with an indelible predisposition to anxiety; but I would add that this predisposition impedes the attainment of signal anxiety, which failure in turn reinforces the predisposition to anxiety. There is a heightened propensity for regression from higher levels of anxiety to traumatic anxiety.

The second hypothesis suggested that efforts to master early trauma may result in a premature development of certain ego functions, in which the infant takes on and enacts the failed maternal function. Again the clinical material supported this hypothesis, but not uniformly. Precocious ego functioning was particularly evident in the cases of Hillary, Kameisha, David and Carlos. As noted in the preceding discussion, the specific functions

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prematurely developed and hypercathected varied in ways that seem related to an interplay of complex constitutional and psychodynamic factors. What is not clear in the clinical material are the factors determining whether or not there will be precocity in the development of ego functions.

The final hypothesis proposed that traumatized children will re-enact the trauma both in their lives and in the treatment, and that such repetitions are multiply determined, involving: attempts at mastery; re-enactment of earlier faulty object relations; and a failure to achieve signal anxiety and a consequent regression to traumatic anxiety. The clinical material tended to support this hypothesis, although the data bearing on this hypothesis is less complete in that an extended logitudinal study would be necessary to assess the degree of repetition in the course of life, and across generations. Such repetition was much in evidence in the three generations of Hillary's family.

The supposition that passive and active roles may be taken in repetitions was greatly in evidence in the clinical material. In Josie's foster family, this element of repetition was prominent. Her foster mother had herself been sexually abused by her stepfather in childhood. After Josie and her sister, already sexually abused by their biological father, had been placed in foster care with her, she allowed the paternal grandmother to reclaim them. The grandmother returned them to the father, who again abused them. Only then could the foster mother mobilize herself sufficiently to rescue the children and fight to adopt them.

Another factor influencing the repetition of trauma in treatment is most likely the frequency and length of the treatment. These factors must be weighed for further consideration.

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Points for Further Study

Anna and Hillary, and the other cases referred to in this study, were exposed to both shock trauma and strain trauma. These two kinds of trauma often occur in tandem; consequently, it can be difficult to separate their respective impacts. It has been pointed out in the literature that early trauma resulting in premature and fragile ego organization leaves the child more vulnerable to shock trauma and future breakdown (Bergman and Escalona, 1949; Khan, 1963). I would add that chronic faulty parenting, which subjects the infant to strain trauma, contributes to the occurrence of shock trauma, e.g., sexual or physical abuse. Both are often the consequence of parental pathology, in which the infant becomes a bad self object for the parent, with whom the parent's fate is repeated. Nonetheless, it would be important to distinguish in further study the sequalae of sexual abuse, as opposed to other forms of trauma, and to differentiate between the impact of strain and shock trauma.

As mentioned above, in many cases of early trauma, there is a consequent precocious development of certain ego functions. Further study is warranted to understand the factors facilitating such development in some cases and not in others. The issue of reconstruction is complicated in such cases because failures in parenting can contribute to greater distortions in the reporting of early development.

These precocious functions are indeed fragile, and prone to breakdown, as reported by Bergman and Escalona (1949). For instance, Hillary's and Carlos' hyperalertness to visual and auditory nuances often lead to misinterpretations and strained reality testing; David's stoicism alternates with tantrums over slight delays in his needs not being met, or his non-verbal cues not being read. But at the same time, these functions may be

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relative strengths (e.g., Hillary's interest in learning) in an otherwise dysfunctional ego. Greater understanding of the adaptive and maladaptive consequences would have important treatment implications.

The cases studied suggest that trauma experienced in the infantile period of relative passivity will be later reinterpreted by the child to assign itself an active role. This need to assume an initiating, active role in fantasy is a consequence of a number of factors. As seen in the details of Hillary's treatment, trauma leaves an organizing imprint, but the child's understanding of (and hence memory of) the trauma is shaped by succeeding phases and stages of development. Thus as the child moves into an active position, it assigns itself an active, initiating role in the earlier trauma. The shift to activity in fantasy is also a consequence of the experience of excitation, and the guilt over any pleasurable feelings of excitation, that preceded the unpleasurable, overwhelming of the ego, and that may have been present simultaneous with fear. (Wishes or fantasies in which the active role is assumed are shaped by all these factors.) It also serves a defensive function, shifting the balance from passivity to activity, as in turning passive into active, and avoiding the memory of the ego's helplessness.

It is important to understand the defensive aspect of assuming the active role of initiator, and the attendant guilt for not preventing trauma. Such feelings are common in rape victims, for instance, and rape counseling tends to focus on assuring victims of their lack of responsibility. While it is important to alleviate the superego recriminations, the self-blame of victims is also an attempt to avoid the feeling of helplessness experienced in trauma, and this aspect must be addressed without leaving the person defensively helpless.

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This issue is equally important in long term treatment setting. Hillary, for instance, only feels lessened vulnerability to traumatic affects when she identifies with her father. Paradoxically, however, this identification with the aggressor leaves her more vulnerable to being overwhelmed by her own impulses, such as sadistic outbursts. Hence an area for further study is to apply the clinical theory of treatment of fragile ego impaired patients to the issue of the defensive assumption of activity consequent to trauma.

The various factors involved in repetition, including the possibility of passive and active repetitions, is an important area of study. Heretofore, studies of repetition have generated conflicting findings. For instance, a recent study of imprisoned sex abusers (reported in *The New York Times,* December 7, 1986) did not find a significant correlation between childhood victims of sex abuse becoming abusers; others have found no correlation between victims becoming victims again in adulthood. Such studies have too narrowly defined repetition (e.g., from passive victim to active perpetrator). They ignore a significant kind of repetition in which the adult, abused as a child, does not herself abuse her children but allows it to occur. This took place with Anna, who preconsciously had the thought that her husband could be a child abuser, and repressed it. Similarly, it occurred with the foster mother of one patient, Josie, as described above. One child, Nicky, was molested by his grandfather, as was his sister. His mother, a borderline psychotic woman, had herself been molested by her father in childhood. Such repetitions over generations—involving the repetition of old object relations (Freud, 1939; Pine, 1985), failures to adequately differentiate from one's child, and the reliance on primitive defense mechanisms—are important to consider in identifying a target population for preventive services.

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Follow-up of patients suffering childhood trauma, as carried out by Terr (1979; 1981;1985) is an additional area warranting further study. As trauma becomes increasingly reported (e.g., sexual abuse) and prevalent (e.g., increased poverty and homelessness among children and rising numbers of foster care placements) in the United States, the treatment and prevention of trauma, and the understanding and mitigation of its consequences, become increasingly important.

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