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Fits and Starts: A Mother-Infant Case-Study Involving Intergenerational Violent Trauma and Pseudoseizures Across Three Generations

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Abstract

This case-study presents in detail the clinical assessment of a 29-year-old mother and her daughter who first presented to infant mental health specialists at age 16-months, with a hospital record suggesting the presence of a dyadic disturbance since age 8-months. Data from psychiatric and neurological assessments, as well as observational measures of child and mother are reviewed with attention to issues of disturbed attachment, intergenerational trauma, and cultural factors for this inner-city Latino dyad. Severe maternal affect dysregulation in the wake of chronic, early-onset violent-trauma exposure manifested as psychogenic seizures, referred to in the mother's native Spanish as "ataques de nervios," the latter, an idiom of distress, commonly associated with childhood trauma and dissociation. We explore the mechanisms by which the mothers' reexperiencing of violent traumatic experience, together with physiologic hyperarousal and associated negative affects, are communicated to the very young child and the clinician-observer via action and language from moment to moment during the assessment process. The paper concludes with a discussion of diagnostic and treatment implications by Drs. Marshall, Gaensbauer, and Zeanah.

Introduction

This case-study will describe a mother and daughter who participated in a research study which the first author is conducting as a collaborative effort between the Columbia College of Physicians & Surgeons Departments of Psychiatry and Pediatrics together with the Parent-Infant Program of the Columbia University Psychoanalytic Center. This research study involves an exploration of the psychological and communicative processes involved in the intergenerational transmission of violent trauma. The goal is to understand the relationship of maternal trauma severity, psychopathology and self-reflective capacity, with mothers' perception of and interactive behavior with their very young children (Schechter, in press; Schechter, Zeanah, Brunelli, Myers, Coates, Grienberger, and Hofer, 2002).

Forty-one inner-city Latino and African-American mothers who have survived interpersonal violent trauma during childhood and adulthood, physical and sexual abuse and assault, as well as domestic violence have been interviewed. More than a third of these mothers have had to face child protective service investigations, filing of restraining orders, suicide attempts, and fear of their own violent behavior. More than a half identify their very young children ages 8-48 months as the main stressor in their lives. These are women who are referred to our Infant-Family Service, formerly known as the Therapeutic Nursery, a clinic within the New York-Presbyterian Hospital Division of General Pediatrics that is meant to service families with

children under 5 years of age who are at risk for violence exposure, abuse and neglect. These are families that are not only referred, but who also present to clinic visits.

In this case-study, one mother's particular adaptation to her own history of violent trauma, and how that adaptation affected her interpretation of her infant daughter's distress are described. The mother's response to her daughter's distress based on her mother's interpretation-as-defense formed a trauma-related communication to her daughter as well as to staff, which if unheard would lead to danger and new trauma for the youngest generation of her family.

The Case

Nancy was a 29-year-old married Dominican-American mother of two girls: Alisa, age 5 years, and Libby, age 8 months, when she brought Libby to the Pediatric Emergency Room with the complaint that Libby was having multiple, prolonged tonic-clonic seizures following a flu-like illness.

Fluent in English, Nancy described Libby's seizures in vivid detail with understandable terror and uncertainty about what would happen next. Her descriptions were convincing to the pediatricians and neurologist that her young daughter had developed a form of epilepsy. This was despite the fact that no medical staff had witnessed any seizure activity, the neurological exam was unremarkable, and an EEG had significant motion artifact, but could be interpreted as supporting the presence of epileptiform activity.

These data plus a family history that she and her older daughter Alisa both suffered from a seizure disorder and took anti-seizure medications convinced the pediatric neurologist to prescribe the sedative Phenobarbital for the infant.

The medication seemed to help for a few months. But then Nancy and Libby returned to the E.R. at age 13, then 15 months of age. Nancy said that despite compliance with the regimen, the seizures had increased in frequency and severity. Only after the Phenobarbital dose had been increased and Valium suppositories had been added, did one neurologist recommend an in-patient 24-hour video-monitored EEG.

Libby, who had been born as the healthy product of a full-term, uncomplicated pregnancy and normal delivery, and who had unremarkably unfolding milestones, turned out to show no evidence of a seizure disorder during the continuous EEG monitoring. MRI and CT scans of the brain were unremarkable. The hospital staff described Libby as "Alert, awake and delightful." Her blood-phenobarbital level was 18.5 mcg/ml, a non-toxic value (therapeutic range: 15-35 mcg/ml). The staff held Libby on the pediatrics ward while her medications were tapered and stopped.

Meanwhile, concerned that Nancy had fictitiously reported seizure activity or taken the sedatives herself, the medical team reported Nancy to the Administration for Children's Services for possible medical neglect and physical maltreatment. When the report was disclosed in the conference room of the pediatrics ward, Nancy was horrified and ran out of the meeting crying. She burst into Libby and Alisa's hospital room shouting, "I'm not going to let them take my children!"

As she was restrained by hospital staff in front of her children, Nancy rolled her eyes back, fell to the floor and displayed whole-body convulsive movements and headbanging. Nancy was strapped to a stretcher while her daughters cried inconsolably and was brought downstairs to the Psychiatric Emergency Room.

The Emergency Room Evaluation

Nancy told the E.R. staff calmly and cooperatively, “I had a kind of seizure... I felt like punching out the pediatrician who reported me and the next thing I knew, I was on the floor having an *ataque* (Spanish word for “fit”).”

Staff found her to be likeable. They felt for her. Nancy asked the staff to imagine what it would be like for her as a mother who is terrified to leave her children with a relative even for a half-hour to contemplate the possibility that her children could be taken from her and put in the care of a stranger.

She described in addition to depressive symptoms and an anniversary reaction to the death of her brother one year prior in a car accident, the following chronic symptoms: intrusive memories of violence, nightmares, nighttime hypervigilance, pervasive mistrust, multiple somatic symptoms, hyperstartle response, severe early and middle insomnia, and compulsive checking of locks and windows. These symptoms of full-blown PTSD were exacerbated by an amalgam of stressors: her daughters’ admission to the Pediatrics Ward, by the staff report to Child Protective Services, and by the re-disclosure of her own trauma history, topped by the one-year anniversary of the sudden death of her brother in a car accident.

Nancy’s terror was clearly fuelled by this history of maltreatment, neglect, violence exposure and sudden, unresolved losses:

She recounted that she had been frequently hit by her father with a belt and shoes up to age 4. Her mother left her stormy marriage and family behind to seek employment in the U.S. when Nancy was 8. After her mother left the family in the care of Nancy’s father and his family, Nancy’s paternal uncle smothered and battered her, and forced her to perform fellatio repeatedly over the next 3 to 4 years, until Nancy was nearly 13. Of note, this uncle, like Nancy’s father, was an alcoholic. Before her fourteenth birthday, Nancy had already given birth to the first of 2 children fathered by that uncle. After their birth, she was sent away to New York to join her mother when she was about 15. Nancy never saw those children again and says that she has difficulty even thinking about them.

At age 24, while on a visit to her native country, Nancy was raped again by this uncle. He broke into her bedroom in the middle of the night, struck her as she tried to flee, and covered her face with a pillow as he had done during the childhood molestation. Of note, Nancy has an intense aversion to pillows, and will not keep any in her home—this is only one of several trauma-based avoidance symptoms.

The rape by her uncle at age 24, she says, precipitated the onset of her “seizures”—Nancy used the Latino idiom of distress “ataques” when asked for how she would call these events in Spanish. Nancy describes a cardinal sensation while having the *ataque* feeling suffocated before she falls to the floor and writhes convulsively. On further history, Nancy stated that her mother, maternal grandmother, and great-grandmother also had these fits.

While Nancy had no formal past psychiatric history, she had been diagnosed with Conversion Disorder (Psychogenic Seizures) and PTSD by a consult-liaison psychiatrist, after her inpatient video-EEG monitoring on the neurology ward four years prior. But Nancy never followed recommendations for psychotherapy and found a community internist who prescribed the anti-seizure medication Valproic Acid, which is also used for mood stabilization. The indication was not clear to Nancy. When asked why she never sought therapy, Nancy said that she did not trust anyone with her personal business and preferred to seek support from her family.

By the end of the emergency room evaluation, Nancy agreed to pursue mental health treatment for herself and her children. While she had been in the E.R., a consult-liaison pediatric psychiatrist had evaluated the family for the possible diagnosis of Factitious Disorder with Physical Symptoms by Proxy (sometimes referred to as Munchausen's by Proxy). This very malignant diagnosis was deemed unlikely for several reasons: Nancy had relied on a familial rather than medical support system. There was not evidence that she had induced seizures or had in any other way directly harmed Libby. Nancy also seemed relieved her children did not have seizure disorders, and while requiring reassurance at several points after the E.R. evaluation, was able to accept a psychological explanation for her child's distress-behavior.

So after a 24-hour observation period in the E.R., Nancy was referred to the adult psychiatry clinic for treatment of her depression and PTSD. Alisa was referred to the Pediatric Psychiatry Clinic for psychotherapy. And Libby and Nancy were referred to our Infant-Family Service for an infant-mother assessment. After an initial screening and informed consent, Nancy and Libby—then age 16 months, returned 2 weeks after her discharge from the E.R. to participate the first author's research protocol.

This protocol, in addition to a usual infant-parent clinical assessment with narrative history consists of three 60-90 minute videotaped visits in a clinic-playroom: The first visit includes measures of maternal life stresses and trauma history, psychopathology, and perception. The second visit, one to two weeks later, centers around a 25-minute play-procedure based (Crowell, Feldman, and Ginsberg, 1988; Zeanah, Larrieu, Heller, and Valliere, 2000). This procedure involves 10 minutes of free play, clean-up, 5 minutes of structured play, and 2 separation-reunions. The investigator and a female assistant are in the room with mother and child the entire time. Research staff inform mothers in detail of what to expect during the visit prior to beginning the procedure. The investigators also take pre- and post-procedure samples of saliva for measurement of cortisol (Schechter, Zeanah, Myers, Brunelli, Marshall, Coates, Baca, and Hofer, 2002).

The third visit is a videofeedback session based on the principles of Interaction Guidance, a form of parent-infant psychotherapy developed by Susan McDonough (1995) with variations by many others (Beebe, 2002; Zelenko and Benham, 2000; Papousek, 2000; Juffer, van IJzendoorn, and Bakermans-Kranenburg, 1997). This method employs videofeedback in a supportive setting with therapist present and active to engage the caregiver in thinking about her own and her child's actions and reactions. For the purposes of this study, the clinician-investigator supports the mothers' strengths, asks mothers what moments stand out in their memory prior to any videofeedback, and then show a clip of what is considered to be an optimal interaction for a given dyad: namely, those interactions that show the most shared joy, attention, and spontaneity. The interviewer then repeats items from the maternal perception measure, before going on to show the stressful moments of separation and reunion (in addition to probing for mothers' understanding of what might be going on in their children's mind and their own during the excerpts, as part of efforts to understand maternal reflective functioning as described in more detail below).

During the first visit, the interviewer administered *The Working Model of the Child Interview*—(Zeanah and Benoit, 1995) for the first time to Nancy as a measure of Nancy's perception of Libby and their relationship. When asked on one item to choose 5 adjectives to describe Libby's personality, Nancy said the following, "She's grouchy...she always has to take charge...she loves to hit and fight, but she's really not such a bad thing. Well, she is mean!" On another item, Nancy associated these attributions to those of her labile abandoning mother and physically abusive father. She saw nothing of herself in Libby. And she stated that she did not believe that her own behavior could have any impact on her relationship with Libby.

At this time, Nancy reported significant post-traumatic stress symptoms, with a Post-traumatic Symptom Checklist score of 70 (Weathers, Litz, Huska, and Keane, 1994). Diagnoses of current and past PTSD were confirmed on the SCID (First, Gibbon, Spitzer, and Williams, 1996). Nancy was moderately depressed without psychotic symptoms (Beck Depression Inventory Score of 23) (Beck, 1978).

One week later, Nancy and Libby carried out the play procedure. While showing the capacity for warm relatedness and contingent sensitivity to Libby's needs, the interaction reflected a predominance of frightening-frightened maternal behavior with frequent hostile-intrusions and self-referencing, rendering the overall coding of the interaction as disruptive.

The following observations were noted from a microanalysis of that videotaped interaction as coded by an independent coder, using the *Atypical Maternal Behavior Instrument (AMBIANCE)* (Bronfman, Lyons-Ruth, and Parsons, 1993). This coder (Dr. Kaminer) was blind to any information about the dyad except for the child's age.

These observations are typical of the dyad's interactive style:

"Mother pulls out puppet from toy box. Infant is interested. Mother brings puppet into infant's face. Infant lifts hand up (defensively) but does not move away. Infant also laughs (so interchange not coded as hostile-intrusion here)—But mother does not adjust game to account for infant's being startled by intensity of game. ... Infant turns away but mother continues tickling. Even though infant's vocalizations are positive, infant appears overstimulated and is facing away from mother, hunching shoulders (and flinching) when mother moves puppet into infant's body... Mother has puppet up high, ready to descend on infant again. Infant makes somewhat whining protesting/ excited sound and mother mimics the infant somewhat critically as she has the puppet bite infant's hand... The infant tries to catch the puppet but mother keeps pulling it away. Mother tells infant to give the puppet a kiss. The infant does not. So mother has puppet kiss infant. Mother then goes into infant's face, first with puppet then with her own face, kissing infant and holding infant firmly on arm with one hand. Infant turns away so mother stops and has the puppet speak to infant in a mocking voice. Mother then repeatedly brings puppet into infant's body abruptly. Infant starts moving away... Mother resumes aggressive tickling of infant..." (At a later point, Libby startles her mother with a surprise attack using the same puppet.)

During the first separation-reunion sequence, Nancy forgot having been told that she would need to leave the room without Libby for 30 seconds. She became visibly anxious at the time of separation and left the room without saying "goodbye"—although made a quick waving gesture. Libby, holding the puppet that her mother had so extensively used in the above observations, screamed, sobbed, then threw the puppet down angrily. The intensity of their attachment was clear.

Yet when Nancy re-entered, Libby was difficult to console. The two avoided eye-contact. Very shortly after, Libby had settled down, Nancy resumed the lunging puppet game. Libby again moved away from mother with hunched shoulders. The attachment is insecure and disorganized.

Libby's symptoms at home: What to make of them?

We know from Nancy's report as corroborated by her sister Alisa that Libby would frequently wake up during the night crying as if she had had a nightmare. She would sit up in bed vigilantly with mother—who also suffers from chronic insomnia; and, according to Nancy, the two would watch the window and door for any signs of an intruder, until exhausted and unable to stay

awake. Nancy said that Libby was easily startled by loud noises at home, as had been observed in the clinic. Moreover, Libby had been noted during the assessment to be apprehensive with a restricted range of affect, sparse vocalization, and constriction of exploration and play. We know that Libby had the capacity for a brighter engagement and interest in her environment by her interaction with staff, who she readily engaged. Of note, Nancy denied that Libby had been exposed to any domestic violence, physical and/or sexual abuse, accidents or medical trauma.

So, while Libby does indeed seem traumatized, she cannot tell others directly what has been traumatic to her.

Can we consider Nancy's "Ataques de Nervios" as an encrypted communication of her violent traumatic experiences to her daughters—and then to medical staff? Are these fits possibly representative of the intergenerational transmission of trauma-associated affect dysregulation? Or more specifically, is it possible that trauma-associated affects and memories are so intolerable to think about and reexperience that they are dissociated and somatically represented in a more acceptable, communicative guise within 2 cultures with which Nancy and her family are linked: North American medical culture, hence "seizures" and Caribbean Hispanic culture, hence "*ataques de nervios*?" Quite possibly.

A recent case series of 45 pseudoseizure patients (Bowman & Markland, 1996) documented that 84% reported a significant history of sexual abuse, physical abuse, and exposure to violence. Among these patients, high rates of PTSD (49%), somatoform disorders (89%), and dissociative disorders (91%) were found. Bowman and Markland (1996) concurred with the classification of pseudoseizures by Nemiah (1991) as a manifestation of dissociative disorder associated with severe trauma.

In Caribbean Spanish, seizures and pseudoseizures alike are often referred to as "ataques." Roberto Lewis-Fernandez (1994) and the DSM-IV (1994) section on culturally-bound syndromes have listed "ataques de nervios," by definition, as dissociative phenomena. This self-labeled Hispanic folk diagnosis typically is used to describe episodic, dramatic outbursts of negative emotion in response to a stressor—such as a mother being told that she is being reported to child protective services. Ataques are often experienced as uncontrollable, derealized and/or depersonalized, and followed by full or partial amnesia.

In a study of over 70 Latino patients by the first author, (Schechter, Marshall, Salman, Goetz, Davies and Liebowitz, 2000), a similar association between ataques de nervios and childhood trauma history was found, such as that between pseudoseizures and childhood trauma by Bowman and Markland. "Ataques" for many individuals likely represent a culturally sanctioned expression of trauma-related affect dysregulation. A very recent study of 40 native Puerto Rican outpatients with high rates of childhood trauma, 16 with ataques and 14 without, has demonstrated an association between presence of pathological dissociation and frequency/severity of ataques, pointing to the possibility of childhood trauma being a necessary but insufficient risk factor for "ataques" (Lewis-Fernandez, Garrido, Bennisar, Parrilla, Laria, Ma and Petkova, 2002).

In the case of Nancy and Libby, upon entering the North American hospital culture of the E.R., the ataques become medicalized concretely as seizures and gain containment with medications rather than with psychosocial support.

In conclusion, this case-study has dramatically illustrated the complexity of one mother's attempt to cope with the adverse effects of her own severe chronic childhood maltreatment that began during infancy and continued into adulthood. She struggles with her own affective and behavioral dysregulation in the wake of horrific assaults to her body and mind while she is

simultaneously attempting to contend with her young daughters' socioemotional needs during critical phases of their development. In effect, Nancy communicates in multiple modes of action and language from moment to moment her history of violent trauma to her preverbal daughter Libby. The dyad in turn communicates their mutual affect dysregulation to me the observer.

Nancy's traumatic experiences and their sequelae color her perception of her daughter's behavior and intentions as threatening. In language, we hear that this toddler, described as "delightful" by hospital staff is, according to her mother, "mean" and "loves to hit and fight." Lieberman (1997; 1999) has linked rigidly held negative and distorted attributions toward the child with frightening-frightened behavior in several case studies. Indeed, in terms of action, Nancy clearly engaged in frightening and frightened behavior with Libby. Schuengel, Bakermans-Kranenberg, and van IJzendoorn (1999) have, in turn, linked disorganized attachment and its parental behavior correlate "frightening-frightened behavior" to dissociation and traumatic loss.

We wonder whether Nancy's dissociative symptoms may well have been exacerbated by her distressed, helpless infant, heard screaming and throwing toys upon separation from mother. This hypothesis is supported by Nancy's telling us that often when she hears Libby crying, she has to either "tune out" or "get out" of the room and lock herself in the bathroom or even leave the apartment, count, or listen to music.

While the investigators did not see such extreme flight reactions during the videotaped play procedure, the principal investigator, coder and, and primary author of the AMBIANCE Elisa Bronfman—as a blind expert 2nd coder of the AMBIANCE measure, noted that Nancy frequently denied Libby's distress cues and even smiled when Libby was clearly frightened, or increased the intensity of her intrusive behavior. Nancy's response to Libby led to an escalation of what Lieberman and Zeanah (1999) have termed "frozen watchfulness." We can understand this apprehensive response on Libby's part during the interaction as her attempt to cope with her own affective dysregulation in the presence of her dysregulated mother who is both a source of comfort and alarm.

When this emerging strategy would break down at home, Libby would throw a tantrum, often banging her own head instead of hitting her mother. Nancy told us that often when Libby would seem to ignore Nancy, by averting her gaze or even playing dead, Nancy would feel the compulsion to provoke a response from Libby, leading to such a tantrum.

As further evidence of this difficulty in being able to tolerate, let alone think about what might be going on in her own mind and in that of her daughter at such distressful moments, Nancy scored low in what Fonagy and Target (1998) have termed "Reflective functioning." Reflective functioning (RF) is indeed an important measure of an individual's ability to think about thinking of the self and other and has been shown to be positively correlated with maternal sensitivity and attachment security, as well as negatively correlated to hostile-intrusive and other atypical maternal behavior, when the Fonagy and Target coding system for RF was applied to parent perception measures (Slade, Bernbach, Grienberger, Levy, and Locker, 2000; Slade and Grienberger, 2001; Grienberger and Slade, 2001).

Nancy's narrative responses to the *Working Model of the Child Interview*, were coded for RF, using Slade et al.'s (2001) adaptation of the coding manual on a scale of 0 (low) to 9 (high), by a reliable coder who was blind to any details about Nancy or Libby except for Libby's age and gender. Verbatim transcripts from the videotaped interviews were coded.

Examples of the extremes of RF using this coding system are as follows:

When the interviewer probes for RF by asking, for example, “What do you think might be going on in your child’s mind?” The score of an interview with a mother who would answer predominantly something like, “I have no idea. He’s crazy...” would be consistent with a score of “1” or quite a low score. “0” is rarely given and is reserved for a predominance of responses suggesting a delusional process such as “He is the devil...he has evil on his mind.”

Alternatively, if the interviewer asked “What do you think might be going on in your child’s mind?” and the mother answered predominantly as follows, the response would be consistent with an interview scored as a “9”:

“I can’t be sure, but I think Jerome might be thinking, “How can I let mommy know how frustrated I am when she’s not there for him...I feel guilty when I think about him being so angry.”

With this coding scheme in mind, Nancy’s overall RF score was “3.”

Despite this low score—by no means the lowest in our sample, after a single session of videofeedback in a non-stressed supportive therapeutic framework, during which an optimal interactive moment was shown, Nancy showed a dramatic change in her perception of Libby. From the 5 adjectives used to describe Libby’s personality being initially “Grouchy...takes charge...likes to hit and fight...not such a bad thing...Well she is mean!,” Nancy, following videofeedback stated that Libby was “More sweet...lovable...wants to bond more...still hits...but is not mean...”

Nancy, like many of the more than 30 traumatized mothers who returned for a videofeedback session 2-4 weeks after the play procedure, showed a significant reduction in the degree of negativity and distortion of her attributions toward her child on a rating scale coded blindly by 4 developmental specialists with interrater reliability coefficients of 0.75 and 0.86 respectively (Schechter, Zeanah, Brunelli, Myers, Coates, Grienberger, and Hofer, 2002).

When shown her child’s distress during the separation sequence in the containing company of a reflective observer, Nancy is able to respond more reflectively and sensitively to her daughter’s and to her own distress. She is also better able to decouple past from present, or as Beebe (2002) has stated, “to integrate procedural and declarative memory of her own early experience as distinct from present experience with her own child.”

The following is a verbatim excerpt transcribed from this part of the feedback session, during which Nancy views with the first author her child’s separation response and then responds to items probing for what she sees, thinks and feels.

The video shows a split screen with Nancy’s face reflected in a mirror on one side, so that her facial affect can be coded as she watches the excerpts. The TV monitor is seen on the other.

Videofeedback excerpt midway through videofeedback session

Nancy sees separation reaction child cries and looks toward door. Nancy watches intently and smiles. Her face grows concerned as Libby throws down the toy puppet that Nancy had been playing with.

Dr. S: Okay so what happened there?

N: You broke her heart. You broke my daughter’s heart in pieces!

Dr. S: What broke her heart?

N: That I left. I never leave her! Never...

Dr. S: Most mothers don't like to leave the room... What do you think was going on in her mind?

N: Mommy left... Mommy never do that. Why she do that now?

Dr. S: Do you remember what was going on in your mind when you left?

N: I was going to come in. I was going to come in and tell you something: "Don't ever do that again!" [ask me to leave without daughter]

Dr. S: How were you feeling then?

N: That I was leaving her behind. That I wasn't protecting her.

Dr. S: Mm... What do think she was feeling? What emotions?

N: Real sad and angry?

Dr. S: Tell me about each—what makes you say those feelings: sad and then angry.

N: Sad because I left and angry because I never did that before. And I always... That's the first time I did that...

Dr. S: How did you know she was angry?

N: Because she threw the puppet.

Dr. S: Why do think I showed you this moment?

N: I don't know... to see how I react when my daughter cries?

Dr. S: Why would I want to do that?

N: I don't know.

Dr. S: Well, I was wondering if we could think together about what she was feeling when you left the room. I was wondering what was going on in her mind when she threw the puppet down. And I think you're on to something when you say that she was angry because you left.

N: Yeah because I left, she was angry.

Dr. S: Who does she remind you of there?

N: Me!

Dr. S: How so?

N: That I would get angry when I would ask anything of my father and he would just leave me there crying he wouldn't even give me a quarter. (stares and seems to focus inwardly)

Dr. S: Are you thinking of a particular memory right now?

N: Yeah... I would get hit. My father would lock me in the bathroom and I would throw things. She gets her angry attitude from me like when she throws things. I would throw the soap... anything that I could get my hands on. And then he would come back and hit me harder... No kid deserves to be locked in the room and be hit for nothing... No kid deserves that...

Dr. S: How old were you then?

N: ...I was 7 or 8... (before mother abandoned family)

Dr. S: Mm... And when you saw yourself leaving—did that image remind you of anyone?

N: It reminded me of my father...he'd leave me there for hours.

Dr. S: Tell me about your father: What was he like?

N: I don't like to talk about my father. I'm not going to say that I'll forget him but I don't like what he did to me or my sister or my mother.

Dr. S: What words would you use to describe his personality?

N: Mean...I never knew if my father loved me or hated me because he never told me.
Cheap Oh my god was he cheap!

Conclusion

This excerpt demonstrates the emerging richness of connection between Nancy and Libby and between Nancy and her *self* in this excerpt—as well as between Nancy and the clinician.

Nancy states to the clinician as her interpretation of her daughter's separation distress, "You broke my daughter's *heart* in pieces." The abandoning mother's own capacity to damage and fragment the child is captured in this phrase and attributed to the "mean" clinician who has Nancy do to her child what her mother did to her, namely, leave her behind-- if only for a few seconds.

By the end of this feedback excerpt, the "mean" figure who seemingly "likes to hit" Nancy is located in the person of her father and in the past. Yet the multiple meanings of this memory are left as mysteries. In reviewing this session, we were struck by how this very emotionally intense memory involving her father, albeit negative and violent in nature, is said to have taken place around the time her mother abandoned her family. Is this remembered intensity preferable to absence of caregiving and the conflicted feelings around the sexual abuse that would later take place? We of course cannot know from this single-session.

Importantly, over the process of the three videotaped sessions, we note change in 1) Nancy's localizing her distress from her body to her psyche, and 2) in her flexibility of abstraction. The excerpt, in fact, begins with Nancy's demonstrated capacity to use the body-as-object-of-violence in metaphor rather than concretely in the enacted and perceived "ataques de nervios," pseudoseizures with head-banging, or other somatic symptoms, as Nancy had done prior to her contact in the Emergency Room. She does this in a friendly, joking manner with the research-clinician, thereby exhibiting her ability to reflect on the events during the taping from an alternative perspective. As noted, her attributions toward her child concomitantly become less negative and distorted following the videofeedback.

In summary, the case of Nancy and Libby illustrates the work we are now doing to begin to understand the processes of intergenerational communication of violent trauma. We have seen how maternal trauma history and its adverse sequelae can affect maternal perception and behavior, as well as that of the child.

Furthermore, the authors hope that in this presentation of the assessment of this complex dyad, the reader will wonder how, in the face of so much tragedy and chaos, even a small amount of well-targeted intervention can lead to much more change than one would expect.

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