HEALING AFTER PARENT LOSS IN CHILDHOOD AND ADOLESCENCE

Therapeutic Interventions and Theoretical Considerations

Edited by Phyllis Cohen, K. Mark Sossin, and Richard Ruth

Foreword by Nancy McWilliams

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Foreword

Nancy McWilliams

This book began as a gleam in the eye of my colleague, Richard Ruth. In 2007, when I was new to the presidency of the Division of Psychoanalysis of the American Psychological Association, I asked him to chair a task force on outreach that would make a contribution to dismantling the stereotype of psychoanalysis as a dated, office-bound *technique* of psychotherapy, fueled by a rigid ideology, applicable only to mildly distressed, cooperative, articulate adult patients. At the time, it had become clear that the psychoanalytic therapies were being represented to the public as a set of ritualized, self-serving, and discredited approaches to helping people. This mischaracterization was being perpetrated by biological psychiatrists excited by the possibilities of drug treatments, by representatives of the insurance industry eager to cut their costs, and by academic psychologists who resented the arrogance of some Freudians and who had scant exposure to contemporary psychoanalytic practice.

In the public sphere, the voices of actual psychoanalytic clinicians were seldom heard. By the time I appealed to Prof. Ruth, I had become aware of, and often close to, many psychoanalytic colleagues who were working with the poor, the homeless, the complexly traumatized, the addicted, the psychotic. They practiced in varied settings, with diverse and often overwhelmingly challenged populations, sometimes completely outside conventional office practice. I had done considerable work myself that went beyond the walls of my consulting room, and in my experience, this outreach was the rule among psychoanalytic practitioners, not the exception.

We saw ourselves as trying to reduce the suffering of the people we came to care about, whatever their circumstances, with a critical reliance on psychoanalytic knowledge, but not with technical rigidity. Instead, we tried to apply analytic understanding sensitively and flexibly to the demands of whatever situation we found ourselves in. Often, such work was movingly effective. I wanted a way to speak of our experience beyond the narrow confines of the psychoanalytic community. In response to this widely shared concern, Prof. Ruth invited Drs. Cohen and Sossin to present their non-traditional work with the women and children bereaved by the attacks of September 11, 2001, at a Division of Psychoanalysis spring meeting. Out of that presentation this book was born.

The focus on bereavement in childhood and adolescence was only one possible outcome of many directions this group of therapists and scholars could have taken. I did not know until the project was well underway that loss was to be the domain in which their clinical wisdom would be elaborated. It was a moving surprise to me when the committee members ultimately zeroed in on an area that is dear to my own heart and central to my own psychology (about this, more shortly), and about which I have always felt there is—as Sossin, Bromberg, and Haddad demonstrate in their readable and comprehensive literature review—a valuable but insufficient psychoanalytic body of work.

The accounts in this book capture some universal themes that attend early, irreversible loss, but they also capture the idiosyncrasy of each child's experience. Across different ages and developmental phases, different experiences of gender and sexual orientation, different family circumstances, different social environments, different religious sensibilities, and different cultures, the voices of these young people can be heard here in all their complexity and nuance. Some were orphaned by a parent's disease, some by violence, some by war, some by the Holocaust, some by the September 11 attacks, some by the negligence and abuse of caregivers from whom they were taken by the justice system. These narratives bring readers into intimate connection with both the general and the particular, and they illuminate the special strengths, not just the psychological deformities, that can result from childhood bereavement.

By depicting the therapist's emotional engagement, theoretical inclinations, and efforts toward meaning-making, the narratives also bring alive the healing process that is at the center of the psychoanalytic vocation. In most of the chapters, a therapist sees the bereaved client in a traditional clinical setting. In others, the therapeutic interventions involve actions that may influence the legal system, facilitate a group response, educate surviving parents, provide for social support, require political action. We meet in these chapters not only the middle-class American and European bereaved children who have more commonly been studied (as in Erna Furman's classic *A Child's Parent Dies*), but also children of poverty and children and families of Latin American, African-American, Vietnamese, Kuwaiti, and Palestinian origin. The disciplined humanity that each therapist brings to the task of offering comfort to a particular person or group of persons, in a particular context, emerges from these pages as a phenomenon that is just as complex and nuanced as the psychologies of the bereaved.

A few of the voices, like that of John in chapter 8 or Paulette in chapter 10, are those of older people who have tried to find ways of understanding and recovering from their earlier losses. In those chapters we have the benefit of hard-won wisdom from individuals who can put their memories into a shared adult language of grief. But most of the characters who people these pages are children and adolescents, struggling in the present without much prior education in loss and how to articulate its effects. The therapists who are trying to build relationships with them are struggling as well, often in the face of realities that Ruth calls "unthinkable, unspeakable and intolerable." Both their therapeutic passion and their openness to learning from their patients come through in what the authors have written.

Many of the themes developed in this book are emotionally familiar to me. I lost my own mother at nine and my beloved stepmother ten years later, both after extended bouts with cancer. If I had not gone into psychoanalysis in my twenties, the pain of my early loss and its weird repetition would have remained ungrieved, unprocessed, unreflected-upon. I have good reason to believe I would have gotten locked into a kind of arrested development in which for the rest of my life I would have rationalized my tendency to act out one after another self-defeating version of what Freud would have called "the return of the repressed."

One of my central defenses—one that my analyst was determined to defeat—was a counterdependent attitude replete with unconscious contempt for psychological "weakness" and "self-pity." That orientation had once been the best adaptation my latency-age self could make to a cruel loss followed by insufficient emotional support. As several authors here mention, given the surviving partner's desolation, a child who loses one parent tends to lose the other as well. My father, whose emotional range had been compromised neurologically by *encephalitis lethargica* in the epidemic of 1916–1927, had lost his own mother at thirteen to a rheumatic heart condition. He was then told, by a resentful aunt who inherited responsibility for him, that his mother had died from the exhaustion she had suffered taking care of him when he was comatose with the sleeping sickness. He was, not surprisingly, psychologically devastated in the aftermath of his wives' respective deaths, which recapitulated the early loss for which he had been made to feel responsible. His capacity for sensitive responsiveness to his daughters' diverse reactions to their own bereavement was consequently minimal.

It would have been ultimately deadly to my goals as a psychotherapist to have retained the unconscious disdain for suffering that allowed me to dissociate my own pain at age nine and move on developmentally in most other ways. Via my engagement over several years in the systematic mourning process that we refer to as psychoanalysis or intensive psychoanalytic therapy, I became eventually more compassionate toward myself and therefore able to be more genuinely compassionate with the sufferings of others. Consequently, my appreciation for the manifold consequences of being helped with childhood bereavement is profound.

Many of these chapters—those offering accounts in which clinicians' faced real-life challenges to find ways to help orphaned children and adolescents—attest to what can be done preventively when therapists intervene close to the time of traumatic childhood experience. By addressing their losses as they were happening or shortly afterward, the therapists of these young clients were inoculating them against a lot of possible future pain, in both themselves and those whose lives would be affected by the emotional legacies of their bereavement. And I cannot help noting, in these times of insufficient mental health resources and pressures on therapists to be "accountable" to cost savers, that this therapeutic work is highly cost-effective: When a child's anguish is sensitively addressed during childhood, there may be no need for the years of on-the-couch grieving that was required for my own recovery from youthful bereavement.

After immersion in these chapters, can any reader defend the current predilection for defining psychotherapy as if it were a set of one-size-fits-all techniques to be applied to a particular category of established pathology? What randomized controlled trial of what kind of treatment could have captured the complexity and diversity of these children's situations? With what psychopathology could we "diagnose" them so that an insurance company would support the needed healing process? Most of them were not suffering a "disorder"; they were suffering a state of complex grief. They were trying to bear emotionally the consequences of realities that are unbearable when unformulated and unwitnessed. Their therapists needed to know something about both research and clinical experience in the areas of mourning, development, attachment, personality, emotion, cognition, and diversity, not about laboratory studies of narrow prescriptive techniques.

Ultimately, this book has gone far beyond what I was hoping Prof. Ruth's committee would find a way to communicate. It is both a significant contribution to psychoanalytic scholarship and a resource for any therapist—psychoanalytic or not—when trying to find a way into a healing relationship with a child or adolescent who has suffered the distinctive psychological disaster of losing a parent. It succeeds in demonstrating what psychoanalytic interventions are really about: respect for the uniqueness of each patient, unflinching pursuit of painful emotional truths, collaborative meaning-making, and appreciation of the powerful unconscious factors that can keep people in chronically tortured states but that can also become sources of their most remarkable recoveries.

Part I

Overview

Chapter One

Loss of a Parent during Childhood and Adolescence

A Prismatic Look at the Literature

K. Mark Sossin, Yelena Bromberg,
and Diana Haddad

A pervading sense of dissolution and helplessness following a child's or adolescent's loss of a parent to death or circumstance evokes the experience of unbearable affect (Krystal, 1978; Kestenberg & Brenner, 1996). While resilience is evidenced by some, for others such loss is an ongoing traumatic experience that can lead to breakdowns in emotional integration and the disruption of developmental pathways (McDougall, 1986; Menes, 1971; Furman, 1974; Sussillo, 2005).

Clinical presentations of children, adolescents and adults having experienced loss of a parent vary widely. Losses vary across many factors, including age, circumstance, preparedness, family supports, and of course, the distinctive features of the parent who is no longer present, contextualized by the distinctive relationships developed between the child/adolescent and the lost parent as well as, when applicable, with the surviving parent or caregivers. How can the dedicated therapist usefully draw upon a rich but oblique literature to help guide case formulation and treatment planning? In this chapter, the authors attempt to highlight fundamental perspectives and findings that can offer such guidance.

Different manifestations of grief are experienced against the backdrop of cognitive development regarding the child's understanding of death at the time of loss (Slaughter & Griffiths, 2007). Qualities of the individual lost, the nature of attachment (Bowlby, 1980), the corresponding loss to the self, the culture-infused meanings of death (Parkes, 1997), and psychological coping styles (Stephenson, 1985; Lerner, 1990) all influence how the loss is experienced. In consideration of children's cognitive attainments, verbatim comments by three- and four-year olds considering the nature of death are instructive (Hoffman, Johnson, Foster, & Wright, 2010), highlighting the gradual developmental pathways children take in the attributions of inevitability, universality, irreversibility, cessation of bodily functions, and causation. Children's grief processes are marked by distinctive cognitively-framed and affectively-imbued attributions following various types of parental loss (Parens, 2010), influencing the kind of anxiety experienced as well as the fantasy-formation that follows.

Individuals demonstrate widely varying capacities and inclinations for taking comfort from the internal memory or internalized representation of a beloved attachment-figure lost in childhood or adolescence (Pine, 1989). Intrapsychic consequences of parent loss include denial and fantasies of reunification (Dietrich, 1989), repetition-compulsion, mastery-seeking, and idealizations of the lost parent that can be distorting or, with adaptive mourning, can serve creativity through a regenerating of what was lost (Loewald, 1962; Furman, 1973; Pollock, 1982).

The analytic lens trains the clinician to examine vulnerability and risk bequeathed to the child or adolescent who has lost a parent, and to consideration of developmental attainments needed to allow that grief to be processed. Varying developmental models lend different perspectives. Klein (1940) proposed that mourning involves a temporary manic-depressive phase. She proposed that in "normal mourning," the reintrojection of "good" objects helps abate tumultuous anxieties. Winnicott (1954) proposed that effectual progress through the "depressive position" is required for successful grief and mourning processes to ensue. Application of these and other models will notably influence the clinician's case formulation.

Emotionally, a child who has lost a parent may experience rapidly shifting and conflicting feelings, sometimes expressed in bouts of irritability. Many parentally-bereaved children experience anger, anxiety, apathy, confusion, dysphoria, guilt, and frustration for a year or more after their loss, in addition to somatic pains, changes in energy, sleep, and appetite, as well as lost prior masteries (Traeger, 2011; Dowdney, 2000). Behaviorally, they may withdraw, act out, or regress (Johnson & Rosenblatt, 1981; Schoen, Burgoyne, & Schoen, 2004). Suicidal ideation without suicidal behavior is not uncommon (Pynoos, 1992).

Children may show an increased need for physical comfort or demonstrate prominent difficulties separating from surviving caregivers (Elizur & Kaffman, 1982; Hooyman & Kramer, 2006). Some struggle socially and academically (Schoen et al., 2004; Webb, 2010b; Traeger, 2011). Remnants of grief are often evident in the symbolism within a child's play (Sossin & Cohen, 2012; Cleve, 2008), providing a potent avenue of therapeutic communication. The interplay of thoughts, emotions, physical manifestations, and behaviors that constitute grief (Freeman & Ward, 1998) may appear immediately following the child's loss, while for others, such states may only emerge after much time has passed (Elizur & Kaffman, 1982).

PARENTAL LOSS: STARK FACTS

There are currently over one hundred million children around the world coping without some form of parental care (United Nations Children's Fund, 2005). An extreme example of the importance of maternal care can be found in statistical studies from Bangladesh, where child survival to age 10 is 89 percent if the mother survives to that point in time, but only 24 percent if she dies prior (Ronsmans, Chowdhury, Dasgupta, Ahmed, & Koblinsky, 2010). In the context of a country that has suffered severe bloodshed and dehumanization, loss of a father's presence and care is reported to have a negligible impact upon this survival statistic. Yet, in less fissured societies, the potentially detrimental effects of both maternal and paternal loss have otherwise been well documented (Bowlby, 1980; Biller & Salter, 1989; Weaver & Festa, 2003; Lewis, 1992; Finkelstein, 1988; Coyne & Beckman, 2012).

Considering mental health in Western societies, predictions of higher levels of depressive and anxiety disorders following parental death have been empirically supported within two years following parental death (Cerel, Fristad, Verducci, Weller, & Weller, 2006), and in relation to lifetime incidence as well (Tyrka, Wier, Price, Ross, & Carpenter, 2008), although some authors (Tennant, Bebbington, & Hurry, 1980; Herrington & Harrison, 1999) challenge this view, arguing that childhood bereavement is not a major mental health risk factor in either childhood or adulthood.

In the United States, approximately 4 percent of children live without either parent and 26 percent live with one parent (U.S. Census Bureau, 2010). Considering psychological sequelae, these children have varied perceptions and fantasies, and display a broad range of coping mechanisms and outcomes. Some children are resilient and well-adjusted (Siegel, Karus, & Raveis, 1996; Mireault & Compas, 1996). They manage to develop working relationships with living, present, and beloved caregivers. Others, meanwhile, exhibit psychological, behavioral, and emotional problems, as they struggle to come to terms with their loss (Kalantari & Vostanis, 2010), manifesting more mental health problems than their non-bereaved peers (Cluver, Operario, & Gardner, 2009).

BEREAVEMENT, GRIEF, AND MOURNING: OVERLAPPING CONSTRUCTS

Psychoanalytic literature clarifies distinctions among experiences termed bereavement, grief, and mourning. An individual calls upon the process of nonpathological (uncomplicated) mourning to restore psychic equilibrium following the loss of a loved one (Bowlby, 1960). Mourning is accompanied by a loss of interest in external reality, preoccupation with memories of the individual who was lost, and a "diminished capacity to make new emotional investments" (Moore & Fine, 1990, p. 122). Notably, Freud (1917) pointed to a lack of self-regard as being a distinguishing feature in melancholia (depression), which otherwise shares many features with mourning. Grief is not as distinct a process, but rather it is the " . . . attendant affective response to loss" (Moore & Fine, 1990, p. 82), e.g., the sadness, regret, and accompanying sleep disturbance. Grief can apply to the loss of a mental representation, whereas bereavement can be understood as the type of grief that applies to loss of a loved one (Pollock, 1978; 1989). The reader will find that these terms are used with some inconsistency in the literature on loss of a parent.

In *Mourning and Melancholia*, Freud (1917) indicated that mourning begins with conscious awareness of what is lost, forced upon the bereaved by reality. A consuming need to forgo the previous attachment may unfold into a contrary "turning away from reality . . . and a clinging to the object" (p. 245). Such detachment occurs gradually, until the bereaved is eventually able to face reality, to relinquish the object (Bowlby, 1960), and to become "free and uninhibited again" (Freud, 1917, p. 245). Young children without a full understanding of their loss, may initially protest and demand return of their lost parent inconsolably, only to seek alternate relationships after their grief has substantially subsided (Bowlby, 1960). Adaptive, yet painful, mourning involves "recognizing the serious and permanent nature of the loss of a loved one, transforming the relationship with the deceased from an active interactional attachment to one of memory, and finding meaning in life in the absence of the deceased" (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002, p. 308).

In melancholia (unlike mourning in Freud's original proposition) not only does a diminution of self-regard ensue, but ambivalence-laden conflict characterizes primary relationships. Freud emphasized how energy-absorbing mourning is, involving "detaching the libido bit by bit" from its attachment to the lost object (Freud, 1917, p. 256). He suggested that mourning also involves new identifications that change the self, and the working-through of ambivalence. Much later in his life, drawing upon personal experience, Freud acknowledged a persistence of crestfallen feelings in mourning that are not depicted in his earlier theory-building work (Gay, 1988; Freud, 1939/1994).

PARENTAL LOSS AND THE NATURE OF CHILDHOOD GRIEF AND MOURNING

The literature is marked by opposing views as to whether bereaved children can engage in the psychic tasks of grief and mourning in manners analogous to adults (Bowlby, 1960; Nagera, 1970; Wolfenstein, 1966, 1969; R. Furman,1973; E. Furman,1974). Some argue that children, and even adolescents, cannot yet mourn (Wolfenstein, 1966). From this perspective, “mourning” could not apply to those yet to attain adulthood in light of the nature of the relationships, the painful affects experienced, and the reality testing and ego-functioning demanded (Wolfenstein, 1966; Rochlin, 1961). Deutsch (1937) had made a similar suggestion earlier, hypothesizing that the “ego of the child is not sufficiently developed to bear the strain of the work of mourning, and it therefore utilizes some mechanism of narcissistic self-protection to circumvent the process” (p. 13). Deutsch saw this inability to mourn as temporary, and that there existed a “striving for realization to mourning” (p. 20) that would unfold in adulthood. In this model, until mourning arose, attachments (e.g., to lost parents) would remain unresolved and painful affects would persist.

R. Furman (1964a) linked the child’s ability to mourn with a comprehension of death, which he estimated to develop between two and three years old. For Anna Freud (1969), children can mourn, but only after achieving object-constancy. Developmental object-relations theory (Mahler, Pine, & Bergman, 1975), serves as a model to describe the gradual attainment of object constancy during the first three years of life. One might wonder whether the more recently conceived attainment of a “temporally extended self [TES]” (Lazaridis, 2013), in which the child develops a sense of self in time during this early period, with a past, present, and future, is related to a capacity to mourn.

Wolfenstein (1966) described forty-two cases in which children and adolescents experienced the death of a parent, highlighting differences perceived between children and adults. Not seeing preoccupation with the lost parent, she deduced that children were denying the finality of parental death. From this perspective, children whose parents die may show an elevation of mood, as in hypomania, with the remembered parent idealized and preserved in fantasy. Wolfenstein (1969) also commented that bereaved children show more rage than grief, and she saw ongoing symbolic repetitions of the parental loss. Denial, idealization, identification with the dead parent, fantasies of amends, and affect-restriction have all been observed in analytic treatment of children and adolescents who lost a parent (Rochlin, 1961; Shambaugh, 1961; Fleming & Altschul, 1963; Laufer, 1966; Mahler, 1961; Altschul, 1968; Menes, 1971). Such observations have been interpreted as supporting a view that bereaved children's responses are quite distinct from those of adults, in line with Wolfenstein's view.

Historically, the works of Bowlby, R. Furman, and E. Furman laid the ground for a shift toward viewing children as capable of mourning. Following upon his work with very young children, Bowlby (1960, 1969, 1973, 1980) contended that even infants and young children grieve and mourn. For Bowlby (1980), the prerequisites for mourning are a secure attachment prior to the loss, information sharing about the loss, participation in family grieving processes, and the comforting support of a surviving parent.

The idea that mourning occurs in stages is generally accepted in psychoanalytic writing (Robertson & Bowlby, 1952; Bowlby, 1961; Pollock, 1989; Fogelman, this volume). The question of whether a child can mourn is partly semantic, but also one that bears on perceived emotions and dynamics. For some, the question is sufficiently answered by the verifiability of children's capacity to grieve (e.g., Webb, 2010a). For others, the question of whether children can mourn is itself conceptually problematic and needs reframing (Palombo, 1981). Some, such as Gaines (1997), make a distinction between a component of mourning that resolves and another that perpetuates. From this point of view, mourning is not only about detachment from the loved-one lost, it is also about creating continuity. Gaines suggests that mourning the affectionate tie may be more or less resolved upon the transfer of affections. However, the adaptation to inner loss through the process of mourning is essential to a sense of continuity and requires ongoing work and never ends.

As psychodynamic developmental theory has undergone revisions in recognition of the very young child's greater awareness, self-other recognition, and temporal perceptivity (Beebe, 2006; Tronick, 1989; Tronick & Reck, 2009), so too has early childhood mourning been more widely recognized (Hurd, 2004; Kaufman & Kaufman, 2005).

For children, a parent's death can never be fully anticipated, regardless of how impending the death (cf. Saldinger, Cain, & Porterfield, 2003). Under all circumstances childhood loss becomes incorporated into personality, identity, and one's world-view (Hung & Rabin, 2009). As stated by Tremblay and Israel (1998), for children, a parent's death "represents a profound crisis in both acute and long-term adaptation" (p. 424).

With a parent's death or loss through absence, a child loses the part of him- or herself that existed in interaction with that parent. The individual child may variously consolidate feelings about the loss in different ways. Personality development may be impacted by the loss of the ability to repair negative and unresolved feelings toward the parent, the loss of shared activities that can no longer continue, the loss of an established routine (Johnson & Rosenblatt, 1981), and/or the loss of an "assumptive world" of safety and familial intactness (Kauffman, 2002).

Some children react more to the loss of sufficient love that would have promoted more unimpeded development; others show a proclivity toward developmental regression (Blos, 1967), others to heightened annihilation anxiety and intense ambivalence, and still others to the loss of narcissistic supplies (E. Furman, 1974). Bereavement has long been understood as linked to narcissistic loss (Pollock, 1961). Furman (1974) noted the "narcissistic depletion" (p. 43) inherent in a young child's loss of a need-fulfilling parent. Others, including Palombo (1981), later proposed that lowered self-regard is an expectable component of a child or adolescent's mourning of a lost parent. Extending Kohut's formulations, Palombo considered how lowered self-esteem would follow from loss of a self-object and, thus, how mourning incorporates the "restoration of one's self-esteem" (p. 12). From a self-psychological perspective, Palombo (1981) expands upon the idea of narcissistic injury:

> Their feelings may range from humiliation at having placed themselves in the vulnerable position of needing someone to feeling that they had been specially chosen by God to suffer and *bear* the cross of bereavement for the rest of their lives. . . . The blow to one's grandiosity may again lead to feelings of impotent rage at one's helplessness. Those to whom the lost figure represented an idealized, valued selfobject would experience disillusionment and disappointment (pp. 11–12).

Broadening the definition of mourning, Palombo posits that mourning is not only about detachment from an object-representation, but is also about restoring one's self-esteem in the wake of loss.

SURVIVING CAREGIVERS AND THE EVOLVING REPRESENTATION OF THE LOST PARENT

A host of influences following loss of a parent contribute as determinants of coping capacities, tolerance for negative affects, the nature of the internalization of the lost parent, and dispositions toward depression and/or aggression. In publishing *A Child's Parent Dies*, Erna Furman (1974) and her colleagues at the Hanna Perkins Center in Cleveland, reflected on child analytic work with twenty-three children who had lost a parent through death. Very distinct grief-processes were observed with individualized treatments conducted. Later, the Furmans published work on fifty-three children (including the original twenty-three) who had lost a parent to death, and on forty-nine additional children who were otherwise separated from a parent (E. Furman & R. Furman, 1989). They pointed to the risk to children raised in one-parent families after early loss/separation, suggesting that early stages of phallic-narcissistic development were made difficult and that progress into the oedipal phase was often impeded. Problematic superego development, identifications, and self-development often followed, with heightened conflicts and ambivalence. The Furmans underscored the importance of the surviving parent's ability to contain and integrate the feelings of the child, authentically reassure the child that he or she was not causal in the parental-loss, and offer realistic reassurance regarding the stability of present attachments.

Osofsky (2011), following Hurricane Katrina, similarly underscored the importance of the surviving caregivers and environment in supporting young children's capacities for resilience following a disaster (sometimes involving parental loss). Too often, the anxiety and emotional dysregulation that a child manifests in the aftermath is not adequately understood by stressed and/or grieving adults. Negative and insensitive misattributions by adults may greatly compromise the child's ability to cope. Cournos (2001) suggests that children and adolescents struggling to adapt to parent loss in the face of non-optimal caregiving are more inclined to actively invest in fantasied interactions with the imagined lost parent.

Worden (1996) reported on research involving seventy families (including 125 children) who experienced death of a father or mother. Children and surviving parents were interviewed three times over the course of two years. This work attends particularly to the child's "construction" of an inner representation of the lost parent that supports the child's ability to make meaning of the loss, and to the child's sustained connection to the lost parent. Worden's observations agree with many others: most children locate, experience, and remember the lost parent, and many communicate with the lost parent and hold on to an object of the parent's (related to the keepsakes and "linking objects" as described by Volkan, 1981, and in this volume; Silverman, Nickman, & Worden, 1992; Silverman & Nickman, 1996; Kestenberg & Brenner, 1996; Christ, 2000; and Sussillo, 2005). Like a transitional object, a keepsake of the lost parent can evoke a sensory-laden memory of, and communion with, the parent by the child.

The benefits of supporting the child's "realistic and detailed inner representation of the absent parent" (E. Furman & R. Furman, 1989, p. 138) were observed to be crucial in equipping the child to developmentally proceed with the least impediment. This key finding of the importance of a surviving caregiver's role in promoting the child's grief process reverberates with findings regarding parental affect mirroring (Gergely & Watson, 1996) and reflective functioning, in fostering self-state representations and attachment security in children (Fonagy & Target, 1997; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). While grieving themselves, surviving-parents can foster a representation of the lost parent in their children, along with experiencing their own distress-regulation (Beebe, 2000), even when the parental loss occurred prior to birth or extremely early in the child's infancy

(Moskowitz, 2012; Reiswig, 2012b; Markese, 2012). At the same time they can also carry out functions of containment, elaboration, and mentalization.

In exquisite detail, Cleve (2008) described the treatment of a young boy, under three years old, who had lost his mother and younger sibling in an auto crash, leaving only himself and his father as survivors of the crash. This case highlights the ability of very young children to reconstruct memory in representational play in highly meaningful ways (especially using sandplay). A keystone of the treatment's success was the parallel treatment of the father, and the facilitation of the father's support for and understanding of his son.

Surviving caregivers offer irreplaceable anchors of security for the child who has lost (Warshaw, 2006; Cleve, 2008). The ability of the surviving caregivers to reflect on their own histories of loss and trauma (Fonagy, Gergely, Jurist, & Target, 2002) can support the development of a coherent narrative of the loss (Kliman, 1990). These are significant factors in managing projections and ascriptions that give shape to the internalized representational world of the child (Bonovitz, 2006). The parent's own unsatisfactorily mourned losses can readily cloud the child in the mind of the caregiver, and in the mind of the child as well. Hence, collateral (or dyadic) work with surviving parent/caregivers is to be given serious consideration within the treatment model, because the child who has lost a parent will be impeded in adaptive mourning and identity formation when influenced by the caregiver's largely unconscious workings of unresolved states of mind, representations, and relationships cast within unresolved grief (see Towns-Miranda in this volume).

Not all surviving caregivers are able to provide sufficient support. McDougall (1986) linked a parent's inability to facilitate a child's bereavement to the surviving parent's own history as well as to empathic deficits earlier in the parent-child relationship. She presents the case of a man of thirty whose father died when he was seven. McDougall's reconstructive work led to the conclusion that a major determinant of his symptomatology in the pre-loss mother-infant relationship. The mother was fearful of her baby's affective distress, and later, she could not tolerate her child's grief response. Optimal intervention for a child who has experienced parental loss would incorporate clinical attention for the surviving caregiver(s).

FURTHER DEVELOPMENTAL CONSIDERATIONS

It has been observed that a child's presentation of grief varies in developmental level, verbal expressive ability, capacity to understand loss, prior experience with loss, as well as dependence upon, and reliability of, the lost parent (Johnson & Rosenblatt, 1981; Schoen et al., 2004; Hooyman & Kramer, 2006; Traeger, 2011; Willis, 2002). Depending on their age, children are likely to have difficulties concentrating as well as experience heightened fears and worries (Traeger, 2011), and they may blame themselves for their loss (Schoen et al., 2004; E. Furman, 1974). Not having yet mastered the idea of the permanence of death, preschoolers are especially prone to engage in “magical thinking” under which they assume that they are powerful enough to influence their parent’s death or to reverse it, just as they are prone to deny the loss by assuming that the parent will return, as if from a trip (Elizur & Mordecai, 1982; Azarian, Miller, McKinsey, Skriptchenko-Gregorian, & Bilyeu, 1999; Cohen et al., 2002; Hooyman & Kramer, 2006).

Moving through development, adolescents more fully understand the permanence of their loss, but are prone to struggle with existential questions and feelings of victimization. They may wonder, for instance, why the loss had to occur at all, and why it had to affect them specifically (Cohen et al., 2002). Sussillo (2005) suggests that the loss of a parent creates a crisis for the adolescent’s sense of self and for attachment/individuation processes. For some, a deep-seated sense of unfairness pervades their sense of themselves vis-à-vis the world. Even after seemingly positive adaptations by the adolescent, life events may elicit reactivation of the mourning process (Gaines, 1997).

The Harvard Medical School Child Bereavement Study (Silverman, Nickman, and Worden, 1992; Silverman & Worden, 1992; Silverman & Nickman, 1996) was distinctive in following a nonclinical sample over several years. Findings are consistent with those clinically working with individual children and adolescents (e.g., Sussillo, 2005; Nagera, 1970; E. Furman, 1974), and with those (via prevention or intervention) following many children after a disaster (Beebe et al., 2012; Osofsky, 2011): a shared observation is how constructive the outcome is when a child and then adolescent proceeds to invest in, and create ongoing and renewed connections to the lost parent. Among others, Sussillo (2005) underscores the adaptive nature of this creativity.

INCOMPLETE AND COMPLICATED GRIEF

There are many instances when mourning is unresolved and, consequently, problematic. Addressing when the death of a parent is traumatic, Erna Furman (1986) wrote: “We can never say before treatment that the death of the parent as such was traumatic” (p. 192). Complex developmental, and relative ego-strength factors, as well as the external circumstances themselves, determine the degree of traumatogenesis of parent-loss. Early loss may set the stage for “. . . recurrences of terror states” (p. 200) and annihilation anxiety, later manifested by developmental fears, resultant personality features and repetitive behaviors. For individuals greatly impacted by loss, Bowlby’s stages of protest, despair, and detachment are not sequenced, and their problematic attachment and other vulnerabilities may lead to complicated grief rather than grief-resolution (Bowlby, 1980; Bravo, 2001). This state may be influenced by varying cultural perspectives and societal expectations (Hooyman & Kramer, 2006). When Johnson and Rosenblatt (1981) use the term "incomplete grief," they are referring to a process in which the child resists involvement in close relationships, forms socially inappropriate identifications with the lost parent, and makes efforts to replace the lost parent by assuming family roles formerly held by the parent. For the child who loses a parent, and whose grief (and, we could also suggest, mourning) is incomplete, a sense of abandonment may pervade. "Incomplete grief" benefits from clinical identification, framing the need to address the resolution of deeper, disguised conflicts, both conscious and unconscious, to avoid regression to a prior state, and to prevent further difficulties, whether psychological or physiological (Azarian et al., 1999).

Related to incomplete grief are the diagnostic conditions of complicated grief and traumatic grief. Prigerson and Jacobs developed a measure of adult complicated grief, the Inventory of Complicated Grief (ICG) (Jacobs, Mazure, & Prigerson, 2000). This instrument was recently extended to apply to the experiences of children as well. Complicated grief is described as "the constellation of symptoms that include: preoccupation with thoughts of the deceased, purposelessness and futility about the future, numbness and detachment from others, difficulty accepting the death, a lost sense of security and control, and anger and bitterness over the death" (Melhem, Moritz, Walker, Shear, & Brent, 2007, p. 493). Separation distress and yearning are at the heart of such problematic grief (Brown et al., 2008). Shear & Shair (2005) add that in complicated grief, early acute grief does not abate. In this state, a more usual integration that involves a shift in the level of internalized representation that incorporates the fact of the death or loss has been encumbered.

"Traumatic grief," following death of a loved one under traumatic circumstances, hampers the process of mourning (Cohen et al., 2002; Brown et al., 2008). Symptoms include: re-experiencing the loss physiologically and psychologically, especially in the face of reminders, through intrusive and distressing thoughts, memories, and images; extreme avoidance; emotional numbing; estrangement from others; exaggerated fears, such as those of other loving people dying too; and denial of any resemblances to the deceased for fear of sharing the same fate or, instead, over-identification with the deceased parent (Cohen et al., 2002). Although often confused with Posttraumatic Stress Disorder (PTSD), both complicated grief and traumatic grief are distinct conditions (Melhem et al., 2007; Brown et al., 2008).

Many factors complicate the grieving process. An extreme example would be when memories of maltreatment conflict with idealizations of the lost parent (Putnam, 1997; Castillo & Bailey, 2002). Dissociation may be present in complicated grief. This has been more directly studied in adults, but notably, evidence of such dissociation has been recently linked to improved treatment response (Bui et al., 2013). Unresolved mourning from a childhood loss is a key disruptor of adult attachment status (Main & Hesse, 1990; Morrell & Steele, 2003), and is reflected in lapses in an individual's proclivity to monitor discourse and rational thinking when discussing the loss. Along with unresolved processing of trauma experiences, as with massive traumatic loss (Kestenberg, 1989), unresolved loss has the potential to negatively impact, via intergenerational transmission, as through frightening maternal behavior (Lyons-Ruth & Jacobvitz, 2008).

Despite the struggle that children experience in adapting to their losses, there are numerous moderating and mediating variables that interface to shape a child's experience of parental loss. Examples of moderating variables include whether the death was expected or unexpected; which parent died; the child's sex and age; and any pre-existing mental health difficulties. Examples of mediating variables include how the surviving parent copes with the loss, as well as overall family functioning (Dowdney, 2000). Children's participation in shared mourning practices need to be adapted as a function of culture (Young & Papadatou, 1997).

THERE ARE MANY WAYS TO LOSE A PARENT

The type of parent loss influences child and adolescent outcome. Among bereaved children, more violent causes of parent death, such as suicide or murder, tend to be associated with qualitatively more difficult and prolonged grieving processes, as well as higher rates of severe mental health symptoms (Brown et al., 2008). Suicide carries with it several complicating factors. The child must cope with the parent being the self-directed cause of death. That in itself is traumatic, and significantly alters the parent-child relationship (Pynoos & Eth, 1985). The child must also face the stigma that accompanies the meaning of suicide, which may get in the way of the child's grieving process. The child may also carry an immense amount of guilt, thinking that not enough was done to prevent the death (Hung & Rabin, 2009).

Treatment and consideration of child survivors of the Holocaust has led to the observation that "loss of a parent or parents intensifies the search for the past" (Kestenberg & Brenner, 1996, p. 10). The importance of remembering trauma and the lost parent(s) to make historical narratives coherent is underscored. Material objects ("multisensory bridges"), inanimate or animate, may augment connection. For infants who lost, this connection may be primarily kinesthetic or embodied somatically. The bridging or linking object can connect and soothe, or can interfere with mourning (cf. Volkan, 1981; this volume). Kestenberg and Brenner (1996) suggest that those infants and young children who lost their parents in the Holocaust, who had no storied memory of parenting or of a protective family, suffered more than those who had such memories, and that the lack of such a memory or narrative was a risk factor in their parenting (cf. Prince, 1998). A recent and large comorbidity study supports this suggested correspondence between earlier age at the time of parental loss and more serious mental health consequence (Nickerman et al., 2013). Such perspectives have laid the basis for therapeutic efforts to help those without explicit memories of their lost parents via support for the construction of coherent narratives that enrich (and fill voids in) their representational worlds (Beebe & Markese, 2012; Cohen, 2012; Sossin, Cohen, & Beebe, 2012; Fogelman, this volume).

Bragin (2005, 2007) has articulated observations, examples, and guidelines for practitioners helping children and adolescents address loss in the context of war and violence. She underscored the importance of thinking of loss in a variety of ways, including: within the cultural context, within the continuity of family and community; in participating in cultural practices (including ones of absolution in the wake of guilt); and with the availability of expressive activities, as well as involvement in symbolic expression and problem-solving.

Although not directly addressed in this book, a variety of circumstances other than death also result in the physical or emotional absence of a parent. Prominent circumstances include brain injury, mental or physical illness, foster care, incarceration, and military deployment—each of which is fraught with its own set of unique challenges. One challenge common to all, however, is the process of grieving a loss that has prevented closure. Whereas with death there is finality, with other types of loss, there is a hampered mourning process due to the idea that there is a lost object who is still alive. The fact that a parent is alive, yet physically or psychologically absent, disrupts the grieving process. This form of traumatic and unclear loss has been referred to as “ambiguous loss” (Boss, 1999, 2010), resulting in symptoms similar to those of complicated grief.

CLINICAL WORK WITH CHILDREN, ADOLESCENTS, AND FAMILIES FOLLOWING PARENTAL LOSS

Some cases call for clinical work regarding parent loss to be incorporated into a traditional 1:1 child-psychotherapy office-context, while other circumstances invite out-of-the office consultations and collaborations. It appears that there is benefit to group-program endeavors that bring children and adolescents together who have shared experiences of parent-loss. Such programs [such as America’s Camp (English, 2003), which was designed to serve children of a parent or parents who died in the terrorist attacks of September 11, 2001, or C.O.P.S. Kids Summer Camp (Sawyer, 2008), designed for surviving children and family members of fallen police officers], help combat a sense of aloneness and atypicality, as well as provide an empathic environment in which close bonds form. One ameliorating factor appears to be that children and adolescents experience pleasure-without-inner-conflict when they are with those who have lost and suffered too, whereas such pleasure is harder to sustain when they are with others who have not shared in loss. Comparative misfortune or envy may impede enjoyment when with individuals who have not shared loss. While programmatic interventions attend only to what is shared among children or adolescents who lost, individual psychodynamic therapies, and creative implementations "in the field," attend to what is unique about each individual's loss, and the distinctive ways in which the lost parent is held-in-mind. Reports of psychological sequelae to parent loss requiring treatment vary. Worden suggested that about a third of children who have lost a parent require professional intervention. Dowdney (2000) suggests that only a small minority of bereaved children are likely to be at risk for depressive, generalized anxiety, or somatizing disorders following the death of a parent. Others (such as Cerel et al., 2006) have noted an increased "psychopathology" in the first two years after the death, with symptoms tending to mitigate over time, albeit at a slower rate in children that have other significant stressors in their lives, such as financial hardship. Retrospective studies of adults in psychiatric treatment have at times pointed to a link between childhood loss and later psychopathology (e.g., Pert, Ferriter, & Saul, 2004; Morgan et al., 2007). On the other hand, some authors have raised the converse, noting that while for some, parental loss may lay the ground for later disturbance, parental loss may, for particular individuals, be an antecedent to a special degree of creativity and success (Eisenstadt, 1978; Pollock, 1982).

Confounding variables and methodological challenges (Crook & Eliot, 1980) complicate interpretation of these findings; however, they remind us of the potential and need for creative resolutions to mourning (cf. Sossin, Cohen, & Beebe, this volume; Schwab & Schechter, this volume). There appears to be a risk for underestimating the psychological burdens of those who experienced parent loss. Individuals who cope via detachment from feeling-states or derailed aspirations may not seek clinical attention. Many have paid a considerable price in their own diminished vitality, suffering restrictions in emotional and relational health that are overdetermined by the strain of coping with loss.

In response to parental loss, there is a threat to a developing individual's subjective experience of a continuity of self (Bowlby, 1980; Gaines, 1997), and implementation of such early response and primary prevention efforts can be protective (Harris, Putnam, & Fairbank, 2006; Osofsky, 2011; Beebe

& Jaffe, 2012; Beebe & Markese, 2012). Difficulties enumerated above, the risk of suicide (Fox, 1985; Webb, 2010b), and potential encumbrances to the child's grief-work, invite a primary-prevention approach in which assessment would judiciously be standard. Suppotive findings stem from developmental psychopathology (Pynoos, Steinberg, & Wraith, 1995), psychobiology (Yehuda, Golier, & Kaufman, 2005) and integrative approaches to dyadic trauma (Markese, 2012).

A therapeutic environment can facilitate communication and recognition of both explicit and implicit meanings. Therapists can utilize different modalities including sandplay (Carey, 1999; Cleve, 2008; Ponder, this volume), play with iconographic and illustrative materials (Sossin & Cohen, 2012), art (Loumeau-May, 2012), music (Hilliard, 2007), attention to nonverbal/movement behaviors (Tortora, 2012; Sossin & Birklein, 2006), scrapbooking (Williams & Lent, 2008), journaling (Pivnick, this volume), storytelling (O'Toole, 2010), and more.

Cases involving an absent parent, traumatic events, or foster-care, especially call upon the therapist to enter multiple realms of the landscape at once. Ruth (2008, and in this volume) exemplifies such therapeutic work, variously assessing, containing, witnessing, holding an empathic presence, and offering needed psychoeducation, while working with a family, all while experiencing both the resources and the limitations of the systems put in place to help such families. Each family member needs to know and make use of what is known.

The importance of psychoeducation (alongside therapeutic endeavors) is evident in work reported by Lieberman (2003) regarding adoptive parenting of prior-institutionalized children with attachment disorders. The adoptive parents' own distress, their proclivity to minimize child expressions of anxiety, their disposition to unintentionally reinforce child fears of being unwanted through disciplinary means, and their lack of preparation by adoption agencies, all underscore psychoeducational goals alongside psychotherapeutic ones. Lieberman emphasized the need for such parents to go beyond "ordinary sensitivity."

A multi-layered psychoanalytic lens has informed rich and varied clinical approaches, including brief interventions with children and adolescents who suffered traumatic loss. In a poignant vignette two weeks after the September 11, 2001, attacks, Coates, Schechter, & First (2003) described participation in a therapeutic space called "Kids Corner," where a therapist spoke to a seven-year-old boy whose father had died in the World Trade Center. Listening to the boy talk about his father, and his comments about the father's love for New York, involved a sharing in imagination of a "future enlivening identification" (p. 47), highlighting the importance of symbolic representations of the lost parent.

The importance of the development and holding of a representation of the lost father as essential in the child's grief-work became integral in a collaborative primary prevention project focused on children who lost fathers in the World Trade Center, many while still in the womb (Beebe & Jaffe, 2012; Cohen, 2012). Reiswig (2012a) shared how the outreach to families and the mother groups embedded in this project captured ways in which the widow/mother held the memory of the deceased, and in so doing, maternally ". . . shaped the early construction of the representations of the deceased fathers for their children" (p. 83). In a case exemplifying her psychoanalytic perspective within a nonanalytic intervention, Reiswig (2012b) further understood the powerful role of one of the group therapists in making the deceased accessible through creation of ". . . a transitional idea, a shadow play, part reality and part fantasy, something that was internal and external at the same time" (p. 96). The importance of facilitating the mourning of the surviving caregiver is essential to support the child's development of a sufficient representation and allow the child's grief work to proceed, whether or not the child had an explicit memory of the lost parent.

In the development and implementation of the Violence Intervention Program for Children and Families in New Orleans, Osofsky (2003) called upon psychoanalytic principles in working with high risk families experiencing traumatic exposures and losses, as well as working with law enforcement officials to increase their sensitivity. Similar influences are evident in the Child-Parent Psychotherapy methods that have also evolved in the wake of trauma and traumatic loss (Lieberman, Ghosh Ippen, & van Horn, 2006; cf. Ghosh Ippen, Lieberman, & Osofsky, this volume). Two key elements of both models, relevant to work with children who have lost a parent, are the benefits of early intervention, rather than waiting for more extreme symptomatology to develop, and the need for therapists to know of and attend to countertransferential issues that arise.

Child psychoanalysis itself has offered a distinct window into a child's experience of parental loss. R. Furman (1964b) reviewed the analysis of Billy, a boy who began therapy at four, and child analysis at six. Billy lost his mother to cancer less than four months after psychoanalytic therapy was initiated. This case forewarns a clinician of the multifaceted dynamics that make every case unique and every generalization applicable only sometimes. In the case of Billy, problematic symptoms predated his mother's illness. The boy then experienced his mother ill, seemingly recover, and then become very ill again, and then, shortly after treatment began, she died. The mother's children, including Billy, were highly exposed to her anxiety, panic, and tears. History matters: in this case a traumatic incident in the mother's history likely impacted the way she managed this ordeal for herself and her children.

Whereas longstanding psychological difficulties often require the psychodynamic therapist to aim toward structural change, Chethik (2000) noted that the “reactive disturbance” of a death of a parent could invite a more “focal therapy,” exemplified in an eight-month treatment (twice weekly) of an 8½ year old girl whose mother died in an auto accident 1½ years before treatment began. A periodic fantasy of communing with her mother above the clouds evolved into a more frequent, elaborated, but compelling fantasy to which she was losing conscious control. Therapy proceeded upon the recognition of the fantasy as a “conscience call.” Chethik took on the psychoeducational role of informing the child that the purpose of the fantasy was to self-soothe and to keep the mother alive. As he became interpretive about her needing to be loyal to her mother, and thus impede connection to her stepmother, her anger turned toward him. Chethik’s recognition of the child’s guilt (and construction of a harsh and punishing superego), linked to original ambivalent feelings toward her mother, and her need to ward off sadness, allowed him to assuage the girl’s distress.

SELF-AWARENESS IN THE PSYCHOTHERAPIST

A fundamental challenge for the clinician is to enter the landscape of minds in a therapeutically effective fashion, and to reflect on one’s role as the therapeutic work proceeds. Beyond the work itself lie the benefits of personal reflections upon the therapist’s own experiences (Ruth, 2008; Beebe, Cohen, Bergman et al., 2012), as well as ever-evolving considerations of role and boundary, as per the function of advocacy on behalf of family members. Some clinicians have written of their own parental loss and its impact, offering particularly sapient reflections on the clinician’s personal knowing of loss (Cournos, 2001) and its place in therapy. Warshaw (1996) shared her own experience of losing her father in early adolescence, and noted the impact of this loss regarding her awareness of mortality, a sense of helplessness, her complex feelings toward her surviving parent, and the relational themes pervading her own analyses. Against this personal backdrop, Warshaw presents a treatment case of a five-year-old boy, whose father died, rather suddenly, at two, whose sense of vulnerability, and coping through withdrawal, control, and hoarding of money (as a way of holding on to the dead father), all bore particular resonance for her. Warshaw’s deep-seated processing of a parallel loss informed her understanding of the boy’s play and fantasies, and her beneficial active parent work with his mother. In later writing of adoptive children, including a ten year old whose adoptive mother died, Warshaw (2006) underscores how “the search for a replacement for the truly needed parent of childhood, as well as the desperate attempt to reinstitute a context of safety . . .” (p. 84) can permeate fantasies and relationships among those suffering early loss.

Clearly, work with a child or adolescent grieving following loss of a parent can evoke feelings (in some relative state of resolution) related to the clinician's own losses, as can work with an adult revisiting an earlier loss. Some suggest that this is not difficult to manage (Maschi & Brown, 2010), but we would concur with Aleksandrowicz (2013), in that it can present formidable challenges, especially in the form of a "parenting" countertransference, and the clinician's approach can either enhance or complicate treatment. E. Cohen (2003, and in this volume) has directly suggested how essential attention to countertransference feelings are, and how judicious self-disclosure of countertransference feelings in the therapist can promote effective treatment, especially in cases involving trauma. Introspection and self-awareness become essential tools for the clinician working with trauma (Wilson & Lindy, 1994) or parental loss, allowing the therapist to tolerate nearly intolerable affect called up in the processing of unresolved grief.

REFLECTING UPON THIS REVIEW

Effective clinical work with individuals who have lost a parent during childhood is a multi-layered process—one that necessitates an understanding of a child's developmental level, sense of identity and outside supports at the time of the loss. Both the psychoanalytic and non-psychoanalytic literature converge in their depiction of parental loss as a jarring event that is often traumatic, and brings with it psychological sequelae that warrant assessment, and, quite often, therapeutic intervention. Theoretical differences pertaining to developmental aspects of mourning highlight the complexity of an internal process required for sufficient-enough grief to proceed without bringing about developmentally interruptive, psychologically complicating, and/or relationally compromising consequences. Insights gleaned from thoughtful, psychodynamically-informed approaches to parent-loss underscore the advantages of informed individualized therapeutic interventions.

Though wide in scope, this literature review is nonetheless selective. There are areas barely touched. For instance, promising research finds evidence that early parental loss is followed by long-term changes in neuroendocrine function (Tyrka et al., 2008). Affective neuroscience underscores the vulnerability of infants and young children to direct experiences of loss and trauma (Hofer, 1996), as well as to caregiver-transmission of such experiences that would impact regulatory functions, attachment processes, and frontal lobe and right-brain development (Schore, 2002; Dawson, 1992; cf. Markese, 2012; Lange, 2012). Clinicians working with individuals grappling with childhood loss of a parent can keep in mind the fundamental ways in which such loss can influence neurobiology, and future work in these areas may generate markers of risk currently unavailable.

A host of factors, such as cognitive developmental attainments, caregiver attachment/loss histories, childhood experiences, dependencies and trusts in the lost parent, ambivalences felt, events precipitating and surrounding the loss, coping and defensive preferences, and fantasies about the lost parent, and more, all need a place in case-formulations, and they need to be held in the clinician’s mind. Attention to pre-loss affect management and self-regulation lends understanding regarding the resources a child or adolescent brings to the task of coping with loss. Such knowledge lays a foundation for potent approaches to assessment, consultation and facilitative support even when goals are more circumscribed. The roles of surviving caregivers in providing support, anchoring security, and facilitating such representational development are central. The therapist can be more facilitative through an understanding of the status of inner representations of the lost/absent parent that serve vital psychological functions for the individual who experienced parent-loss. In a sense, the therapist needs to “know” the lost parent, and participate in co-constructing an inner-representation and narrative to foster a psychologically successful mourning process.

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Part II

Therapy in the Office with Children and Their Caregivers

Chapter Two

"Do You Know Anyone Who is Dead?"

A Four Year Old Boy Comes to Understand the Unexpected Loss of His Father in the Context of Culture

Luz Towns-Miranda

In this chapter Luz Towns-Miranda describes her work with Max—a four-year-old, urban Latino boy from a working class background, who lost his father to violence. Towns-Miranda writes from a position fully inhabiting both her psychoanalytic and her Latina identities. In her comfortable and empathic understanding of Max's family structure and culture, and with fluid ease, Towns-Miranda involves the child's mother and grandmother in the therapeutic work. Her cultural dexterity is evident in the way she crafts an effective, short- to medium-term approach with excellent goodness-of-fit, ideal for this ethnic minority family's first psychotherapeutic experience.

Max had a positive developmental and family experience prior to the loss of his father. He showed, in Towns-Miranda's astute appraisal, well-developed ego resources, availability for a therapeutic relationship, and symptoms that seemed circumscribed to reactions to the loss of his father and family-system dynamics in its aftermath. That said, his difficulties extended beyond the narrowly behavioral into unconscious, emotional, and fantasy dimensions, which Towns-Miranda effectively addresses in her therapeutic work.

Substantial and growing numbers of ethnic minority psychoanalytic psychotherapists are sought out by members of their own ethnic minority communities, even though some argue that ethnic minority persons do not seek, or benefit from, psychoanalytically informed psychotherapies. The methods by which these therapists help their patients are often similar to, but sometimes differ from, those of majority-culture colleagues as one can see in this chapter. Children from all cultures can benefit from a clinician who is sensitive to culture, and clinicians working with a variety of children who have lost parents, from diverse backgrounds and in diverse circumstances, are likely to find Towns-Miranda's approach applicable and highly practical. —Eds.

The notion that infants and toddlers are incapable of registering, grasping and processing the loss of a loved one is not uncommon in many cultures. While young children lack the cognitive abilities to comprehend the details of the particular loss, they do experience the rupture in the bond with the individual who is now absent. The loss of a parent is registered on multiple levels and compounded by the frequently accompanied emotional unavailability of other attachment figures, also caught up in the mourning process. There are disruptions in previously predictable routines. With the loss of such a major figure, young children typically find themselves in new caretaking configurations and routines (Bowlby, 1982).

In many Latino cultures, toddlers have been perceived as having minimal understanding and recall of early events. In more traditional Latino families, children are expected to gradually abide by expected behavioral norms of respecting their parents and behaving obediently (Falicov, 1998). The agrarian idiom "Los ninos hablan cuando las gallinas mean," meaning "Children speak when the hens pee" (chickens do not overtly urinate) captures the expectation that children are seen and not heard.

The events that unfolded in the case of young Max and his mother were consistent with a lack of knowledge of early psychological development and the Latino cultural belief that young children do not remember or process early events from their infancy and toddlerhood. There had been adherence to the expectation of silence, especially in reference to the circumstances related to the absence of the child's father.

My therapeutic intervention with Max and his mother lasted for a period of six months. It consisted of weekly sessions with Max, a brief joint meeting of Max with his mother at the end of each of Max's sessions, and a monthly individual collateral session with his mother. I often use this model of sharing with the parent at the end of the session for young children who have been unable to broach subjects, and/or to establish a communication experience that continues beyond the therapy. In this model, the children have typically used me to convey feelings and concerns that they have been unable to express, often eagerly. Over time, they become ready to initiate the dialogue with their caregivers directly. Even very verbal children have used me to share with their parent, as if when they have spoken in the past, they were not heard or were unable to communicate what they were thinking. I have not had a young child express reticence, fear or concern about including their parent in these conversations and am watchful for a visceral response from children. Were there to be any indication of unwillingness to include the parent, the child's wishes would be respected and further inquiry regarding their communication would be explored. I have not utilized this model in cases where there has been harsh or abusive parenting, as it could serve to place the child at risk for belated consequences.

In this method the bulk of the children’s sessions are still shrouded in confidentiality. Only what the child chooses to speak about is shared. If the child does not want to share any information, that choice is honored. Interestingly, children have been eager to share select portions of their session. This model has been useful in cases where the communication between the child and parent was problematic. When young children who are participating in this model have shared specific information with me and related that they did not want their parent to know, their confidentiality has been honored. Young children may fear expressing particular concerns or broaching key topics, as was the case issue in Max’s situation. By sharing preselected segments of the session, a model is established for venturing to address emotional topics that are of concern to the young child. Children have been quick to pick up on the modeling of the introductory sentences used by the therapist, e.g., “X wanted to tell you that . . . but was afraid/reluctant to share this information, because X thought you might get mad/sad/worried, etc.” It has been my experience that as the sessions progress, communication begins to carry over outside of the therapy sessions, and the shared portion facilitates a smooth transition for the parent and child to communicate following the child therapy session.

This model presupposes a receptive adult who is interested in being responsive to the issues that may emerge in the course of the child’s therapy, issues that reflect what is on the child’s mind. Not uncommonly, during the initial familial data gathering that occurs prior to the first session with the child, the parents’ narrative provides a basis for determining if the model is suitable. For children whose parents are struggling to understand the nature of their child’s difficulties and are aware of the importance of their role in helping the child, the model can be facilitative. In cases where the parent has little or no sense of his or her contribution to the child’s development and behavior, this model would not be introduced. In many of these cases the child is being brought to therapy to be “fixed” by the therapist, thus localizing the problem within the child and not in the child’s experience in the world and family. In these cases separate parent collateral work would be implemented as often as possible.

THE CASE

Max, a four-year-old boy, was referred by his local preschool for behavioral concerns, including difficulty sitting still, limited attention and suspicion of ADHD. His mother had contacted me as one of the few private child practitioners in the predominantly Hispanic neighborhood identified by her insurance carrier. During the initial parental interview, his mother, Ms. A, revealed that her husband, Max’s father, had been killed in a random shooting at his place of employment when Max was two. The individuals responsible for his death were never identified. Both parents were from the same Latin American country. The father had immigrated in preadolescence and the mother in her adolescence. As is common, they were from the same town of origin and reconnected in the United States, as they were part of a close-knit immigrant community. Mr. A attended vocational training and was hired as a skilled laborer. His place of employment was in an area with similar establishments but with a significant crime rate due to drugs.

Ms. A and her husband had been married for several years before Max's birth. They led a comfortable working class life and had been thrilled by the birth of their first child. Mr. A had taken a minor non-traditional role in his son's caretaking, evident by his having assumed the responsibility for his son's baths. Ms. A stayed home to be the primary caretaker. She reported that Max had been an easy baby with a regular sleep pattern and he was a good eater. He had not been an unusually active child.

Ms. A related that the funeral for her husband had been prolonged, and that the body was interred in a Latin American country where he was born. At the time, Max had become clingy and often difficult to soothe. Her mother had overseen the majority of the funeral arrangements as well as the arrangements for Max. He was cared for by a rotation of relatives, some familiar, some not, during the wake and funeral. Ms. A had been too disoriented herself to be attuned to the arrangements made for Max by her mother over the course of the two weeks during which the events transpired. The abdication of responsibility for the funeral arrangements and acquiescence to her mother's plan sparked a loss of Ms. A's adult individuation as she allowed herself to be cared for by her mother.

Ms. A had been traumatized by the senseless, unpredictable death of her hardworking, devoted spouse. As was typical in their culture, after Mr. A was killed, Ms. A's mother advised her to eliminate all traces of her husband, to spare her and her son pain. Upon returning to New York City, she and Max stayed with her mother for several days, while her mother had their apartment purged of all traces of her husband. She followed her family's directive at the time since she was in shock. As time passed, the strategy that served to help her initially cope with the traumatic loss actually made it more difficult for Ms. A because the entire subject was forbidden. Not only did this forestall her mourning, it also compromised her ability to help her son. Her mother's theory was that Max was too young to remember, much less understand the sudden loss of his father. Ms. A's family believed that Max would simply forget his father in his absence. Max was being "protected' from all family mourning traditions. Immediately after the funeral, not only were all traces of the father removed from the home, but Mr. A was never mentioned again. Max was not told that his father was dead; just that he was away working. Max had gotten the unspoken message that he was not to ask or speak about his father.

Ms. A attributed Max's disrupted sleep schedule, difficulty being soothed, and clinginess, to her own difficulty adjusting to her new life. Understandably, she had been so emotionally devastated that questions about what Max might have heard or seen in the aftermath of the event appeared to catch her off guard, as if she had no recall of her son during that time. She explained that her mother had made sure that Max was cared for as she had been too distraught. She acknowledged that Max likely saw persons crying at times, but minimized his capacity to understand the behavior. She noted that they tried to keep him away from persons who were acutely distressed.

WORKING WITH MAX

As the first weekly session with Max began, he sat in a child rocker and spent most of his time in curious conversation. He began by asking me if I knew anyone who was dead. I paused, and responded that I did. He proceeded to ask who had died and how they died. Being cognizant of Max's traumatic loss, I shared information of a non-family elderly person who I knew had died of natural causes or illness. Inquiring into his curiosity was unproductive. He claimed not to know anyone who died but just wanted to know.

To begin an initial session with such a specific and relevant question, in light of his family's history, conveyed the message that Max had death on his mind. It was also clear that he understood that I was someone who could help him understand the unexpected loss of his father. Max had been powerfully impacted by his father's absence and had an unknown knowledge of his disappearance. In several sessions at the beginning of the therapy he would continually ask me about dead people I knew and he was focused on knowing how they died. He was more interested in learning about death than in engaging in play therapy. Having been told that this was a place where he could share his worries, Max responded by going to the heart of his concerns that up until now were tacitly to remain unspoken. He appeared to recognize that I might be the one to finally provide answers to the questions he could not ask his mother.

During the first session, although I introduced Max to the toys, he remained seated in a child's rocker that he found in the office, and he continued to rock continuously throughout the session, all the while posing questions to me. It would not be until after three months of therapy, following a critical joint session with his mother that he would seek out any play materials.

I told Max toward the end of each session that it would be helpful to let his mother know the most important thing that we talked about during the session. He could tell his mother, or I could tell her until he was ready to tell her, about his thoughts and worries. Toward the end of each session we would review what we had talked about and he would decide what he thought he wanted his mother to know. Max was pleased that his mother would learn of his concerns. It would be several months before Max was able to directly address his mother, preferring me to mention each topic that he wanted her to know about. As Max's first session drew to a close, he was asked what he wanted to share with his mother about that session. He could not think of what he might want his mother to know. I suggested that his mother would be interested in his curiosity about heaven and people who had died. Toward the end of that first session, Max asked me to tell his mother about the dead person that I knew. Ms. A appeared stunned by the focus of the first session that was briefly described.

To reiterate, although only four years old, Max was a talker and did not seek out play materials even though they were introduced and readily available. He enjoyed rocking actively in the child rocker in the office as he spoke about his days at home and school. He liked school and was puzzled about how he got into trouble as often as he did. He had friends and got along well with his peers. Max's inability to play initially was understood to be related to the unprocessed mourning of his father. The limitation of his knowledge regarding his father's death appeared to impede his capacity to engage in representational and pretend play. Having been given permission to speak of his worries, it was as if a torrent of concerns about death that had previously gone unspoken could now be voiced. It was several months into the therapy, after being told of his father's death by his mother, that Max began to seek out play materials.

Max had been told that when people died they went to heaven. He wanted to know if I had ever been to heaven. Given his young age, he had a concrete understanding of heaven as an actual location. He wanted to know if he could visit. He would not mention that he wanted to visit anyone in particular.

During the second session, Max again asked if I knew anyone else who had died and again he wanted to know the manner of death. Again I asked him if he knew anyone who had died. Max reported not knowing anyone who had died. He had seen a cartoon in which a dog had died and gone to heaven. The dog had come back to earth but eventually returned to heaven. He wanted to know if that was possible. Not having seen the cartoon, but recognizing the theme of connecting with someone in heaven or the wish for having someone return from heaven, I asked him why he might want to go to heaven. Max said that he wanted to see it. He reported that he had seen pictures of people dressed in white gowns in clouds, but did not think it was really like that.

Max wondered if he would go to heaven when he died. He knew that bad people did not go to heaven and worried that since he was sometimes bad in school, he might not be allowed in. As his second session drew to a close, once again Max was asked what he wanted to share with his mother. Max said he wanted me to ask her if she knew anyone in heaven. Ms. A told him that her grandparents were in heaven. He asked if she could visit. Ms. A explained that Heaven was a place that you could only go to when you died. There was no visiting. Max accepted the explanation. Unlike some children who express a wish to die in order to join or visit a loved one, Max did not express a wish to die either before or after learning of his father's death. He did not express an interest in what it was like to die. At that point, he was more intrigued by its location and physical attributes.

As the sessions progressed Max continued to express his curiosity about death. He mentioned wondering at what age he would die. He knew that most people died when they were old. He knew that people sometimes died in car accidents or other accidents. He was aware that there were some illnesses that could be fatal, but did not know what illness could make a person sick or anyone who had died of any. Interestingly, he never mentioned criminal activity as a manner in which people died. His father had been a victim of a drive-by shooting close to his place of employment. His shooter was never apprehended. But since none of this had been directly communicated to Max, his mother did not believe he knew any of these details. At the end of each session, Max increasingly developed comfort sharing his curiosity with his mother.

As we shared the snippets at the end of each of our sessions, Ms. A began to realize the importance of eventually sharing the truth with Max. He had continued to express his interest in death and was able to participate in conversations by the end of the first month. The conversations, however, did not continue at home. Max's thoughts and concerns were contained within our sessions. He felt safe inquiring and speaking about death with me and he followed the unspoken ban at home.

In our sessions Ms. A primarily spoke in Spanish. Having been in preschool for two years, Max was more comfortable speaking in English with me, although he was bilingual. During the brief joint portion of the session, the conversation was always held in Spanish; Max knew to speak in Spanish to his mother.

INDIVIDUAL WORK WITH MS. A

During the course of the six month individual treatment with Max, collateral work with Max's mother ran parallel to the individual work. Ms. A's own mourning had been stunted by her following her mother's directive to minimize the existence of Max's father. During the initial meeting with Ms. A, I instructed her to tell Max that she was bringing him to a worry doctor, because everybody worried. She knew that he was worried about getting into trouble at school. Following the first two individual sessions with Max, Ms. A was seen for a session alone. Subsequently, she was seen monthly. It had become apparent to both of us that Max had a preoccupation with death, as that was how he typically opened each individual session and what was shared with his mother at the end of his sessions. He continued to ask about the dead people I knew. At first Ms. A had mixed reactions to Max's inquiries about death. She wondered if he had overheard conversations about his father's death. She was saddened that he had not felt able to approach her about his intense curiosity about death. I gently reminded her that he seemed to have learned that death, and his father, were two subjects that were not to be spoken about at home. I reassured her that the fact that he was eager and able to share his curiosity was an important step toward addressing the significant unspoken vacuum created by the absence of his father. Ms. A questioned how much Max might know about the death of his father. I told her that it was likely that a part of Max knew his father was dead, but since his father could not be spoken about, his preoccupation had shifted to learning about death in general. He had been given permission to talk about his worries with me, and from the beginning he had made clear the source of his worries.

After the first collateral session with Ms. A, she accurately wondered if Max's preoccupation with death meant that she would need to inform him of the truth. I began to explore with her what it had been like to participate in the cover-up. She acknowledged that by not having spoken about it around Max, she had brushed her grief aside and buried her distress, so as to not upset Max. She gradually came to acknowledge that by agreeing to the cover-up and sharing in the fantasy that her husband would return someday, she had actually avoided her own pain. She described that it had initially been painful to be home without a trace of her husband, though she had grown used to it. She recognized that it had kept her from being continually reminded of his absence. Ms. A began to understand that she had not fully mourned, nor had she moved on emotionally, and that the same thing might be true for her son. She began to realize that she would have no way to explain to Max why there might be another man in her life at some point in the future. Until Max began therapy she had not allowed herself to contemplate another relationship. They were both waiting for his father to come home. She gradually recognized that she had sought a refuge in the constructed cover-up as she avoided having to contend with her future without her husband.

Ms. A had not experienced pressure from her in-laws as to how to manage the situation in any way. Initially, the unsolved nature of the event had powerfully bound the families. As time passed, and the perpetrators were unlikely to be captured, there was less contact. Max's paternal relatives kept in communication. As the maternal grandmother had assumed a matriarchal role with her daughter and grandson. Ms. A slowly began to understand her mother's efforts as not solely to spare Max pain but also to spare herself. It was not uncommon to exclude children from matters concerning death. In the Hispanic culture, infants and toddlers are commonly not told about death in any manner. The grandmother’s response was not atypical, but the extreme disavowal of the father’s existence, with the blanket silence that ensued, was unusual. More typically, children are usually told that the person has gone away and will not be returning. In religious homes, heaven is where the person is. In deeply religious homes, the deceased is said to be with God.

The stark early recognition of Max’s confusion and pain, and subsequently his behavioral symptomatology, came into focus in the shared portions of his sessions. Over time Ms. A was able to work on her reactions in her collateral session. These were powerful images that allowed Ms. A to begin to connect with her son’s distress. Like Max, his mother had similarly been caught up in the denial of the cover-up, and she began to recognize a parallel process in herself.

After the second collateral session, Ms. A began to talk about disclosing the truth to Max. She expressed anxiety regarding her mother’s response to ending the cover-up. She knew her mother had mostly acted in what she believed was Max’s best interest, and that she believed him to be too young to recall his early years with his father. Thus, she had attempted to hasten the memory loss by removing reminders. Ms. A expressed her fear of Max’s reaction, in addition to her fear of her mother’s reaction, to disclosing the truth. Ms. A became amenable to informing Max, but initially felt quite helpless and conflicted because of the extensive family cover up and the possible ramifications.

After the second month of therapy, Ms. A reported that Max’s behavior in school had been reported to have begun to improve. He was more focused during activities. Ms. A also noted that he had begun to ask her questions at home about known deceased relatives. He was still confused about the concept of heaven.

In between the monthly sessions, Ms. A laid the groundwork for disclosing the truth to Max. She related to me that she had begun to talk to her mother and other maternal relatives about Max’s school difficulties. Ms. A had a growing awareness of Max’s need to know the truth since death was a source of worry for him. My providing psycho-education and empathic support in the collateral sessions with Mrs. A allowed her to broach the topic with her mother and her extended family.

Ms. A was given the option of inviting her mother to one of her sessions to speak of the importance of telling Max the truth. It became clear to Ms. A that it was her role to speak to her mother. She had begun to explain the problems that had brought Max to therapy and their connection to the silence around his father’s absence. As she reached this decision, she articulated the need to resume responsibility for Max’s future well being, and relinquished the shelter of her mother’s authority. She was heartened by her decision to have sought therapy for Max and his steady behavioral improvement in school. She had sought therapy reluctantly as no one in her family had ever been in therapy. It was traditionally perceived to be for very disturbed people. By following through with the school's recommendation, she began her own process of separation/individuation from her mother as well.

Ms. A initially reported that after expressing some hesitation, her mother had responded supportively to the plan to disclose the truth to Max. Her mother had related that at the time she thought not speaking about Mr. A was the best way to manage the tragic situation as she had not thought that Max would have any recall of his father since he was so young. Ms. A described how she had shared with her mother aspects of her own understanding of Max's confusion and loss with the sudden disappearance of so important a figure in his life. They had commiserated about the painful period, and they shared their regrets about their limited appreciation for Max's experience at the time. The grandmother had offered support in retrieving photos and momentos of the deceased. In preparation for the disclosure, Ms. A retrieved from storage photo albums and videotapes to share with Max.

During her collateral sessions, Ms. A began to talk about her husband, and about their short but happy marriage with their focus on Max. She used the sessions to process her grief, gather the strength to undo the family denial, and emotionally reconnect with Max. She reminisced about the family times that they had shared. Her husband had been thrilled that their first child was a son, a traditional Latino reaction. She described the three of them often going to the park, both doting on their son. Their family had been strongly bonded. She became aware that by having kept the truth from Max she had not felt able to be as close to him as she had previously felt, as she would have liked, and as he needed. Ms. A reflected on her mixed emotions of how she had handled the death with Max. She recognized that the cover-up had impinged on her bond with Max. She questioned her own capacity to have been more emotionally available, since she had sought refuge in her mother's care. As she struggled with her previously unaddressed grief, Ms. A was certain that she wanted to be able to re-strengthen her emotional connection with Max.

DISCLOSURE IN A MOTHER-SON SESSION AFTER THREE MONTHS OF TREATMENT

By the fourth month, Ms. A was ready to tell Max about his father's death and chose to do it during his session. Of note was the fact that Max would be told that his father died, but not the manner in which he died. Ms. A feared causing Max unnecessary anxiety about the possibility of a random act of violence befalling him or her. At the beginning of the session I told Max that instead of waiting until the end of the session to speak with his mother, she had asked to share his time with him. He appeared pleased. Ms. A recognized that it would be helpful for her to share this crucial information with Max having his therapist present. Ms. A had brought a photo album to make a visual connection that she believed might have faded in the two years of silence.

Ms. A began by restating that Max believed his father was at work because that was what he had been told. She now told him that when he was much younger his father had died, but since he was so young he had not been told. She told him that since he had expressed so much interest in family and other persons who had died, she thought that he was now old enough to understand. Max had been watching his mother intently, and he had an expression of curiosity on his face, not shock. He responded by asking if it meant that his daddy would not be coming home. Ms. A told him that he did understand; that since his father had died it meant that he would not be coming home.

Ms. A went on to tell Max that his father loved him very much. She began to describe the many activities they engaged in, e.g., his father loved to give him a bath, and to take him to the park. She then brought out a photo album that contained pictures of Max as an infant and with his father. Max was fascinated as his mother described the context of each photo, e.g., meals, birthdays, etc. Max kept asking if he was the baby in the pictures. He had not been shown his baby pictures since the age of two. In the haste to remove evidence of his father, memories of his early childhood had also been buried. Ms. A appeared moved as Max expressed pleasure at seeing the photos. He began to ask questions about his father in relation to himself. She answered him thoughtfully, eager to fill the vacuum that had existed since his father's passing. As the session drew to a close, Ms. A was noticeably relieved by Max's positive response to the disclosure. Max left carrying one of the small photo albums that his mother had brought.

POST DISCLOSURE

Following the disclosure session, Max began to explore play materials in the office in a more age-appropriate way, in contrast to his previously exclusively talking about his concerns. The theme of illness and sudden loss was addressed through his play. He sought out animal puppets and expressed concern about their well-being. He would reassure them that if they got sick and died they could go to heaven. He was keenly attuned to materials in the office and would ask where they were if he did not see them from one week to the next. Typically the material would be found, reassuring Max of the continuity in the office. Max acknowledged that he worried about what had happened to the animal puppet if it was not readily visible. As the sessions progressed, Max began to wonder where the puppet was rather than fear its disappearance, reflective of his increased reassurance of constancy and predictability. After learning of his father's death, his ability to shift from talking to playing out representational play themes of absence and loss was a developmental shift. This was reflective of Max's newly gained capacity to process the truth of his father's death and play out his concerns of loss.

Max's remaining sessions were notable for the absence of curiosity about dead persons and a positive shift in his affect. He began to refer to his father, talking about videotapes that he had seen. Max asked if I knew about events in his early life. He wanted me to know that his father had loved him very much as was represented by the memories that he shared from the photos and videos. Ms. A had displayed photos of Max and his father in their home. His end of the session snippets now consisted of sharing with his mother the information he had shared with me about his father. He was excited and eager to describe his early life with his father. He elaborated about the stories his mother had shared and videos they had seen. It was evident that Max and his mother had reconnected with each other, and both were cherishing memories as they processed their loss together. Ms. A was now comfortable addressing Max's questions and shared his joy in rediscovering his lost father.

Max's behavior at school dramatically improved. He was reported to be attending to instructions as well as peers. He was sitting still and not disrupting the class with interruptions as he had when referred. The teachers no longer intimated that he needed medication for suspected ADHD. Before therapy Ms. A had not shared her tragedy with the school staff. Afterwards, she had informed them that Max had been evaluated as recommended and was receiving therapy. At home, Ms. A reported that Max had begun to speak about his father and approached her with questions as they occurred to him. He had shared his photo albums with visiting family members, happily describing his childhood events with his father. Max's apparent pleasure served to ease Ms. A's guilt over having withheld the truth from Max for as long as she did. By reintegrating Mr. A into the fabric of their family history, Ms. A recovered the connection with her son that they had previously established.

Max had significantly shifted his affect over the course of the therapy. His initial presentation was of a serious child, concerned with the confusing theme of death. The permission to speak of his worries freed him to speak of a topic that had been forbidden. Over the course of several months, as his concerns were addressed in the therapy, by sharing a small portion of his session Max was able to continue his conversation at home. The emotional vacuum that had been created by the death of his father, and the way the family had handled it, had been fully evident in the lack of communication between him and his mother. Following the disclosure, Max and his mother's psychological and emotional connection was solidified, and Max's range of affect expanded fully. Ms. A's reservations about following the school's recommendations for therapy for Max diminished only after she began to grasp the extent of Max's unspoken concerns about death and the loss of his father in the shared portion of his session. It was to Ms. A's credit that she brought Max to therapy.

During the final weeks of the therapy, Max eagerly shared stories of his father. His obvious pride and pleasure was in recounting the stories that he had heard and describing the videos he had seen of him and his father. He did not express sadness or anger at the death of his father. Having suffered through a period in which he had experienced the loss of his father and the emotional unavailability of his mother, now Max appeared whole with his newfound knowledge. It was as if the recovered emotional pieces had filled the void created by the unspoken tragedy.

Max was pleased to report that he was no longer getting into trouble in school. The termination process came about as the school year was winding down. We spoke about how his worries had changed over time. Max confidently stated that he did not think he would continue to get into trouble. He was following the teacher's instructions better. He no longer raised the issue of death as his main source of concern. When I asked if he still had questions about people and how they died, he simply shook his head from side to side. He had become excited about his upcoming trip to his parents' country of origin.

Ms. A reported that she was planning to travel with Max. They were going to visit his father's grave as well as both maternal and paternal relatives. The trip would occur shortly after the end of school. Although Max had many questions about flying in an airplane, he was eager to see where his father's remains were placed. Max reported the trip during one of the last sessions and he chose to talk about it with his mother at the end of the session. He was happy during his final session, expressing his excitement about continuing to discover more information about his father during the upcoming trip.

In her remaining sessions, Ms. A had concerns about how to handle questions Max might belatedly ask about how his father had died. She feared that he might develop fears of being the victim of a random violent mortal act or that she might be taken away from him in a similar manner. I advised her to reassure Max of her ability to have kept him safe to date and her commitment to continue. If he were to have an exacerbation of behavioral symptoms Ms. A was encouraged to return to therapy. At the time of writing this chapter, it has been more than a decade since Max was seen.

DISCUSSION

My work with behaviorally disturbed toddlers and their mothers in a South Bronx therapeutic nursery shaped my method of working with young children and their caretakers in private practice. The patients in my practice have been of color and of working or lower middle class, typically with no previous exposure to psychotherapy. The therapeutic nursery families were exclusively of color and poor, requiring psychoeducation as well as reflective therapeutic interventions (Dios-Kenn et al., 2005). Through this work I have learned that a child's emotional and behavioral improvement must proceed in tandem with the caregiver's grasp and progress or risk losing the family as on occasion has occurred. Ms. A had defied her family and the strong Latino cultural taboos in seeking psychological services. By addressing Ms. A's unresolved mourning in her individual sessions, and by including her in the dyadic work at the end of the sessions, Max was able to process his significant loss. At the same time my including Ms. A in Max's therapeutic process, by having her participate in the work at the end of his sessions, was key to the success of my work with Max. Ms. A felt included in Max's sessions though not present. Her reservations about following the school's recommendation diminished as she slowly grasped the extent of Max's unspoken concerns through the shared portion of his sessions.

I have utilized this method in child and adolescent treatments with people from all cultures, when the communication between the young person and his or her caregiver was a central factor in the disturbance of the child or adolescent. It is important to begin with a caregiver who has the capacity to be empathic with the child, who has some awareness of contributing to the underlying difficulty with a reasonable maturity level and a willingness to be flexible and open for change. My assessment of this readiness usually occurs in the initial meeting with the parent or caregiver. On occasion, when the caregiver has been unable to make appropriate use of the shared portion with the child, the method has been suspended until some change has taken place and there would be more readiness and ability to participate. In these cases I would offer additional sessions to work with the caregiver individually as often as indicated. With adolescents whose treatment has been solely individual, introducing this method well into the therapy has proven useful in allowing the youngster to feel heard in a way that had not occurred outside the office. The method described in this chapter lends itself to work with families who are unfamiliar with the psychotherapeutic process, and whose cultural, race and class backgrounds may predispose them to reject psychotherapeutic services due to a stigma against psychotherapy.

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Chapter Three

Walking in Their Shoes

Therapeutic Journeys With Young Girls Who Lost Mothers

JoAnn Ponder

While all children who suffer the loss of a parent experience some similar challenges and reactions, JoAnn Ponder reminds us that all situations are not the same. Ponder's rich paper details the treatment of two eight-year-old girls who both lost mothers, one from an intact family with multiple supports and services available to her, the other, a girl who carried a history of multiple traumas, including domestic violence, divorce, and witnessing one parent murdering the other.

As the therapy unfolds, we see how traumatic grief differs from "normal" mourning, yet Ponder uses symbolic sand play methods in both treatments to great effect. Ponder's sensitivities to timing add to her understanding of transference and countertransference in insightful ways that will be enlightening to child clinicians. Whether or when a therapist should explore details of a traumatic past, or wait for traces of the material to appear, is discussed through the eyes of this well-seasoned clinician. Paying careful attention to what experts have written about children, mourning, and trauma, Ponder grapples with the notion of whether or not directly addressing serious trauma can be re-traumatizing to a child. In the end, Ponder takes these two girls on a meaningful journey through their mourning process. Eventually they are both able to communicate their inner thoughts about their dead mother through the action of play. —Eds.

Nothing can fully prepare a psychotherapist for the emotional upheavals of treating a young child who has lost a parent. There is no greater loss for a young girl who is still dependent on adult care than the death of her mother and primary caregiver. The loss not only is untimely and devastating, it can result in lasting developmental consequences. With the mother deceased and father and other relatives still grieving, there may not be adequate emotional support for the child. We clinicians must bear and contain the child's intense emotional pain and suffering, which become overwhelming if she has not yet developed the capacity for self-soothing. The depth of the child's grief can invoke inner pain about our own prior losses, fear of future losses, discomfort with death, feelings of helplessness and inadequacy, or rescue fantasies. Thus, the analytic terrain is dark and arduous as we put ourselves in the child's shoes and accompany her on her therapeutic journey.

In the following chapter, I present the cases of two bereaved children for comparison purposes. Though I worked with a number of children who lost parents, I selected two children of the same sex who were close in age when treated. "Emma" and "Kiki" were about eight years old, and both had lost mothers. Emma had an emotionally avoidant style, but otherwise was developing typically prior to her mother's terminal illness and eventual death. In contrast, Kiki showed compromised development from years of exposure to domestic violence prior to witnessing her mother's murder. The girls differed greatly with regard to their circumstances, presentation, and clinical process, as well as the countertransference elicited. Nonetheless, both were helped with individual psychotherapy based on a combination of psychoanalytic and Jungian approaches. Sandplay (Kalff, 1966/2003) was particularly useful in elucidating both girls' inner worlds, bringing issues to consciousness, helping the girls to mourn, and allowing them to work in the displacement before they were ready to talk about their feelings.[1] I intend for the stories of their therapeutic journeys to stand mostly on their own, but preface each with a brief literature review for a theoretical framework.

TREATING CHILDREN'S GRIEF REACTIONS

Freud (1917) defined adult mourning as the gradual, painful decathexis of the mental representations of the deceased. In his view, mourning is accomplished in a withdrawn state, remembering each aspect of the object and relationship, reminding oneself that the object is gone. When the process is complete, the bereaved is considered capable of forming a loving attachment to a new object. Freud (1939) amended his view after the death of his daughter and his grandson, concluding that one can never completely recover from or replace a lost love. Based on his original definition, some analysts asserted that children who lost parents were incapable of mourning before late adolescence due to their cognitive immaturity and need for ongoing care (e.g., Nagera, 1970; Wolfenstein, 1966). In contrast, most contemporary clinicians believe that young children can mourn, though differently from adults. Children's reactions to parental death vary widely with factors such as age, developmental stage, and personality; relationship with the deceased and surviving parents; the nature of the death; and availability of age-appropriate care and external support (e.g., Barnes, 1964; Bowlby, 1960, 1980; E. Furman, 1974, 1981; R. Furman, 1964a, 1964b, 1968, 1973; Lopez & Kliman, 1979; McCann, 1974).

A child generally sustains more losses than an adult when a parent is lost. A child not only loses the loved one, but also the provider of nurturance. The primary caregiver's death robs the child of a developmental object (Hurry, 1998), auxiliary ego (Spitz, 1965), or self-object (Shane & Shane, 1990), which provide functions needed for continued psychological growth and development. Thus, the work of mourning is greater for a child than an adult who loses a parent (Fallon, 2001), and the child has fewer inner resources with which to cope.

In a classical text by Erna Furman (1974), she outlined the bereaved child's tasks as (1) to cope with the immediate circumstances, (2) to mourn, and (3) resume emotional development. The immediate stressors include a fear of illness or death, difficulty differentiating from the deceased, anxiety related to the cause of death, or concern with bodily and psychological need fulfillment. The younger child experiences more stress due to limitations in reality testing and mastering anxiety. A child is incapable of mastering anxiety without external support until he or she has developed object constancy, which refers to a nurturing internal object used for self-soothing. This does not imply that all children who lose parents are destined to develop lasting emotional problems, but younger children are more vulnerable if they do not receive optimal adult care.

A beloved parent is forever missed, the loss reexperienced with each new developmental step and significant event (Dietrich, 1989; E. Furman, 1974). Mourning revives prior losses and affects subsequent losses (E. Furman, 1974). Bereaved children who are denied a supportive environment and opportunity to mourn may be unable to give up the tie to the lost object (Shane & Shane, 1990). They remain fixated, seeking a continued relationship in fantasy and enactment. Moreover, feelings that stay invested in the deceased are unavailable for maturation or new attachments (R. Furman, 1973). Pathological defenses also interfere with mourning (Frankiel, 1994). For example, the child may use splitting by idealizing the lost parent and/or devaluing the surviving parent (Neubauer, 1960).

Parental loss can influence the child's expression of love and aggression. One possibility is that the child might become an oedipal victor or loser, with the parent's death intensifying strong ties and incestuous-like strivings toward the surviving parent (Blum, 1983; Neubauer, 1960). Given that all children experience competition or hostility toward parents at one time or another, the parent's death might reinforce the child's sense of omnipotence or guilt, as if the child's thoughts somehow caused the death (Dietrich, 1989). If the parent's death was a homicide, the child might fear and inhibit his or her own aggression. Conversely, the child might exhibit increased anger and aggression, identifying with the aggressor or unconsciously hoping for a different sort of outcome. When unmastered conflicts and anxiety result in behavioral symptoms, this may occur at the time of the loss, or later when additional stress had a cumulative effect (E. Furman, 1974). These symptoms are not specific to parental loss, and may include any of a wide variety of indications of emotional distress.

All child therapists function both as a transference object (Sandler, Kennedy, & Tyson, 1980) and a developmental object (Hurry, 1998), but the developmental functions are emphasized in treating a child who has lost a parent (Green, 1998). In other words, the therapist may symbolize the child’s significant others in fantasy, but the therapist also intervenes to foster the child’s emotional development in reality. Pioneer child analysts debated about what was more curative, the relationship (A. Freud, 1926) or interpretation (Klein, 1927). I believe that the relationship is essential in treating bereaved children, but I also think that an interpretation can be beneficial if used judiciously. I like the approach described by Berta Bornstein (1945, 1949), who focused on current emotions and interpreted defenses against unbearable affects. Whereas countertransference previously was considered an obstacle in understanding the child, it is now considered a useful source of information to deepen and facilitate the treatment (Blos, 2001). The therapist’s memories, fantasies, physical/sensory experiences, and affect facilitate contact with his or her “self” as “child,” further symbolizing different states of mind, thus aiding the exploration of the child’s mind (Bonovitz, 2009). According to Robert Furman (1973), a bereaved child may invoke emotional pain, or discomfort with death.

Play is an essential component of therapy with children (Ablon, 2001; Cohen & Solnit, 1993; Neubauer, 1987; Slade, 1994), including bereaved children. The child displaces his or her own feelings and issues onto the toy or pretend figure, and the therapist may attribute any wishes, fantasies, or emotions to the toy or figure rather than directly to the child. This technique, which is termed working or interpreting within the displacement, helps the child to put thoughts and feelings into words without becoming overwhelmed by pain or anxiety before he or she is ready to face the issues directly (Neubauer, 1994; Sugarman, 2008). Working in the displacement thus promotes a conscious awareness of defenses and conflicts without making the child self-conscious or overwhelmed. It might not be necessary to interpret outside the displacement by linking wishes and emotions directly to the child, but talking directly becomes possible once the child is capable of insight and able to tolerate his or her emotions.

Children may become rule-bound and self-conscious about fantasies and impulses as they reach latency. Hence, many back away from fantasy play in favor of card or board games where the clinical material is not as rich.

Nonetheless, I have had success in using sandplay with individuals from age four years, including latency-age and bereaved children. Sandplay is a nondirective technique founded by Dora Kalff (1966/2003) based on Jungian theory. Others have described differing approaches to working in the sandtray (i.e., Lowenfeld, 2005). The Kalffian technique is used in depth treatments that also focus on transference, dreams, and daily issues (Mitchell & Friedman, 1994). While most clinicians who use this method are Jungian in orientation, I find the technique compatible with a psychoanalytic approach as well. In sandplay, the child chooses from a variety of miniature figures and arranges them in the sandtray to create a picture while the therapist sits silently behind the child. Once completed, the child is given opportunity to comment on the scene. The therapist does not interpret it (Chiaia, 2006) or at least postpones interpretation until the issues are close to consciousness (Kalff, 1966/2003).

In a sandplay process, children often show chaotic scenes followed by calmer ones (Kaplan, 2011), reflecting developmental sequences of integration, de-integration, and re-integration (Fordham, 1985). From a neuroscience viewpoint, the therapist's attunement and containment during the nonverbal symbolic process are similar to what happens between mother and child to promote brain structure and mind (Turner, 2005). Based on an extensive review of empirical findings, Allan Schore (2003) delineated an intersubjective process involving right-brain synchronization in helping infants or therapy patients learn to regulate affect and develop a sense of self. Ed Tronick (2007) described mutual processes of emotional regulation and a dyadic expansion of consciousness and meaning-making. Thus, the affect-regulating, relational aspects of psychotherapy may forge new neural pathways that promote the development of the mind (Wilkinson, 2006).

THE CASE OF EMMA: REGAINING HER FOOTING

A concerned mother, Ms. D, contacted me late one summer and requested therapy for her eight-year-old daughter, Emma. Ms. D had terminal cancer and had already outlived medical expectations. Though Emma had been athletic and sure-footed, she was reacting to her mother's illness with anger, fearfulness, accident-prone behavior, and somatic complaints. During a family ski trip, she was afraid of difficult slopes that she had previously mastered. Once during gymnastics, she fell and reportedly lost sensation in one foot. Doctors found no physical basis for her paralysis, which subsided within a few days. It seemed that Emma lost her footing, so to speak, amid intense anxiety. I saw her for individual therapy twice per week for a year and once weekly for another year, with occasional parent consultation. Her mother died eight months into Emma's treatment.

Ms. D met her husband abroad and he emigrated from Belgium to marry her. He owned a business; she was a homemaker. Emma had one older brother, excelled at school, and had many friends. She and her family seemed to have it all—a large home, vacation cabin, trips to Europe each summer. Both parents seemed self-absorbed, but were in their own therapy dealing with childhood issues. When Ms. D was diagnosed with inoperable cancer, they referred both children for therapy.

Emma was so involved with extracurricular activities that therapy sessions followed one or two activities after school. I did not often see her parents, in that a nanny usually transported Emma to my office. Emotionally constricted, Emma avoided any mention of her mother's illness, instead chatting about school and activities. When I suggested that her schedule left no time to play with friends (without mentioning a lack of energy for therapy), she replied that her activities were her friends. I suspected some parental collusion to keep Emma too busy to think or feel, in that her mother scheduled the activities.

After I introduced Emma to the sandtray, toys, games, and art materials in my office, she gravitated toward the sandtray without ever using the other items. I used the Kalffian Sandplay Technique in conjunction with a relational psychoanalytic orientation. Though Emma initially created pleasant, organized pictures in the sand, she soon began showing her vulnerability by introducing dangerous elements into her scenes, such as fire, volcanoes, dragons, and teeth-baring animals. She agreed with me that the world can be a frightening place at times. When volcanoes appeared in multiple scenes, I asked what she thought about them. She explained that her family had vacationed in Hawaii last year and saw an active volcano. She smiled slightly, reminiscing about how they snorkeled, bicycled, and "did everything together." When asked if that was unusual, she replied affirmatively, with a slight edge in her voice. In contrast, when the family went skiing, she and her brother were enrolled in ski classes almost every day while her parents skied on their own. I commented that she sounded angry, and she acknowledged her resentment that family members often spent vacations doing things separately. Whereas I had anticipated a strictly malevolent interpretation of the volcano, for Emma it brought forth memories of family togetherness in Hawaii, as well as underlying anger about their lack of togetherness during ski trips. I also suspect that she was angry about being cheated of future opportunities for togetherness with her mother. I did not say this aloud, however, because Emma had not yet directly broached her mother's terminal condition.

Over the next months, the sandtray scenes became more chaotic and deintegrated, revealing what Emma could not yet express in words about her mother's illness. Perhaps there was not yet a space to consciously know or anticipate certain things. Emma created scenes that included malevolent figures surrounded by fences, as if she were trying to wall off the danger and feelings of vulnerability. She included superheroes, suggesting desires for rescue and protection. I initially confined my comments to the figures in the scenes. About four months into treatment, I said, “It must be hard for you to go on with life as usual when your mom is so sick.” Emma did not verbally respond, but her eyes widened. Nonetheless, I did not realize how much I upset her by interpreting outside the displacement. My interpretation probably was premature in that Emma still had not spoken directly about her mother’s illness or prognosis. In retrospect, my statement might have been an enactment reflecting my own panic and countertransference—in reaction to my childhood fears and my worry that I was not helping enough.

I have not yet lost my mother, but my thoughts wandered to my life at age eleven when my grandmother was diagnosed with cancer. My father had gone to war in Vietnam, so my mother, sisters, and I moved close to relatives. The purpose of the move was to obtain additional support and also to help my grandmother. Soon after our arrival, I spent two weeks with her, picking berries, making soup, and learning to sew. It seemed idyllic, like Emma and her trip to Hawaii. As my grandmother endured surgeries, chemotherapy, and radiation, my idealized memories intermingled with disturbing images of prosthetic breasts, her nausea, newscasts from Vietnam. When she developed a lingering cough, my mother gave cough syrup to her, as if that would help. As the cancer spread, my grandmother was dying, yet no one talked about it. My fear and helplessness clearly were akin to what Emma was now trying to ward off. So how could I have used this countertransference in treating her? I might have been more aware that Emma usually showed little outward emotion and had displaced her feelings onto the figures in her sandplay rather than discussing her mother’s illness. Hence, I might have confined my comments to the sandplay until Emma showed more affect or spoke about the illness.

The day after my premature interpretation, Ms. D telephoned to say that Emma wanted to discontinue therapy. Ms. D agreed to bring Emma to her session the next day to talk about it. I felt guilty and inadequate, as if I had injured the child. These feelings intensified when she arrived with a glum facial expression, carrying a huge teddy bear and walking slowly as if her shoes were weighted with concrete. After she sat down, I attempted to repair the rupture. I told her that I was here to help with her feelings. I could see that she was not ready to talk, however, so we could focus on other things. She did not respond verbally, but went to work in the sandtray. She created another scene with malevolent figures and superheroes, then asked if she could invite her mother in to see it. It was as if Emma herself wanted to be seen by her mother. When Ms. D came in, she did not stand back and admire the tray as most parents do. She giggled and, without asking permission, excitedly began adding figures to the scene. Piqued with curiosity, Emma joined her mother. They talked about the scene and rearranged figures. This was an unplanned event, clearly a warm, shared, mother-daughter experience that Emma craved.

The figures that Ms. D placed in the sandtray included Snow White, the seven dwarves, and a witch holding a poisoned apple. I wondered if Ms. D felt poisoned by the cancer and medicines invading her body. I did not verbalize my thoughts because it seemed intrusive, given that she is not my client. Nonetheless, the sandplay process somehow lowered her defenses and freed her to start talking to her daughter. I suspect that they had not had many conversations about the illness, each one frightened and trying to shield the other. After exhausting all available medical treatments, Ms. D recently had begun a non-medical intervention, wearing a gadget to receive radio waves. I thought to myself that she longed for a magical rescue much like Snow White's. She showed bright affect, claiming to feel better and more energetic than she had for months. Though I worried that she intensified Emma's denial, the session was a turning point as Emma and I began talking more openly about things. Not only was the therapeutic rupture repaired, the mother and daughter's unspoken contract for silence finally was rescinded. I remained cautious in my subsequent interpretations, however, fearful of scaring away Emma when she most needed emotional support.

Ms. D's vitality was short-lived. Within three weeks, her cancer became more aggressive than ever, sapping her strength. Ms. D spent most of her remaining days in bed, but still managed Emma's daily schedule and accomplished a few maternal tasks. Emma became increasingly quiet, sad, and withdrawn, walking slowly into the office and slumping on the sofa. In one session, she sat silently gazing at her fingernails. When I asked what she was thinking, she responded that her mother had just cut her nails for her, which was something that nobody else ever did. Suddenly, Emma implored, "But who will cut my nails . . . ?" This anguished question said it all: nobody has a close investment in the child's body like a mother does, and her mother would not be cutting her nails much longer. These small, special things about a mother are what a child will miss the most. Emma and I began talking about the future. Her father had reassured her that he or a close family friend would take over most of her mother's jobs . . . but Emma knew that no one could replace her mother. Emma cried a little that day, and I stifled tears, too.

This was the most difficult period of Emma's therapy for me. I became a mother for the first time just before I started seeing Emma, and now I felt really sad for both Emma and her mother. I tried to contain my distress so that I could validate and contain Emma's helplessness and anxiety as her mother's condition deteriorated. At that point Emma created a scene with nothing but a volcano in the middle of an otherwise barren sandtray. It had the appearance of either a breast or volcano, but dry or depleted. Emma's pain and suffering were palpable. I thought that an interpretation would be intrusive, so I sat silently to help her to bear the unbearable and tolerate her overwhelming affect.

Soon thereafter, Ms. D lapsed into a coma and died. Emma was absent from therapy for two weeks. Friends brought meals to the home and assisted her grieving father with childcare and household responsibilities. Numerous people attended Ms. D's memorial service. Afterward, the family members donated a park bench in her memory. They also planned to go to their cabin that summer to scatter her ashes and erect a cross. Emma was understandably sad, quiet, and listless upon her return to therapy. She spoke about some of the events of the past two weeks. I met with her father, who told me that he had returned to work and was managing the household with help from others.

A few weeks later, before the family left for the cabin and then Europe, Emma created a poignant scene in the sandtray. It was a cabin amid the mountains, forest, and animals, a white cross erected prominently atop a hill. The scene prompted me to think about my grandmother's death soon after my father's return from war and our family move to the east coast. I was not permitted to attend the funeral, which delayed my mourning. I considered it healthy that Emma was included in her family's grieving rituals, and I felt honored to witness her sandplay ritual. Emma was sad, but nodded when I suggested that she had chosen a beautiful site for the cross.

Upon returning from Europe, Mr. D announced that Emma wanted to decrease the frequency of her sessions to once per week. I worried that it was not the best time to do so, but he had already made the decision. I wondered to myself whether he was jealously trying to prevent me from becoming as, or more, important to Emma than he was. When she returned to therapy, she told me that her time in Europe had been different this year because her mother was not there and her father spent a lot of time doing things with the children. Perhaps this made Emma something of an oedipal victor, now being the only female in the family, with no competition from her mother for her father's attention. At the same time, I knew that Emma needed his comfort and nurturance. During therapy sessions, she avoided talking about her mother, and instead focused on her return to school and extracurricular activities. Her father's jealousy of Emma's relationship with me seemingly forecast her jealousy of the new woman who would enter his life.

Mr. D began dating that fall and soon got involved in a serious relationship. Emma initially welcomed this woman as if she were a mother-substitute, but became jealous and resentful when her father began spending more time away from home. Emma busied herself with school, friends, and activities, which is appropriate for a ten-year-old child, but this activity also served to avoid strong affect. During therapy, she seldom engaged in sandplay or talked about negative feelings. However, these sessions interspersed with others in which she continued the grieving process, such as her first holidays without her mother. Emma gradually developed relationships with adult female friends of the family.

Near the first anniversary of Ms. D's death, Emma created a lovely sandtray scene with a volcano in the center, surrounded by forest, flowers, birds, and other animals. I thought to myself that volcanic eruptions cause destruction, but fertilize the soil and foster new life. Emma had lost her mother in reality, but not her internalized image. Indeed, Emma reminisced about her mother and their similarities and differences. Thus, Emma was dealing with identity issues, as was appropriate for a pre-adolescent girl. It was not long until she asked to discontinue therapy. Though still not as emotionally expressive as I would have liked, she had grieved her mother with external support, resumed age-appropriate activities without interfering symptoms, and developed new attachments. I knew that Emma would continue mourning over time as her ego functions matured. Hence, I saw it as a "good enough" termination (Gabbard, 2009). Emma and I met for two more months, said our goodbyes, and she scampered out of my office.

TREATING CHILDREN'S TRAUMATIC BEREAVEMENT

Parental loss is especially traumatic if the child has lost several family members at once, or the death was untimely, unanticipated, or violent (E. Furman, 1986). The primary response to bereavement is grief, which consists of deep sorrow, painful regret, or distress over a loss, whereas trauma elicits massive anxiety (Blum, 2003). Similarly, anniversary reactions in grief usually consist of depressive episodes, while traumatized individuals might have an anxiety attack. Typical grieving does not involve posttraumatic stress disorder (American Psychiatric Association, 1994), or PTSD.

The classical psychoanalytic view of trauma is that stimuli from an internal or external danger overwhelm the ego (A. Freud, 1964; S. Freud, 1920). Reparative and defensive measures include withdrawal, avoidance of stimuli, insistence on sameness, a focus on things instead of people because the latter are less predictable, and frantic separation anxiety. The psyche gradually begins to bind excess stimuli, consisting of a repetition compulsion until all stimuli are mastered and brought under ego control (Freud, 1920). The two types of repetition are (1) the pre-ego process of a compulsion to repeat the traumatic event in a rigid, unchanging manner and (2) an ego mechanism in which the trauma is repeated in varying forms suitable for assimilation, such as turning passive into active. This repair occurs as the patient stops identifying with submissive victims and instead takes an active role in dealing with the traumatic event, sometimes identifying with the aggressor. The transition from pre-ego to ego mechanisms signifies progress. Another sign of progress is that trauma states are not random, but occur in reaction to specific reminders of the trauma. Eventually, recurrences may occur, and, when they are in the therapy, they may be linked to the transference. With reemerging ego functions, the child can resume development.

Repeated exposure to violence causes regression to mental states prior to symbol formation, shielding the child from awareness of his or her own violent tendencies (Bragin, 2005). Two kinds of identification may follow trauma: (1) identification with the dead, to avoid survivor guilt, and (2) identification with the aggressor, to feel empowered (Garland, 2004). The child may experience revenge fantasies, thus blurring distinctions between victim and perpetrator (Lemma, 2004). Ultimately, the child must come to terms with his or her vulnerability and destructiveness (Levy & Young, 2004).

Some trauma specialists believe that trauma is encoded differently from most memories. Terr (1988) suggested that trauma is encoded in implicit, procedural memory, which is not affected by explicit knowledge. Other trauma specialists suggest that traumatic memories do not fundamentally differ from other memory processes (Bohleber, 2007), and overlapping features of implicit and explicit memory suggest that these systems are not entirely separate (Gaensbauer, 1995).

There is major disagreement about whether it is helpful to discuss a trauma. Some clinicians consider it retraumatizing to analyze or otherwise eradicate defenses against remembering the event (Terr, 1991). Clinicians who assume that trauma is stored in implicit memory see little point in attempting to put such memory into words (Busch, 2004). Stern and colleagues (1998) believe that healing involves the reexperiencing and modifying of procedural memories in the analytic relationship by some aspect of the emotional interaction between the child and analyst. Another view is that, if traumatic memories do not differ fundamentally from other memory processes, trauma should be accessible to verbal analysis much like other unknown thoughts, feelings, and experiences.

Some analysts believe that even shock trauma requires reconstruction and remembrance (Bohleber, 2007). In the treatment validation and ego support are essential, suggesting that the therapist must acknowledge the real experience and not just fantasy (Levy, 2004). The patient should be helped to convey the sensory/affective experience while reflecting on thoughts/feelings connected with the event (Herman, 1992). As affects are named and tamed, anxiety is alleviated and converted to signal anxiety (Blum, 2003). The patient comes to realize that recalling trauma is not equivalent to reexperiencing it and that the event belongs in past history (van der Kolk, McFarlane, & van der Hart, 1996).

Early relational traumas may hamper development of right-side brain functions, resulting in pervasive developmental problems, including emotional dysregulation, attachment disorders, and an immature sense of self

(Schore, 2001). When traumas occur prior to age three to four years, memories are likely to be preverbal and, hence, unavailable for conscious processing (Gaensbauer, 1995). Healing involves a reexperiencing and modifying of procedural memories within the analytic relationship (Stern et al., 1998).

THE CASE OF KIKI: GROWING INTO BIGGER SHOES

Two years ago, a therapist on the west coast contacted me to refer a girl who was moving to Texas. My gut knotted when the therapist told me that the girl had been exposed to domestic violence and ultimately witnessed her father murder her mother. For a year while the girl was in foster care and relatives battled for custody, the therapist provided pro bono services as part of a national program for foster youth, A Home Within.[2] I agreed to continue the free therapy after the girl was placed with her aunt in a town near my office. When the aunt telephoned for an appointment, it turned out that the girl had two younger siblings who also needed treatment. The aunt had neither the time nor resources to take them to separate appointments each week, so I agreed to work with all three, which is not something that I usually do. This report will focus on Kiki, the middle child and only girl, almost eight years old when I started treating her. I saw her individually and occasionally in a sibling group once per week for the first year, once every other week the next six months, and one to two times per month since then. This plan was less frequent than optimal owing to the family's chaos and constraints.

Kiki's parents were college-educated professionals who married in their native country in Africa. They emigrated to the United States in search of a better life and settled on the west coast, where her father had relatives. The three children were born in the United States as their parents' relationship was unraveling. Their father was underemployed or unemployed, whereas their mother advanced her education and career in a healthcare field. She worked the evening shift, leaving the children with their father or babysitters. Marital strain led to domestic violence, separations, and reconciliations.

I have virtually no information about Kiki's early development. When Kiki was almost seven years old, her mother decided to pursue divorce. The papers had not yet been filed when Kiki's maternal grandfather died from a heart attack. Her mother went to Africa for two weeks to attend the funeral. When she returned to the United States after Christmas, her estranged husband unexpectedly met her at the airport to drive her home. Upon arrival, a bitter argument ensued and quickly became violent. The father ordered the children to the basement, but they came back upstairs just as he wielded a knife. The children screamed for him to stop as he stabbed their mother to death. Kiki's father ushered the children into the car and led authorities on a high-speed chase. Police vehicles surrounded the car, which crashed into several vehicles before coming to a stop. The children did not suffer serious physical injuries, but their emotional trauma was horrendous. Their father was arrested and ultimately sentenced to a long prison term.

When the children entered a foster home, they were so frightened that they huddled together under the beds rather than sleeping atop them. They received individual therapy for the next year while relatives battled for custody. Though the children had close relationships with paternal relatives in the area, the judge awarded custody to a maternal aunt in Texas. The children barely knew this aunt who planned to adopt them. Kiki thus experienced multiple losses: her mother to murder, her father to prison, contact with relatives and foster parents, home and familiar surroundings, and trust in her father and the world. A year after the murder, Kiki still experienced nightmares, emotional outbursts, nocturnal enuresis, hoarding of food, weight gain, and underachievement.

Although Aunt “Ida” cared a great deal for the children, she was chronically stressed and easily overwhelmed. She told me that she and her younger sister (Kiki’s mother) came from a good family: their grandfather was a tribal chief, their father a church bishop, their mother a retired educator. Ida was a college-educated professional in Africa prior to coming to the United States three years ago. She and her husband had their first child a few months before Kiki’s grandfather died suddenly of natural causes and her sister was murdered. Ida was grief-stricken about their deaths, enraged with her brother-in-law, easily exasperated with the children. Kiki’s widowed grandmother joined the family in Texas in order to assist Ida with the children. Ida also found some support in the local West African community and her fundamentalist religion. Since her family size had doubled, she and her husband struggled to pay bills. He held two jobs, but lost one due to downsizing and became a full-time truck driver. Ida worked part-time as a janitor while trying to pass her licensing examination in Texas. She drove a long distance to the children’s therapy sessions, but her vehicle was unreliable and it was a year before she could afford another. It seemed as if there always was some sort of crisis.

Concurrently with treating Kiki and her siblings, I provided validation and guidance to shore up Ida’s ability to contain their emotions. I suggested that Ida needed to take care of herself in order to be able to care for the children. She had not had the time or opportunity to mourn, and became tearful whenever she talked about the deaths of her father and sister. Ida was traumatized when attending the murder trial, especially after her brother-in-law threatened her, too. I validated her need to talk, cry, and grieve her losses, suggesting that she make time and space for mourning. She tried not to show her feelings in front of the children, but neither her suppression nor flooding was beneficial to them.

Ida was frustrated by the children’s bedwetting and perturbed by their fighting. She viewed the aggression as a sign that the children could become homicidal like their father, so she imposed strict punishments for fighting and other rule violations. She became defensive, as if I were criticizing her when I suggested that some of their aggression was normal, some of their behavior was symptomatic of trauma, or shorter restrictions might be more developmentally appropriate. No matter how gently I offered suggestions, these interactions ended with Ida becoming visibly annoyed. Sensing that I needed to strengthen my connection with her, I disclosed that I, too, was an adoptive mother. I said that I knew firsthand how difficult it was to rear an older adopted child, especially a traumatized child. I immediately sensed Ida’s relief and decreased defensiveness. I believe that my self-disclosure helped Ida to discuss her difficulties in parenting without feeling judged. She showed a more collegial stance in consulting with me, sometimes mentioning that both of us were professionals and adoptive mothers.

When Ida subsequently expressed concern about the children’s behavior, she and I talked about developmental norms and sibling rivalry versus trauma symptoms. She gradually developed increased understanding of their actions and emotions, coming to view the children as troubled rather than bad. She and I discussed positive and age-appropriate ways of intervening in their maladaptive behavior at home. When her rules were too strict, we talked about religious and cultural influences, child development, and American childrearing practices. I expressed concern that the children did not have friends, and told Ida that American parents usually arranged play dates to help their children develop friendships. Ida responded that she was reluctant to do so because she lived in a “bad neighborhood,” did not trust her neighbors, and felt shame about the condition of her apartment. I suspect that her concerns were partly realistic, but exaggerated by her own trauma and her uneasiness with American culture. Therefore, I suggested supervised extracurricular activities for the children.

I first met with Kiki a week after her move to Texas. She was like a messy toddler, with food stains on her clothes, her hair and clothing disheveled. She did not put her feet all the way into her shoes, so the backs of the shoes were squashed like flat tires. She showed bright affect, referred to her aunt as “Mom,” readily accompanied me to my office, and conversed as if she always knew me. Given Kiki’s affect dysregulation, over-familiarity with relative strangers, and history of frequent maternal absences, parents’ violence and marital separations, multiple babysitters, and the losses of her mother, father, and foster parents, I wondered to myself about the possibility of an attachment disorder, disinhibited type (American Psychiatric Association, 1994). Kiki chattered nonstop and explored my office like a whirlwind, touching everything, handling toys, and throwing them down. When I gave a granola bar to her, she got crumbs everywhere, asked for another, and protested when I told her that I only gave one per child. The next weeks, she complained about how few Christmas gifts she received. I said that it must be hard not to get what she wanted.

Rather than summarizing the entire treatment, I will focus on a few prevalent themes and incidents, and describe how I addressed them. From the beginning, I served as a developmental object, accepting Kiki's initial messiness, but showing interest in her physical maturation and appearance in order to help her to internalize self-care and a positive self-image. Kiki and I began sitting at the table in the conference room when she ate a snack and then cleaned the mess together. Once she became neater, I permitted her to eat in my office. I paid attention to her clothing, reminding her to fasten her shoes, and so forth. I carefully tracked her play, asking questions or making comments (to help her focus), suggesting that she finish an activity (to foster goal-direction), and helping her to put away one set of toys before starting to play with another (to facilitate organization). Her play gradually became less chaotic and disorganized. When Kiki got new shoes, I inquired about the size and her growth. She got her first eyeglasses a year into the treatment, and we compared glasses frames and talked about how nice it was to see things in detail. While playing the board game of Guess Who, it turned out that she did not know the meaning of the term "African-American." We subsequently discussed our human similarities and racial differences. Over time, she became more neat and organized, taking pride in her appearance and the emergence of new skills.

Kiki utilized a variety of toys as well as the sandtray. With regard to sandplay, I used the Kalffian technique embedded in psychoanalytic talk and play therapy. Rather than creating a static picture in the sandtray, Kiki initially played like a younger child, using the miniatures to engage in actions. I quickly noticed a mechanistic, rigid quality to her play scenes, invariably consisting of one group of soldiers or other people completely obliterating the other group. For several sessions, she enacted the same event in the sand, seemingly identifying with the victims. I recognized this as a pre-ego repetition compulsion (Freud, 1920), or traumatic reenactment (Gil, 1998), and became concerned when I saw no sign that the play was progressing toward ego mastery after a few months. Though I am typically nondirective in sandplay in accordance with the Kalffian tradition, in this case I tried a directive technique that I once saw Eliana Gil (1998, 2006) demonstrate. The next time that Kiki began enacting the battle scene, I handed a rescue vehicle to her and said, "Here! This might help." I later made a similar prompt and, on other occasions, handed a cannon and additional soldiers to her to reinforce her troops. Kiki started incorporating figures associated with protection and finally began fighting back. The protective figures and passive-to-active stance each suggested that she was starting to assimilate the trauma. In response to my direct intervention, Kiki's sandplay scenes evolved. From the dyadic sandplay process came psychic repair and the emergence of ego mechanisms in which the trauma was repeated in changing forms as it was mastered and assimilated in play.

Kiki's sense of victimization was the most pronounced longstanding theme in her therapy. Kiki constantly complained that she had no friends, her classmates and brothers were mean to her, and adults were unfair. However, she almost invited disappointment by making undue demands of others and interpreting benign remarks as critical. When she did not get her way, she whined, pouted, cried, or yelled. Not surprisingly, Kiki's behavior elicited rejection and antagonism more often than sympathy. I saw her actions as a reenactment of parental dynamics: Kiki identified with her mother's victimization and projected her own hostility onto others. While this awareness fostered empathy on my part, I also tried to foster mentalization on her part (Fonagy et al., 2002), "How might others feel when you . . . ?"

Kiki's feelings of victimization surfaced in the transference with me. When I met individually with Kiki and siblings, Kiki always asked to be first, then yelled when told no. She often entered my office with a scowl, her arms crossed across her chest, her lower lip puckered. In response to this pouting I felt more anger than I usually experience toward children, a reaction that I came to recognize as a projective identification. Melanie Klein (1946) described projective identification as a two-fold intrapsychic and object relational process in which an infant, child (or client) projects a difficult or unacknowledged aspect of him- or herself onto its mother (or therapist) who, in turn, introjects the projected characteristics. When the mother or therapist recognizes the projection and metabolizes it, the infant or child can identify with the metabolized projection, and can then take back the projections in the metabolized form, thereby fostering intrapsychic development.

In Kiki's therapy, projective identification occurred as a communication and transference (Ogden, 1982). Kiki was identifying with her mother's maltreatment and victimization, but split off her own hostility and projected it onto me. Though I initially introjected the hostility without conscious awareness, the relative magnitude of my anger piqued my curiosity. As I came to see what was happening in the transference, my anger became more conscious and ego-dystonic. This enabled me to metabolize my projected feelings and respond more therapeutically. Kiki's pouting and my annoyance subsided as I began to empathize with her thwarted wish to be special and have more attention. Over time, Kiki was able to integrate and understand some of her aggression.

Other prominent themes were related to Kiki's feelings of deprivation and her insatiable hunger. Her early sandtray scenes often included miniature food items, usually all the toy foods. When I asked her about her request for more snacks, Kiki replied that she never got enough to eat and always felt hungry. I commented how uncomfortable that must be. I asked if her aunt, whom she now called "Auntie," was a good cook, and I got a lukewarm response. When I asked Kiki if her mother was a good cook, I got an enthusiastic, "Yes!" Kiki told me that her favorite food was her mother's pancakes. She and I already had discussed the loss of her mother, so I interpreted, "It sounds like you really enjoyed your mother's pancakes. It must make you very hungry to know that you can't have them anymore." Kiki responded wistfully, "Yes, it does." On another occasion, I said that no matter how much food she hid in her room, it could never make up for those pancakes. I also said that maybe she could learn to enjoy other foods and feel full again, though she might always miss the pancakes. Over time, her food obsession diminished and she became slimmer.

The first spring Kiki had a three-week break from therapy due to illnesses in her family. Upon her return, she greeted me with a grin, then appeared puzzled. She asked, as if I were the one who had been gone, "Where were you?!" I agreed that it had been quite awhile since we last saw each other, acknowledging that she no longer saw some adults who had been part of her life. I said that I had been here at my office, however, waiting for her. Soon afterward, she went through a period of burying and unburying items in the sandtray. I wondered to myself if she was trying to master her separation anxiety or symbolically seek the lost object. I stated that she did not want to lose things. Whenever possible, I tried to allay her anxiety by preparing her for breaks in our work.

Kiki's sandplay scenes gradually became more varied and organized. On one occasion, Kiki created a scene containing a family group, fairy tale characters, balloons, and so forth. When I invited her comments, she described a previous family trip to Disneyland, where everyone had fun. She said that she missed both parents and having her family together. If not for the sandplay scene, I am not sure how long it would have taken to access her tender feelings about her father. However, Kiki also had difficulty integrating her feelings about him.

When her paternal aunt and uncle visited a few weeks later, her aunt asked the children if they wanted to exchange letters with their father in prison. Following the visit, Aunt Ida told me that Kiki had not had a nightmare for weeks, but that she had one during her relatives' visit. It was about a man chasing and trying to harm her. I viewed this as a traumatic reaction to the reminder of her father and his violence during his families' visit. On the other hand, it was progress that Kiki's nightmares were decreasing and this one seemed to be triggered by a trauma-specific reminder. I asked Kiki for her thoughts and details about the dream, but she simply stated that a man was chasing her and she was scared. She said that it was like many of her dreams, but she had little curiosity about why the dream occurred at this particular point in time. She usually was more talkative, but it seemed as if the potential space (Winnicott, 1953) had collapsed in the face of trauma, leaving no room for fantasy or symbolism. I reassured her that it was only a dream, and dreams cannot hurt people. I explained that although people argue, most of them do not injure others as her father had. I said that he would remain in prison until Kiki was an adult. She and I had similar discussions on other occasions when she became frightened of him. I pointed out that she could better protect herself from harm as she got older, bigger, and stronger.

That summer Kiki showed up for therapy one day with braided hair extensions all over her head. She told me that her mother had the same style on the day she came back from Africa. Although Kiki and I had many talks about her mother, this was the first mention of the day of the murder. I asked Kiki, “What else do you remember about that day?” She replied that her father drove her mother home from the airport, “then they got in a big fight and he did this.” Kiki demonstrated by grabbing her collar, pulling herself forward, and pretending to choke herself, her eyes bulging. I said, “That’s awful! You were just a little girl, and couldn’t stop him or help her.” Kiki nodded silently. When I asked if she remembered anything else, she described the high-speed car chase and car crash, then mentioned that a “nice policeman” took the children to McDonald’s to eat.

I knew that Kiki had witnessed the stabbing because her older brother had testified that all three children were present. However, I did not know if she had amnesia or chose not to discuss the stabbing. I did not ask for more details for fear of retraumatizing her, given that she did not volunteer more, nor had she previously alluded to the stabbing or enacted it in play. In general I feel comfortable exploring a traumatic event if the child initiates the discussion or volunteers details in response to one or two open-ended questions. Trauma can be processed in the displacement if the child reenacts it in play or offers details in dreams. Otherwise, I think it is important to avoid implanting information, hammering a child with questions, or retraumatizing the child if he or she is actively avoiding the topic. This avoidance could indicate that the child does not yet have the inner resources to directly face the trauma. Moreover, Kiki’s demonstration of her father choking her mother until her eyes bulged had sufficiently validated the reality of his violence even if no further details had surfaced. Thus, there seemed to be no therapeutic reason to dredge up gory details.

Kiki’s demonstration of her father’s violence rekindled memories of my prior employment in a maximum-security juvenile correctional facility for five years. While treating juvenile homicidal offenders, I heard detail after grisly detail about the murders that they committed. I experienced secondary trauma (Figley, 1995; McCann & Pearlman, 1990), including repetitive fantasies and intrusive memories of the scenes that the youth described. Indeed, even in writing this chapter, I had a nightmare about being attacked by a man while three young figures watched in silent horror. This clearly was an identification with Kiki and her siblings and/or her mother, and yet I am an adult who did not directly witness their mother's murder. As such, it is difficult to fathom the full extent of Kiki's terror and emotional paralysis. I experienced a maternal sort of protectiveness in wanting to shield her from further psychic pain.

A year into treatment, Ida took the children on their first trip to Africa to meet their relatives and visit their mother's grave. I spent several sessions preparing Kiki by talking with her about the coming events, suggesting that she might remember things that she had not thought about for a long time. We talked about death—how people cannot see, hear, or feel anything after they die. I let Kiki choose one of my miniature figures to take with her. I thought it might help her to have a concrete reminder of a soothing object. My rationale was that Kiki still had not fully developed object constancy and might regress under stress. A concrete toy would not be necessary if she had a real caregiver available for emotional support, but in Kiki's situation Ida was grief-stricken and Kiki did not know her relatives in Africa. In retrospect, I believe that the miniature figure served its intended purpose. When Kiki returned to the United States and my office, she returned the figure to me. As she showed photos to me of family members and her mother's grave, Kiki was able to talk about her feelings without reliving them. A few months later, Ida took the children to the west coast for a court hearing to finalize their adoption. Prior to departure, I spoke to the children about what it meant to be adopted. Ida would care for them as a substitute mother, but could not replace their birth mother, nor would they forget their mother.

Following a break the second summer, Ida contacted me to say that the children asked to meet with me. It showed significant progress that they knew that I was here and could ask for me. I started the session by inviting the children into my office for a snack. Kiki smiled radiantly and acted as spokesperson. She stated each child's age, grade level at school, and shoe size, then announced, "*None* of us wet the bed anymore!"

Kiki still has nightmares and feels mistreated occasionally, but her internal objects are less malevolent, her anxiety decreased, her self-regulation and self-agency improved. She has friends and shows satisfactory achievement at school. She was able to begin the process of mourning for her mother, though I presume the process will continue as Kiki's ego functioning matures. Kiki tends to idealize her mother and still has not worked through all of her feelings about her father, but these are complicated issues even for an adult. I anticipate that Kiki and her siblings will continue to progress with time, maturity, and external support.

DISCUSSION AND CONCLUSIONS

Despite prior controversy about whether children have the capacity to mourn a parent's death, most current data suggests that even young children can do so with external support and within the confines of their age, development, personality, the nature of the relationship, and the circumstances of the death. Children encounter difficulty in grieving when there are internal impediments or a lack of external support. In the case of eight-year-old Emma, she had an emotionally avoidant personality style. Though her parents consciously wanted to help her, there was parental collusion for her to stay too busy to think or feel about her mother's terminal illness. Emma formerly was athletic and sure-footed, but became fearful and lost her footing in the face of great stress. She communicated through action what she could not yet put into words. While play can be healing in and of itself, play therapy offers a transitional space (Winnicott, 1953) and opportunity to work in the displacement.

I find the nonverbal symbolic process of sandplay to be particularly useful with latency-age emotionally avoidant children such as Emma, who otherwise tend to back away from fantasy play, and who have difficulty talking about feelings. The sandplay process brought forth powerful memories for her, which elucidated her family dynamics and current emotions. When her mother attended a session, the mother and daughter collaborated on a sandtray scene, and they began to talk about her illness. This freed Emma to talk, too. Emma began to process issues directly, yet she also used sandplay to express feelings that she was not ready to verbalize. She deeply grieved her mother's subsequent death. As Emma's grieving subsided, she regained her footing, and she actively reengaged with the world.

In contrast to Emma, Kiki was severely traumatized by years of exposure to domestic violence, culminating in her mother's murder. She sustained multiple losses: her mother to homicide, her father to prison, contact with her foster mother and paternal relatives, her home and community, and her trust in the world at large. Kiki had identified with her mother as a victim and she projected her hostility. She did not receive adequate containment in her new home in that her aunt was grief-stricken and emotionally overwhelmed. Moreover, the frequency of therapy sessions was less than optimal due to the family's chaos and constraints. It is standard practice for child therapists to work with parents, but it is essential when caregivers are too overwhelmed to meet the child's emotional needs.

I believe that severely traumatized children require a directive approach and active intervention to reduce their acute anxiety before they really begin to mourn. This is especially true when they lack object constancy and therapy sessions are relatively infrequent. Initially, Kiki was stuck in pre-ego repetition compulsions in her sandplay battle scenes, which showed little signs of progressing to ego mastery. On several occasions, I moved the play along by handing a rescue vehicle or additional soldiers to her. I also educated her about death and separated her mental symptoms from the actual trauma. The early phase of therapy emphasized my role as a developmental object.

Once Kiki showed less anxiety, she was able to begin mourning. Some of this involved a reexperiencing and modifying of procedural memories in the therapeutic relationship. Over time her victim stance lessened, and Kiki showed occasional identification with the aggressor. Despite ongoing controversy about whether it is retraumatizing to discuss a serious trauma, it seems warranted when the issue is conscious, though I see no reason to dwell on the gruesome details of a murder. Once Kiki was better able to tolerate her feelings, I was able to effectively utilize a psychodynamic approach with her. She worked in the displacement in play therapy and in the transference with me. Sandplay was useful in elucidating her complex feelings about her father and providing clues about her inner world. Her traumatic symptoms subsided with increasing ego mastery. Literally and metaphorically, Kiki grew into bigger shoes.

Kiki and Emma both made significant progress in mourning their mothers, though their processes are ongoing. With Emma, my countertransference involved feelings of sadness and helplessness. In contrast, I initially responded to Kiki's victim stance with angry feelings that I later recognized as projective identification. I also experienced traumatic memories and a nightmare. I do not know if these differences are common in treating grief versus traumatic bereavement, but I would not be surprised. Throughout these treatments, my countertransference provided useful insights into salient issues, often before the girls could face their feelings directly or put them into words. I used my countertransference in combination with their clinical presentations to guide my interventions—to decide when to remain quiet, when to comment, and whether to interpret inside or outside the displacement. In retrospect, there were some technical issues that I might have handled differently. On the other hand, most enactments and ruptures can be processed and repaired, provided that the therapist has the client's best interest in mind. I believe that the most important aspect of my work with both Kiki and Emma was my willingness to accompany them on their therapeutic paths, to walk in their shoes. I was not fully prepared for the dark and rocky analytic terrain that we encountered, but we persevered. In summary, I am honored to have been a part of each girl's journey to recovery.

NOTES

1. The computer website for Sandplay Therapists of America, www.sandplay.org, offers information about Dora Kalff's Sandplay Technique. The website also contains references, education and training opportunities, certification criteria, and a membership directory.

2. A Home Within is a national organization dedicated to meeting the emotional needs of current and former foster children. The nonprofit program is based in San Francisco, California, and has chapters across the United States. Within the program, screened psychotherapists volunteer their time to meet weekly with a foster youth on a pro bono basis for as long as it takes to address the youth's issues. The program also provides professional consultation and training. For contacts and further information, refer to the program website at www.ahomewithin.org.

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Chapter Four

"My Daddy Is a Star in the Sky"

Understanding and Treating Traumatic Grief in Early Childhood

Chandra Ghosh Ippen, Alicia F. Lieberman,
and Joy D. Osofsky

Therapeutic support for the psychological healing of young children who have undergone traumatic experiences, particularly parental loss, is delicate work that must consider and include surviving caregivers. Chandra Ghosh Ippen, Alicia Lieberman, and Joy Osofsky have each made major contributions to the literature in this regard, and they further their substantive contributions to the literature in this chapter collaboration.

The reader of this chapter is skillfully introduced to the concepts of Childhood Traumatic Grief (CTG), in the cases of three young children who experienced the misfortune of events leading to CTG. The authors discuss an empirically validated method of relationship-based treatment as it is used with children ages 0–6, known as Child-Parent Psychotherapy-CTG (CPP-CTG), specifically designed for such children. CPP-CTG is grounded in psychoanalytic and attachment theories, as well as developmental, trauma-informed, social learning, and cognitive-behavioral therapeutic modalities. Play, memory-facilitation, fantasy-awareness, meaning-making, and caregiver support are all implemented. We are also reminded of the sociocultural influences that the therapist must take into consideration with sensitive mastery.

In each of the three cases, the authors share how the CPP-CTG aims to keep the child/surviving-caregiver unit central. The surviving caregiver needs to process the tragic events and to know both the potential and the limits of a grieving, remembering child. A vital feature of the approach is its flexibility. Each case involves a judiciously individualized application of the therapeutic method, with particular attention paid to the internal workings and reactions of the therapist. Readers will gain an understanding of how therapists who work with traumatized children might sensitively work toward building *psychic strength in both child and caregiver while simultaneously attending to their own psychic needs.* —Eds.

"My daddy is a star in the sky."
(Carolina, age 3, ethnicity: Mexican American)

"My mama sends me kisses with the butterflies."
(Leo, age 3, ethnicity: Caucasian)

"My mama loved clouds, and so do I. . . .
When Jesus comes, we will ascend and be together again."
(Desheon, age 5, ethnicity: African American)[1]

This chapter begins with the words of three young children, each of whom experienced the traumatic loss of a parent. Their words are bittersweet; pain and loss mixed with connection and love. When we work with young children who have had a traumatic loss, this is the essence of our work. Their words serve as a beacon, guiding and reminding us that young children are aware of and strongly feel the death and loss of significant people in their lives. They need to maintain their connection to their loved ones and process and make meaning of their experience in a way that is consistent with their family's beliefs. The words that begin this chapter may also affect the reader, highlighting that as we do this work, we will need to process our own reactions and support caregivers who may hear words like these on a daily basis.

This chapter shares clinical descriptions and research data gathered during our work with Carolina, Leo, Desheon and their caregivers. Rather than presenting their stories sequentially, the material is organized to illustrate key traumatic bereavement treatment processes, concepts, and themes and variability in the way themes may manifest themselves.

Unfortunately, like Carolina, Leo, and Desheon, approximately 3.5 percent of children in the United States have experienced the death of a parent (Social Security Administration, 2000). This is over ten times the prevalence rate of childhood cancer (Hewitt, Weiner, & Simone, 2003) and 13.5 times the rate of childhood diabetes (U.S. Department of Health and Human Services, 2011). In low-income, urban populations, traumatic loss may be even more widespread.

Several studies underscore the importance of developing comprehensive approaches for addressing parental loss in early childhood. Loss of a parent in childhood and subsequent negative events lead not only to greater risk for anxiety disorders and Posttraumatic Stress Disorder (PTSD) but to disruptions in neurophysiological functioning (Hagan, Luecken, Sandler, & Tein, 2010; Pfeffer, Altemus, Heo, & Jiang, 2007). Young children may be at particularly high risk because they depend on their caregivers for protection and emotional and neurophysiological regulation (Lieberman, Compton, Van Horn, & Ghosh Ippen, 2003; Osofsky, 2011). Moreover, during the first five years of life, important brain structures and key hormonal stress response systems are developing and thus are highly vulnerable to stress that may accompany parental loss (Watamura, Donzella, Kertes, & Gunnar, 2004).

While many children and families who have lost loved ones possess incredible resilience and do not show dysfunction, both research and clinical work indicate that the death of a parent in early childhood has the potential to disrupt the child's developmental trajectory (Dowdney, 2000). One study found that six months following the death of a parent, bereaved preschoolers reported feeling more scared and less happy than non-bereaved preschoolers and were rated by parents and teachers as having higher levels of behavior problems (Kranzler, Shaffer, Wasserman, & Davies, 1990).

Clinical work and research data both vividly illustrate these outcomes. When four-year-old Desheon entered treatment, he had already been expelled from kindergarten, sent back to preschool, and was in danger of being expelled from his current preschool. Although his grandparents did not note any problems in his behavior at home, his teachers rated him on the Caregiver-Teacher Report Form (C-TRF; Achenbach & Rescorla, 2000) as having clinically significant aggressive behavior (T=75) and oppositional defiant problems (T=73) as well as high externalizing (T=69) and total scores (T=67). To understand the severity of his symptoms, it may be helpful to understand that a T-score of 70 is two standard deviations higher than the mean; only 2.5 percent of children are said to have scores above 70. Carolina was 38 months old and not yet in school, but based on her mother's report on the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005), her total PTSD score (T=92) was over 3 standard deviations above the norm and was well above the cutoff for identifying PTSD (Briere, 2007). In addition, she showed problems in the areas of Anxiety (T=66) and Anger/Aggression (T=69) and clinically significant scores on Avoidance (T=103) and Arousal (T=95). A formal assessment was not conducted with 22 month old Leo due to the circumstances under which he entered treatment after both of his parents died. However, his current caregivers were concerned about his aggressive behaviors, which included hitting his aunt on the head, overwhelming temper tantrums, and inability to sleep if he was not being held by his aunt. All of these symptoms were expectable given the loss of his primary caregivers.

Desheon, Carolina, and Leo all showed symptoms of Childhood Traumatic Grief (CTG), a condition where traumatic memories, real or imagined, and trauma-related symptoms interfere with the child's capacity to mourn the loss of a loved one (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002; Layne, Warren, Saltzman, Fulton, Steinberg, & Pynoos, 2006). Their parents' deaths occurred under traumatic circumstances. When Desheon was four, his mother was killed while withdrawing money from a cash machine. He was not present and was never told what happened, but he had nightmares about her murder. Carolina's father was hit by a bus right in front of her when she was thirty-four months old. She watched as the ambulance took him away. Leo's mother was killed during an incidence of domestic violence when he was twenty-one months old. Shortly thereafter, his father committed suicide. Carolina, Leo, and Desheon had to cope not only with the daily pain of loss but also with memories, real and imagined, of the way their caregivers died.

In CTG, as with PTSD, stimuli linked to the traumatic event, called trauma reminders (Pynoos, Steinberg, & Piacentini, 1999), continue to trigger the child long after the event has ended leading to psychological and physiological disruptions and to possible avoidance of any stimuli the child may have connected to the traumatic events (e.g., objects, people, internal feelings). Carolina, for example, would become fearful any time she heard sirens. There had been so many sirens the day her father died. Her behavior shifted when the weather became hot because her father died during a heat wave. Her mother learned that sometimes when Carolina saw the color red, like in school when they painted with red paint, she would freeze. Her mother connected her reaction to the fact that they had seen blood in the street after her father was hit by the bus. Desheon was fascinated by weapons. He did not know how his mother died, but he had seen enough television to imagine that she had been killed by a knife or a gun. In school, when he found these objects, like a knife in a cooking set or a stick that might look like a weapon, he played with them in an aggressive way, telling people he was going to kill them. His teachers noted that lots of boys played with guns, but when Desheon did it, he seemed possessed. Cash machines and banks also triggered Desheon. His grandma noticed this right away, so she didn't take him there, but he pointed them out when they drove past them until she grew frustrated and told him to "stop looking for the bad guy at the bank because he wasn't there." Leo cried inconsolably at night. His mother had died at night. His aunt would sit with him, but nothing she did seemed to help him calm down. He also became very upset and ran around frantically whenever people were angry with one another. "No fight" he would say. His parents used to argue, and his mother had died during one of these fights.

In CTG, in addition to trauma reminders, the child and remaining caregivers must also contend with loss reminders (Layne et al., 2006). Loss reminders include anything that serves as a reminder of the person who died, such as objects connected to the person, the person's favorite holiday, reading a book about a family with two parents, seeing children being picked up by their parents, activities the child used to do with this person, daily caregiving routines (like bedtime, diaper changes, feeding), and even emotional states. When Desheon became frustrated in school, he would cry and say he missed his mother. His mother used to soothe him when he was frustrated. She gave him kisses and told him he could do it because he was her smart little man. As he started learning his letters, he thought of his mother because she had been teaching him to write his name. For Carolina, naptime at preschool brought back memories of cuddling with her dad during their mid-day siesta. When she saw her brother’s soccer ball, she remembered how her dad used to play soccer with them in the park. She no longer wanted to go to the park. When her uncle came to visit, she would run to him and then back up and seem angry with him. Her mother noted that Carolina needed to be respectful of her uncle but said it was hard for her to because he looked so much like her father. Leo, rather than being protected from loss by his young age, seemed to remember his mother at all times of the day. At first he would not eat. It seemed as though whenever he was hungry, he missed his mother. His auntie did not feed him in the same way. When she read him bedtime stories, she did not know how to make the same “choo choo” noise his mom made. She didn’t make the dinosaurs roar and say they didn’t want to sleep. Nothing was the same, and he showed in his behavior how acutely he felt the loss.

In CTG, not only are loss reminders painful in their own right, but they become linked to the traumatic experience (Pynoos, 1992). In the presence of a loss reminder, the child often thinks not only of the person who died but also how they died. These memories trigger and dysregulate the child and often lead the child to avoid any memory of the person who died. This in turn interferes with the child’s ability to accomplish key goals associated with bereavement, including accepting that the parent has died, fully experiencing emotional distress associated with the loss, remembering and holding on to important memories of the parent and of their relationship, making meaning of the death, and integrating the parent who has died into an ongoing sense of self (Cohen et al., 2002; Lieberman et al., 2003). As Pynoos (1992, p. 7) graphically but so clearly described, “it is difficult for a child to reminisce about his or her parent when an image of that parent’s mutilation is what first comes to mind.”

As Desheon, Carolina, and Leo began treatment, each showed impairment in their ability to speak about their dead parent that was unrelated to their young age. When family members spoke about Desheon’s mother, even to mention the things she enjoyed doing, Desheon would storm out and leave the room. Early in treatment when his therapist brought up his mother, he retreated under the table and began yelling “don’t talk about my mother.” During the assessment, Carolina’s mother noted that Carolina did not bring up her father even though he had been a primary caregiver. Her mother wondered if she had forgotten him. She hoped she had forgotten what had happened. She was waiting for Carolina to mention her dad, but as she never did, her mom thought perhaps it would hurt her to talk about him. In contrast, Leo asked about his mother incessantly. He searched for her. He asked to see her picture, but after looking at it, he would withdraw, curl up, and hide in the closet. He wanted very much to be connected to his mother, but it seemed as though remembering her caused him significant distress.

The loss of a parent in early childhood presents risks for the child's relationships with remaining caregivers. As was the case for Desheon and Leo, the child's challenging behaviors may be stressful and even triggering for a caregiver who is dealing with his or her own trauma and loss reactions. In some cases, the remaining caregiver's grief and trauma reactions, while understandable, may interfere with the caregiver's capacity to respond to the child in optimal ways. Initially when Leo would ask "mama mama?" his aunt would burst into tears as she thought about her sister's murder. She would turn on the tv so Leo could watch cartoons and would then lock herself in the bathroom and cry. "I know he needs me" she said, "but I just didn't know what to say. I can't even think of her without falling apart." When Leo's aunt would leave, Leo became even more triggered. He had learned that people you love can leave and never come back. Not only had his secure base, his mother, disappeared, he now needed desperately to find a new secure base, someone who could comfort him and help him regulate, when all the adults around him were shattered by what had happened. Desheon's grandparents were able to understand and support his reactions, but his aggression and sadness triggered his teachers, some of whom were dealing with their own histories of loss and all of whom were coping with violence that occurred on a regular basis in their neighborhood. Carolina's mother said she did not want to cry in front of Carolina. She would cry, but when Carolina would approach, she would quickly wipe her tears and smile brightly. Early in treatment, it seemed as though Carolina had learned from her mother to banish negative feelings. When people talked about being sad, she would smile in a way that seemed fixed and unreal. Her mother acknowledged that Carolina tried to smile all the time, but at night, nearly every night, she would cry.

Desheon, Carolina, and Leo were treated using child-parent psychotherapy for childhood traumatic grief (CPP-CTG; Lieberman et al., 2003). The treatment is described more fully in the book *"Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood"* (Lieberman et al., 2003). CPP-CTG is based on child-parent psychotherapy (CPP), an empirically validated, relationship-based treatment for children aged 0-6 who have experienced an interpersonal trauma (Lieberman & Van Horn, 2004; Lieberman & Van Horn, 2008). CPP is grounded in psychoanalytic theory and attachment theory and integrates developmental, trauma-informed, social learning, and cognitive behavioral therapeutic modalities. The model incorporates a focus on psychological trauma experienced by the child, caregiver, or both and examines how the trauma experienced by the dyad affects the caregiver-child relationship and the child's developmental trajectory. Consistent with its psychoanalytic roots, CPP also incorporates a focus on the caregiver's early relationship history, understanding that conflicts in this area can affect the caregivers' relationship with the child through distorted representations and lack of attunement (Fraiberg, Adelson, & Shapiro, 1975).

The model also acknowledges that therapists may be strongly affected by hearing about traumatic experiences and incorporates team support and reflective supervision as critical elements of the treatment. A hallmark of trauma-focused CPP that distinguishes it from general psychoanalytically-informed child therapy is that the therapist and the parent collaborate in describing to the child the specific reasons for treatment, including explicit mention of the traumatic event(s), the child's emotional and behavioral responses since the trauma took place, and the parent's desire to find ways of helping the child and restoring feelings of safety and trust in the parent-child relationship.

Five randomized controlled trials provide support for CPP's efficacy (see Lieberman, Ghosh Ippen, & Marans, 2008 for a summary). Four of these studies were conducted with predominantly, low-income ethnic minority families. Like CPP, the fundamental goal of CPP-CTG is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's sense of safety and attachment relationships and improving the child's emotion regulation and cognitive, behavioral, and social functioning.

Jointly, through CPP-CTG, these children and their caregivers were helped to process their loss, to regulate overwhelming emotions in a more adaptive way, and to make meaning of the tragedy that had affected them all. Their treatment consisted predominantly of joint caregiver-child sessions, but in the beginning, treatment also involved individual sessions with the caregivers and sessions with other family members to help them process their reactions and begin to see how they might work together to support the child. Individual caregiver sessions are an integral part of CPP-CTG and provide an opportunity for the therapist to support the caregiver so that the caregiver can support the child. During these meetings, caregivers often cried and shared their experience of what had happened. They talked about their concerns for the child and they discussed how they saw the traumatic loss as affecting the child. They talked about their anger toward those they felt were responsible, including at times their anger at God. The therapist provided a safe space for the caregiver at the same time that the therapist learned information that would be valuable later in treatment related to the child's and caregivers' experience of the death. Sometimes the therapist and caregiver talked about the caregiver's prior experiences, including experiences of childhood trauma and loss, as a way of understanding how prior history may influence current reactions. Together the therapist and caregiver planned how they might begin talking with the young child not only about the fact that their caregiver had died but that they had died in a scary way. Carolina's mother was initially uncertain as to whether to speak to Carolina about her dad, but as she processed the loss with the therapist, she recognized how strange it was that Carolina no longer talked about him. She saw that Carolina startled whenever she heard a siren. She understood that at night, Carolina cried for her dad, and she realized that Carolina likely remembered her dad and how he died. With the therapist's help, she decided to talk to Carolina about her dad. The therapist and mother decided to use the following words. "Your mommy told me that your daddy died. He was hit by a bus, and you and mommy were there. Your mommy said it was very sad and also very scary. You and your mommy can talk and play with me about what happened and how you feel." Our rationale for beginning treatment this way is that it helps the child to see the therapist not just as someone with cool toys but as someone with whom the child and caregiver can speak about the unspoken.

Approximately one month after Carolina and her mother began treatment in this way, Carolina, the child who had stopped talking about her dad since the moment of his death, walked into the room and announced the following, "my mommy and I are sad because my daddy died." She then said the words with which we began this chapter. "My daddy is a star in the sky." Her mom said that over the past week the family had talked about him. For the first time they had cried together. They spoke about how he was now at peace and could see them from the sky. Then, throughout the week, as they walked through the city, Carolina pointed out all the places her daddy had taken her. Now at night when they went to bed, they looked at the stars, and they said their prayers for him and believed he heard them. Carolina had found her daddy again, and she began to speak through play and with words about her memories of the beautiful things they did together. As her mother shared these changes, she remarked to the therapist "I can see that if she remembers this, she must remember everything including how he died."

Continued treatment provided Carolina and her mother with an opportunity to talk, through play, about the day her father died. She played out the accident, and in her play, she showed how clearly she remembered and had been holding on to the details and emotions of that day. Treatment did not remove the pain, but it allowed her to express it and to be supported by her mother when she did. The therapist continued to serve as a support for her mother, offering a safe space where she could process her worries for Carolina. They thought jointly about triggers that continued to affect Carolina and might affect her, although to a lesser degree, for the rest of her life, and they thought of ways that her mother could help her.

Treatment for Leo and Desheon followed a similar path but also involved different components. Leo's aunt was triggered by his play, which graphically showed what he remembered. She could not bear to hear the details of her sister's final moments, so she and the therapist jointly decided to conduct sessions in the home where the aunt could listen or leave as she needed. She would begin the session and then would leave to cook. She could hear what was happening from the kitchen if she wanted. Toward the end of the session, she would return, and Leo and the therapist would share the broad content and emotions of Leo's play while sparing her from the specific details. As Leo ran off to play in the garden, the therapist could check in with the aunt to see how she was doing. In this way, his aunt learned to hold his emotions even though she could not hold his memories; his therapist shared that burden with him. Leo saw that his aunt could be emotionally available to him in her own way. For Desheon, because his feelings of safety and his behavior varied widely from home to preschool, treatment involved consultation and visits at the school. In addition, because he was triggered by school work (just trying to read or write letters reminded him of his mother), as part of his therapy his grandparents and therapist sat with him and did school work. As he got triggered, they helped him process his reactions.

Over the course of treatment, these children evidenced many changes. They began talking and playing about their parents, their feelings, and their memories. They remembered not only how their parents had died but the love they had shared. Their current caregivers supported them as they struggled with the concept of death and explored their feelings of loss, and these very young children were able to understand in ways that were consistent with their developmental age that their parents had died and would not come back. Their caregivers also understood that as they grew, they would ask new questions and would develop a deeper understanding of the concept of death and a more complex understanding of what had happened. As they did all this, these children showed us in so many ways, including through the phrases with which we opened this chapter, that they were still connected to their parents whom they had loved so much.

For Carolina and Desheon, the changes that the therapists perceived were confirmed by data gathered at posttest from their caregivers, teachers, and clinical testing. A structured evaluation was not conducted with Leo because it had not been possible to do a formal assessment when he entered treatment. Carolina's PTSD scores declined by 2.7 standard deviations, from T=92 to T=65. Moreover, her mother no longer endorsed problems related to anger/aggression, arousal, or avoidance. She still had some problems with PTSD-intrusion (T=65) and clinically significant levels of anxiety (T=88), but this was likely due to the fact that in the month prior to ending therapy, she and her mother witnessed a severe car accident where a pedestrian was hit and killed. Her preschool teachers noted no significant problems on the C-TRF. Moreover cognitive testing, using the Wechsler Primary and Preschool Scale of Intelligence, Third Edition (WPPSI III; Wechsler, 2002), revealed a 20 point increase (SD=1.33) on her Performance IQ from intake to posttest.

While it is unlikely that her actual "IQ" changed, these findings can be interpreted as showing how processing her experience allowed her to regain access to her innate capacities.

Data from Desheon's caregivers showed that at posttest, similar to at intake, they had no clinical concerns regarding his in-home behavior. However, they did note that he was doing better at school and in his learning. His total score on the WPPSI-III increased by 10 points (SD=.67). Moreover, teacher data revealed numerous positive changes related to his school behavior. At intake, the C-TRF showed elevations on 4 scales, the highest being aggressive behavior (T=75). At posttest, there were no elevations on any scale. All scores were in the normal range. From intake to posttest he showed significant declines on aggression (SD=2.2), oppositional defiant problems (SD=2.1), externalizing (SD=1.8), and total score (SD=1.7). These changes are especially meaningful given that prior to beginning treatment, Desheon had been expelled from kindergarten and sent back to preschool. He had also had difficulty making the transition when he finally did start kindergarten. As he ended treatment, his kindergarten teacher described him in this way: "Very motivated with attention. Loves learning to read and is proud of this independent work. Very social, joyful, kind, thoughtful. Reveals strong ethical principals in play and interactions. Comes from a loving home and church community. His grandmother is his guiding force, and he loves her dearly. At first he was impatient and uncomfortable with academic challenges. He is learning to manage them effectively. He has a positive attitude toward school, expects success, believes in himself."

Both the clinical and research findings are heartening because they show that positive change is possible even following the tragic loss of a parent. They are also thought provoking. How did these changes occur? What were the possible mechanisms? In the remainder of this chapter, we reflect on key themes and lessons that our teams, the Child Trauma Research Program at the University of California, San Francisco and the Violence Intervention and Violence Assistance Program, at Louisiana State University Health Sciences Center have seen through our work conducted over the past fifteen years with young children who lost loved ones. Children like Desheon, Carolina, and Leo and their family members taught us so much. We hope that by sharing their stories, we all advance in our understanding of how traumatic loss can affect early childhood development and learn ways to work with their caregivers to support what they are already doing and reduce the potential negative impact of parental loss.

TREATING TRAUMATIC GRIEF INVOLVES HEARING ABOUT AND HOLDING PAINFUL EXPERIENCES

Up to this point, we have shared only broad details regarding Carolina, Leo, and Desheon's experience of the moments when their caregivers died. An overarching goal of traumatic bereavement treatment involves helping the family make meaning of and process not only the loss, but also memories associated with the way their loved ones died. This means that when we conduct treatment for CTG, we have to be ready to elicit and hear the details of their moment by moment experience (Pynoos et al., 1999). By walking through these memories with families, we help them make meaning of internal and external sensory experiences, integrate their emotional and body-based memories with their cognitive understanding of what happened, and identify and learn to manage potential reminders associated with these moments.

Carolina's treatment exemplifies how the task of hearing difficult memories begins during the assessment and continues throughout the course of treatment. During the assessment, the therapist met alone with Carolina's mother, so she could openly share the details of what had happened. Carolina's mother talked about how she, Carolina, and Carolina's father had been walking home. As they reached the corner and were about to cross the street, a bus came toward them and hit Carolina's father. Carolina was in her mother's arms. Her mother remembered how his body flew and how it landed. She didn't know what to do. She didn't want Carolina to see. She felt petrified. She didn't want to cross the street to where he was because she was so scared, but finally she did. She noted that it seemed like a long time until the ambulance came. She tried to help Carolina, but she didn't even feel like she was in her body. As she shared her moment by moment experience of her husband's death, it became clear that at each moment, her brain and body had encoded different external sensory and internal experiences. The sound of sirens, people yelling, Carolina crying, the way her body felt, her feelings of helplessness, the busy street, these stimuli were now linked to the traumatic moments she had experienced and became trauma reminders, bringing her mind and body back to that day whenever she encountered them.

During treatment, Carolina showed that she had both shared in these same traumatic moments and had her own experience and perspective. She talked and played about what happened in little bits and pieces, her trauma play often embedded in seemingly normal play rather than shared in a fluid trauma narrative. If the therapist and caregiver had not held her experience in mind and been able to link this experience to what she was now showing, they may have easily overlooked or even overridden her play. Instead, their initial conversations helped them reflect on the potential meanings of her play. On her fifth session, after playing about feelings and fixing things that were hurt, she began a theme that she would repeat over multiple sessions. She had a superhero fly through the sky and then fall. Although she quickly switched activities, the therapist noted that the superhero flew and then fell and maybe was hurt. Over the next couple months, different characters, dogs, princesses, superheroes would fly and fall, their bodies always following the same arc. Her mother and the therapist watched and in collateral sessions noted how sad and strange it was that these bodies flew and fell exactly as her dad had. Sometimes an ambulance would arrive and try to help them. Sometimes the figures would recover. Other times Carolina would shake her head no; the doctors could not help. Her mother and the therapist acknowledged that these figures were hurt badly just like her daddy. So many people had tried to help, but he was hurt too badly. He had died. Carolina would nod and then would often curl up with her mother. It was a difficult story to share, but it seemed that sharing it with her mother was a relief compared to holding it all inside her.

Each week more details emerged. One week after the figure fell, she asked for a towel. When the therapist gave her a tissue, she covered the figure's head. Her mother recognized this action as connected to experience and said softly that after the accident someone had covered her dad's face. Then Carolina said, "there was blood on my daddy's towel." The therapist, mom, and Carolina all sat in silence and then the therapist noted how badly daddy had been hurt and that there had been blood, and it was scary. In later weeks, Carolina's mom said that Carolina had told relatives that her dad had died and that "there was a lot of blood." Her mother also realized that Carolina had been talking about the towel even before they began therapy, but she had not understood what she meant. She had often said that there was blood on her dad's towel. Before, her mother would go to the bathroom and bring out the towel her dad used to use that they had kept because Carolina had wanted it. She would show Carolina that there was no blood; the towel was clean, but this had not calmed Carolina. She thought Carolina was talking about how dad had cut himself when he was shaving. Now she finally understood what Carolina had been trying to say. The more her mother understood, the more this seemed to help Carolina.

As treatment continued, Carolina often talked about ambulances and repeatedly played with the siren of a toy fire truck that was in the room. As she played, it became clear that Carolina had a different perspective on ambulances than her mother. Both were triggered by their sound, but as an adult, her mother had understood that the paramedics were trying to save her husband. Carolina had interpreted their life saving interventions as aggressive. Her reactions to ambulances began to make more sense. She would freeze and curl up when they passed by. She believed they hurt her daddy and then took him away. The more she played, the more her mother and the therapist were able to see her perspective and clarify misunderstandings. They were also able to repair ruptures in Carolina and her mother's relationship. The day that her father died, Carolina's mother had gone in the ambulance with her husband, leaving Carolina in the care of relatives who were on the scene of the accident. Her mother said that she had not wanted to leave her. She did not know what to do that day. She shared how much she had wished to protect Carolina from what had happened. Carolina seemed to take it all in, and as they played and talked, it seemed as though wounds in their relationship created on that day, began to heal.

THE WORK AFFECTS THE WORKER

It is important to acknowledge that reading the vivid case material in this chapter may provoke reactions. Trauma, by its very nature, can cause changes not only in families who directly experience the events, but also in all those who work with the families. The field recognizes this impact through terms such as vicarious trauma and secondary traumatic stress. Work with very young children may be particularly difficult (Osofsky, 2011). Vicarious trauma refers to possible alterations in beliefs about self, others, and the world occurring in those who work with trauma survivors (Pearlman & Saakvitne, 1995). Secondary traumatic stress includes reactions similar to PTSD that workers may experience as a result of hearing traumatic material (Figley, 1998). As we do this work, it is important to be aware of our reactions and to consciously think about how we process, make meaning of, and cope with our reactions. Below are questions that may guide personal reflection in this area.

- Does the work affect our sense of safety, world view, and the way we relate to others?
- Do we notice any symptoms (e.g., physiological arousal, change in emotions, inability to be fully present in the moment, intrusive recollections of the family's or our own prior experiences)?
- How do we understand why we do this work, including why it is important to hear these stories?
- If we have reactions, what coping strategies and supports do we have at a personal and systems level?
- How do our reactions affect our response to and work with the child and caregivers?

While much of the literature has focused on the potential negative impact of trauma work, research is beginning to highlight potential positive effects (e.g., Hernández, Gangsei, & Engstrom, 2007; Linley & Joseph, 2007). Thus, as we reflect on our answers, it is also important to think about ways that this work may be fulfilling and growth promoting, and identify factors that may contribute to more positive outcomes for each of us. Research suggests that the following factors are associated with better outcomes: supervision, especially reflective supervision, specialized trauma training, having more experience with trauma work, working in a supportive environment, feeling more connected to the families, being able to make sense of the work, having the resources to deal with challenges, and feeling that challenges are worth the effort (Craig and Sprang, 2010; Hernández et al., 2007; Linley & Joseph, 2007; Linley, Joseph, Loumidis, 2005; Osofsky, 2011; Sprang, Clark, Whitt-Woosley, 2007).

The therapists working with Carolina, Leo, and Desheon noted that at times it was difficult to hear these children's memories and feel their loss. It was hard when caregivers were too overwhelmed by their own experiences to provide what the therapist might consider an "ideal" response. At times the work caused them to reflect on what a loss like this might mean to their own children. They found that even when they weren't at work, many things reminded them of the families and what they had experienced. Sometimes it caused them to worry about things that they might otherwise not consider. Other times it made them more aware of precious moments with their children. What helped them do the difficult work was having the opportunity to talk to others who did similar work, support from their team, and a strong sense of meaning and purpose related to their work. They recognized that young children need to be able to share and process traumatic experiences through play and language with their primary caregivers. They realized that even loving caregivers can have difficulty hearing these stories, and they saw how supporting the caregivers often resulted in significant positive changes in the caregivers' ability to respond to the child. Bearing witness to heroic struggles can promote therapists' growth and development by helping them to reevaluate their own lives and priorities, and showing them the incredible capacity of humans to overcome adversity. Those doing work in this area often grow spiritually and learn new strengths to integrate into their sense of self. Hernández et al. (2007) refer to this concept as vicarious resilience and remind us that just as this work has costs, it also has innumerable benefits.

YOUNG CHILDREN REMEMBER

Avoidance is a central process of PTSD and CTG that can negatively affect development. Research involving older children whose parents have died has shown that avoidance is associated with functional impairment (Melhem, Moritz, Walker, Shear, & Brent, 2007). When working with young children who have lost loved ones, avoidance is understandable. No one wants them to endure painful memories, not the children, their families, or even those of us who work with them. Even when they share their experience through language, play, or behavior reenactments, it is normal to not recognize what they are saying, to wish the memories would go away, and to avoid speaking about what happened. Instead, we may choose to focus on behavioral symptoms, and consciously or unconsciously by-pass the traumatic material. Sometimes this may work, but when symptoms linger or intensify, it may be important to acknowledge that unfortunately, when traumatic events happen, young children, even babies, remember.

Discussions about memory often focus on explicit, declarative, memory. Can children tell us what happened? When they don't talk about it, or when what they say is inaccurate or confusing, does it mean they have forgotten? Research has shown that very young children can later provide verbal recall of personally significant events. Peterson and colleagues (Peterson & Parsons, 2005; Peterson & Rideout, 1998) followed children treated in an ER for medical trauma injuries when they were between thirteen and thirty-three months old. Five years later, 77 percent of those who were between twenty-five and thirty-five months of age and 40 percent of those between thirteen and twenty-four months of age had some recall of the injury although they also included errors in memory. Young children's recall of previously encoded memories appears to be supported by contextual supports (Bauer, Van Abbemann, Wiebe, Cary, Phill, & Burch, 2004; Gaensbauer, 2002). Toys that allow for symbolic representation of the traumatic experience (e.g., doctor's kit) may facilitate the child's sharing of previously encoded verbal and nonverbal memories. When children do not talk about or share their experiences, it is important to be aware that studies of nonverbal memory have found that infants younger than twelve months of age can recall laboratory-based tests (Bauer, 2006). Bornstein, Arterberry, & Mash (2004) reported that five-month old infants remembered emotionally salient laboratory events when assessed fifteen months later. If these very young infants can remember laboratory events, we can hypothesize that autobiographical events involving danger and affective arousal are likely to be encoded even before the child has the capacity to fully understand them. We see then it is not whether they remember, but how they remember, with research and clinical work showing that emotional and body-based memories may exist in the absence of a verbal narrative. In his paper, "On knowing what you're not supposed to know and feeling what you're not supposed to feel," Bowlby (1988) describes how experiences that are shut off from conscious memory continue to influence thoughts, feelings, and behavior. In treatment, we acknowledge past experiences and provide a space where children can connect with caregivers, share their memories at their own pace, and be supported as they remember.

During treatment, Carolina, Leo, and Desheon slowly showed how much they remembered. Carolina was thirty-four months old when her father died, and, as we have discussed, even though her mother did not talk to her about his death, she remembered detailed descriptions of the day her dad died, including the way his body flew and the towel that a passerby used to cover his face. Leo's aunt knew little about how her sister died, but his therapist quickly saw that Leo was playing out scenes that occurred when Leo was twenty-one months old, that she had read about in the police reports. When Leo looked at his mother's picture, his family reported he would retreat and hide in a closet; his mother's body had been found in a closet. Immediately after his mother's death, his father had taken him on a long car ride to get away. Leo played over and over with the car in a way that felt pressured and filled with both anxiety and aggression.

Desheon had not seen what had happened, but his therapist and grandparents soon realized that what he didn't know, he imagined and integrated into his own construction of what had happened. One day, as Desheon was playing, he asked "why did they take my mama's legs?" Stunned, the therapist and his grandparents asked questions until they realized he was talking about her funeral. They had held an open casket ceremony, but only half the casket was open. Desheon, four years old at the time, had imagined that his mother had no legs. He believed the bad guys had taken them, and he had integrated this last image of her into his memory of how he believed she had died. He was relieved when his grandmother reassured him that she had her legs, was whole, and was at peace. Interestingly, after sharing this story, his symptoms declined and he was better able to speak about his mother. This example highlights the intricacies of early childhood memory. Memory is constructed from what the child has experienced, what the child has overheard, and what the child imagines. The child's caregivers serve as both custodians and co-constructors of these memories helping the child understand, clarify, integrate and cope with memories that emerge and develop as the child grows.

LIMITED CAPACITY TO TOLERATE STRONG NEGATIVE AFFECT

As adults attempt to help the young child process memories of the traumatic events, they may push them to share what they remember. To counteract the desire to make them share quickly and process at our speed, it is important to remember that young children have a limited capacity to tolerate sustained negative affect. Wolfenstein (1966) described this as a short sadness span. We have seen that it is difficult for young children to hold strong feelings of fear, anger, and sadness. In treatment, young children often share some part of their experience only to quickly shift activities, become very active, or need to sit and connect with caregivers. It is critical that caregivers understand this pattern because otherwise they may become frustrated because the child doesn't "talk" about what happened or may misinterpret the child's switching as a sign that the child was not affected because now the child seems just fine.

In the beginning, Carolina would quickly play out a scene with an accident and an ambulance. Then she would rapidly shift and begin cooking for the next half hour. Her therapist and mother slowly came to understand her pattern. She seemed to make forays into her story and then, as she felt the wave of accompanying emotions, she needed to do something different, so she could calm down. Her mother supported her as she did this and understood that learning to regulate was as much a part of treatment as making meaning of what had happened. The first time Carolina played out the scene where the figure flew through the air, she suddenly shifted and pretended to be a cat, hid under a chair, and hissed. Her mother and the therapist searched for her and talked about how much they cared for the kitty; the poor kitty who seemed so scared. She hissed some more, breathing slowly with each hiss. Then she crawled out and climbed into her mother's lap where she pretended to purr.

Desheon played out scenes where the "bad guys" ran rampant. He would run around the house. "Come and get me" he would say. His elderly grandparents gave the role of chaser to the therapist. As she ran after him, his grandparents cheered her on. It seemed that not only was she showing how much they wanted to catch the bad guys, but she and Desheon were getting quite a workout that was helping to regulate their physiological arousal. Sometimes after playing about the bad guys, Desheon would melt down over some small seemingly unrelated issue. He would storm off to his room and begin crying and yelling that no one cared about him. Before, his grandparents noted they would often just leave him be; they worried he was getting spoiled. Now the therapist and grandparents noted that what they had been talking about was hard. His grandmother would go to him, and eventually he would allow himself to be comforted and would sink into her arms. As they processed their memories, Carolina and Desheon needed breaks where they could regulate their affect and connect with caregivers. They shared their memories at their own pace. Leo interestingly responded differently, teaching us that while it is important to recognize therapeutic patterns, we need to think about the needs of each child. His therapist noted that rather than stopping the story, Leo would get carried away and would flood. She saw that he needed help regulating. She helped him become aware of his emotional states and learn to calm himself so that as he told the story his affect did not overwhelm him.

GETTING EVEN WITH THE BAD GUYS: THE RIGHTFUL PLACE OF AGGRESSION IS IN THE PLAY

Clinicians and researchers working with older children and adults have noted that revenge fantasies are common in PTSD and CTG. Orth, Montada, & Maercker (2006) found that in the initial period following the trauma, feelings of revenge may not be problematic but over time become more maladaptive and contribute to PTSD symptoms. Horowitz (2007) noted that revenge fantasies may serve an adaptive function, helping those who have experienced trauma to gain a sense of power and control and feel solid and coherent. Pynoos (1992) raises the issue that when others have been involved in the trauma, children struggle with issues of accountability and wonder if the “bad guys” have been punished.

In our work with children under age five, revenge fantasies are often apparent in the child’s statements and play. Treatment helps children process these fantasies with their caregivers supporting their expressions of anger and their desire not just for vengeance but for accountability, responsibility, and protection. Desheon’s play, for example, was filled with themes involving catching and punishing the “bad guys.” He beat them up, locked them up, but they would always escape. Initially, his grandparents were concerned with his aggressive play; did it mean that he would become aggressive? The therapist was able to share a core belief of CPP, that the rightful place of aggression is in play. Aggressive play is a way of communicating feelings. One day as Desheon was playing, the therapist noted that Desheon was angry at the bad guys because a bad guy had killed his mother. He looked up and nodded. The therapist then noted that his grandmother was also very angry at the bad guys. He seemed surprised, but she acknowledged that she was angry, very angry. That session, they jointly punished the bad guys. She told them how angry she was. She helped lock them up. They still escaped, but Desheon now had a partner in finding them and making them pay for what they had done. Over the next few weeks they worked together to jail the bad guys. Because in real life the police had failed to catch the bad guys who killed Desheon’s mom, they ultimately brought in a higher power, Jesus. Through play, Jesus held those bad guys accountable. They had done wrong, they had not repented, and according to the rules of the family’s religion, when Jesus came, they would not ascend. As his grandmother explained this, Desheon seemed satisfied; it was as if he could finally relax knowing justice would someday be served.

SUMMARY

As we end this chapter, we reflect on the lessons we have learned. The children and families described in this chapter and their stories, clearly show the importance of adopting a flexible approach. Each child, family, and loss is unique. To help them, we have to understand not only the child, but the caregivers and their reaction to the child and to the tragedy they are all experiencing. Just as there is no standard experience of loss, there is no one treatment pathway. We tailor our treatment to their story and to their joint ability to tolerate the story. Yet, as we do this work, we follow common guidelines and goals. We remember that the caregiver has the rightful place of the child's guide through life and through this trauma. We focus on strengthening the caregiver-child relationship as the vehicle for healing. We work to enhance the child and caregiver's sense of safety. We help caregivers understand both their own and the child's moment by moment experience of the trauma, and when necessary we connect this experience to the child and/or caregiver's prior history. We support dyadic affect regulation, and we help the caregiver and child jointly process and make meaning of this experience at their own pace and in their own way. These families have taught us the importance of helping young children stay connected to their history and to those who were a part of it. Even when bad things have happened, the task, even for young children, is to remember both the good and bad and to acknowledge that both have shaped them and will continue to do so.

NOTES

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1. Carolina, Leo, and Desheon are fictitious composite cases, but the words that begin this chapter, the data, and the details of their experience and treatment represent the real lived experience of children and families seen in our programs.

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Part III

Therapy in the Office with Adolescents

Chapter Five

A Terrible Thing Happened on the Way to Becoming a Girl

Transgender Trauma, Parental Loss, and Recovery

Diane Ehrensaft

Diane Ehrensaft writes about her clinical work with Jesse/Jessie, whose coming out as transgender intersected with the loss of a beloved and supportive father. Her chapter highlights her efforts to understand the complexity of Jesse/Jessie's internal dynamics and her unambiguous commitment to create a therapeutic potential space in which the teenager could both mourn the father's loss and make progress in development toward a self-determined, fluidly gender-variant identity.

In an earlier age, many clinicians believed that developmental pathways that were not the most usual were not normal, and thus, needed to be addressed through psychotherapy. While the larger society often stigmatized psychotherapy, it adopted these "findings" in ways that caused deep and lasting damage to youth on the way to becoming lesbian, gay, bisexual, or transgender and their families and communities.

The center of gravity in fields of mental health has shifted. Most clinicians today are sensitive to a diversity of normal and healthy developmental trajectories. Many work to undo the damage of prejudices that are still insidiously grounded in false psychological science, as they support the development of diverse children and the aspirations of marginalized groups.

Diane Ehrensaft has been a leader in this shift. In both her clinical work and her theoretical writing about gender-variant and transgender children and their families, she has shifted the center of attention from work that is pathology-focused, needing to be private and sequestered, to a work that occupies a generative transitional space, suspended between the personal and the public and political. Ehrensaft has helped envision the possibility of clinicians as allies of social change toward the empowerment of LGBT individuals.

> *Ehrensaft's case study orients itself toward the particularities of Jesse/Jessie's subjectivity, yet its implications and applicability are broad. All clinicians working with children whose parental losses intersect with diverse pathways of development will find creative and useful guidance in this chapter.* —Eds.

> *. . . [I]t was now my turn to transform my actual family into an*
> *imaginary one, to pretend that our markedly divergent criteria*
> *for living in the world didn't exist, that the incredible gulf*
> *that faced us when we sought one another wasn't there.*
> —Butch in a Tutu[1]

This chapter documents the intrusion of both trauma and grief in the life of a transgender youth in the struggle to establish a true gender self (Ehrensaft, 2011). This youth's experience in a therapeutic relationship is presented to demonstrate the complicated work of recovery when both trauma and parental loss co-mingle with a child's search for authentic gender identity.

To be a gender-nonconforming or transgender child is to be in a creative but precarious position. Sensational mass media reports alert us to the sobering reality that many of these children and youth are at risk for being brutally attacked or killed for transgressing societal prescriptions and proscriptions regarding "appropriate" gender behaviors and presentations (Roberts et al., 2012). In desperation, some of these children take their own lives when they can find no place to safely inhabit their authentic gender selves (Grant et al., 2011). Short of such tragedies, many of these children find themselves harassed, confused, and misunderstood within a social environment infused with transphobia and angst or animosity toward children and youth who go against society's gender grain.

Gender-nonconforming and transgender children and youth are among the minority of individuals in our society who must anticipate bigotry and antipathy from those who do not understand or are ill-informed. Such individuals may govern their thinking with myth rather than reality, or may, from insecurities and internalized prejudices going back to their own childhoods, project hatred onto those markedly Other than themselves. At the same time, gender-nonconforming children and youth, along with gay youth, are differentiated from almost all other minority children in that they may face aspersion from their very own families—loved ones who are supposed to be their protectors. Parents of gender-nonconforming or gay children may feel distressed or disgusted by their own offspring and wonder why they as parents are being punished with such "perversion" (Ryan et al., 2010). By adolescence, these youth may find themselves thrown out on the streets by their own families, becoming poor, homeless, and socially orphaned. Alternatively, youth may flee from the families where they have been harassed and bullied because of their gender presentation. Either way, they can find themselves in a category of youth at increased risk for suicide, depression, substance abuse, and targeted hate crimes (Toomey et al., 2010).

Psychoanalytic developmental theory differentiates two anxieties that infants or young children confront when faced with the possibility of a breech in the link with their parents. First, until children are able to establish object constancy (being able to hold in mind that a loved one comes and goes, but does not disappear), they fear they will lose the parent altogether—that the parent may leave, never come back, and be forever lost. When children grow up in secure and loving circumstances they internalize a confidence that their parent will not disappear but will always come back. With these children a second type of fear replaces the first—fear of loss of the love of the object: they think, my parent may be right here, but he or she may withdraw love and turn away from me, particularly if I express aggression or hate (Blatt, 1974; A. Freud, 1965; S. Freud, 1926; Klein et al., 1952).

Transgender or gender-nonconforming children stand to lose the love of their parents if parents feel uncomfortable, disappointed, distressed, disparaging, or disgusted by their child’s unconventional gender presentation. These youth may also experience the actual loss of the parent if they persist in their gender nonconformity and are ejected from the home, or disowned on the basis of their gender presentation or identity. Or alternatively, the youth may feel compelled to flee from a toxic or potentially life-threatening familial situation.

No trauma is more severe than one that would cause a youth to destroy his or her own life because life comes to feel unbearable as a result of events outside the youth’s control but for which he or she feels personally accountable. That is the fate of many transgender youth today, because of poor treatment in an unsupportive, negating family that was supposed to be a heaven, not a hell (Grant et al., 2011; Roberts et al., 2012). And there are few losses more traumatic than the loss of either parental love or the actual parent in the face of the transgender or gender-nonconforming child’s struggles to establish an authentic gender self and stay afloat in a non-supportive world (Ryan et al., 2010). As Eth and Pynoos (1985) state in their study of children’s responses to traumatic losses, “Although trauma and grief are profoundly different human experiences, a single event can precipitate both responses” (p. 175). Such was the case for the gender-nonconforming child I am about to present.

JESSE

Jesse was fifteen when he came to see me. He was as gender creative[2] as any youth could be, decked out in colorful, sparkly outfits (some from the women’s department, some from the men’s), heavy black eye make-up, dangling earrings, ever-changing hair colors and extensions, and a tiara from time to time. He wove together a gender self that was a combination of male, female, and other. As he described himself, "I'm a gender smoothie. Just take everything about gender, throw it in the blender, press the button, and that's me."

Jesse and his mother, Marlene, heard me interviewed on an NPR program on transgender children. At the conclusion of the program, Jesse had looked at his mother as if a light bulb had gone on in his head and declared, "That's me." They lived at a distance from my office, in an area with few, if any, child and adolescent gender specialists, so Marlene decided to contact me to see if I would be available to see Jesse and help him with his gender conundrums. She explained that Jesse had had a trauma earlier in his life that she thought was also affecting him—the sudden death of his father, when he was eight years old.

So began our work together over eighteen months, until the economic recession hit and the family found it financially necessary to discontinue the long, expensive commute to my office and seek services at a clinic covered by their new insurance. As fortune would have it, there happened to be a therapist at that clinic who had extensive experience with gender-nonconforming and transgender youth. With permission from the family, I was afforded the opportunity to collaborate with this therapist and follow Jesse's progress.

Soon after I began meeting with Jesse, I discovered that he was not simply a youth sorting out his gender. He had suffered repeated losses and chronic trauma. If Pynoos and Eth are correct that "psychic trauma occurs when an individual is exposed to an overwhelming event and is rendered helpless in the face of intolerable danger, anxiety, or instinctual arousal" (1985, p. 23), Jesse had encountered this on six fronts: (1) the terrible cacophony between his gendered body and his gendered psyche; (2) the sudden death of his father at age eight; (3) a sexual molestation at age thirteen by a neighbor, followed by a predatory pedophilic relationship with a twenty-nine-year-old man; (4) the loss of the stable love of his mother after she remarried and presented her son with a blended family that alternated between support, condemnation, and insidious undercutting of his gender-nonconforming self; (5) the disconnect from his mother during his placement in a residential treatment program that attempted to "repair" his gender-nonconforming self; and (6) on-going harassment and threat of physical violence in his social environment, triggered by his colorful, gender-bending presentation.

Judith Herman (1992) posits that people exposed to chronic, prolonged, or repeated trauma suffer an insidious, progressive form of distress that invades and erodes the personality, which she labeled complex post-traumatic stress disorder. There is strong evidence that Jesse was suffering from just such a disorder. First, like his cohort of other gender-nonconforming and transgender youth, he was hurt by unrelenting harassment, rejection, and condemnation encountered from the world around him (Grossman et al., 2006); and second, he suffered the hurt his other cohort, of youth who had incurred the sudden loss of a parent, and who often had to contend with lack of support from the remaining parent, experience.

TRAUMA AND LOSS ON SIX FRONTS

The following history was gathered from reports from Jesse's mother, consultation with the treating psychiatrist, and information gleaned over time from my sessions with Jesse:

Gender-wise, Jesse had always been a child who played outside the box, both literally and figuratively. Since early childhood, Jesse always preferred things feminine. All of his friends had been girls. Through mid-childhood, he reveled in playing dress-up in girls' clothes. By third grade, he had accumulated a wealth of friends, and teachers referred to "Jesse and his harem." Both his mother and his father were accepting and supportive of his gender-nonconforming self, and he counted on that support to steady himself in an unsteady world not quite ready for his gender-creative presentation. Running parallel to his gender nonconformity, and in part because of it, Jesse was an anxious little boy, even suspected of being autistic in his early years. In third grade he began therapy to deal with his anxiety.

Six months after Jesse began treatment, his father—a journalist to whom Jesse was very close and on whom he counted as his major support in his gender nonconformity—collapsed at his office desk and died the next day from a massive heart attack. Ironically, on the very day of his father's collapse, Jesse's therapist, who could not have known of the impending tragedy, had scheduled Jesse's last session, as she felt she was not able to help Jesse, either with his anxiety or his gender. Although I never had an opportunity to consult with this therapist, I know it is not uncommon for therapists who lack training in working with gender-nonconforming children to find themselves stymied how to offer therapeutic guidance (Ehrensaft, 2011; Lev, 2004). Thus Jesse experienced the simultaneous loss of two significant individuals in his life, his father and his therapist.

To handle the shock and sudden loss of his father, Jesse went in search of a safe place. He found it within the walls of his elementary school. His mother was a teacher at the adjoining high school, in close proximity to him every day. Despite permission to stay home from school as long as he needed, Jesse insisted on going to school the day after his father's death. Before he could grieve, he did everything he could to keep his head afloat after the profound shake-up in his emotional universe. Jesse had now encountered the first major trauma in his life—the sudden loss of his father.

Jesse continued to be his gender-nonconforming self, but now a very angry one, handling his grief and mourning through aggressive acting out. His mother was desperate for practical and emotional support in her unexpected role as a single working mother raising Jesse and his younger sister. A year and a half after his father's death, Jesse's mother got romantically involved with an acquaintance, Samuel, who eventually moved into her home with his teenage son, Michael. Unfortunately, Samuel failed to serve as a surrogate father who could soothe the pangs of loss and despair that periodically overwhelmed Jesse. Instead, Samuel was subject to violent outbursts, a result of his own abuse as a child. These outbursts frightened Jesse and his sister, and only highlighted the traumatic loss of a loving father who would never have exposed them to such out-of-control behavior. Stoking the fires of Jesse's own tumultuous grieving, and in self-protection and counterphobic response to Samuel's explosions, Jesse's anger began to escalate sharply, with outbursts including verbal assaults, sobbing tantrums, and hurling objects, six to seven times a day.

Samuel's anger and its effects on Jesse were exacerbated by the homophobia and transphobia Samuel and Michael introduced into the home. Jesse's mother and father had always been accepting of his gender nonconformity, but Jesse was not as fortunate with Samuel and Michael. Initially, Jesse latched on to Michael, as a new older brother and potentially a better substitute than Samuel for the father he so desperately missed. The affection, however, was not reciprocated. Michael teased Jesse mercilessly for liking girl things. Jesse persisted in trying to win Michael's love and attention, putting up with the verbal abuse. But, unlike other gender-nonconforming children traumatized by the toxic reactions of their social world, Jesse did not suppress or go underground with his gender-fluid presentation, desires, and identity. The bond with his birth father had been sufficiently strong and enduring to allow Jesse to hold his positive identification with his lost object, his father, remaining the same boy who played outside gender boxes, only now a very conflicted and distraught boy.

Years passed, and Jesse reached puberty. As adolescence arrived, Jesse began to express himself alternatively as gay, gender queer, or transgender. Now Samuel erupted into homophobic or transphobic harassment of Jesse, highlighting for Jesse once again his traumatic loss and the replacement of his beloved father with a seemingly monstrous brute.

Samuel called Jesse a faggot for prancing around the house in boxer shorts over leggings. He accused Jesse of bestiality for liking boys. In response, Jesse began to engage in fantasies of retribution, in which his beloved father would rise from his grave, show up on the scene, and force Samuel to trade places with him and be suspended forever in purgatory with the fires of hell lapping at his feet. His lost father remained embedded in his psyche as his all-seeing gender protector. Yet Jesse was ruefully aware that his Dad was never really going to show up again to save him from the horrible father substitute.

This left only Jesse's mother to come to his rescue. Regretfully, she did not. Marlene had never recovered from the sudden and traumatic loss of her husband and the resulting financial downward spiral. She was emotionally spent and totally dependent on Samuel, financially and psychologically. Jesse had lost not just one but two allies, his mother *and* father, as Marlene did nothing to put a stop to either Michael's or Samuel's harassment.

Thus came Jesse's second chronic trauma in the face of many—the loss of the love of his mother. Now, instead of protection from outside persecution or maltreatment, home replicated the unsafe social world (Ehrensaft, 2011). Marlene's role as a bystander who did nothing to intervene on Jesse's behalf exacerbated Jesse's traumatic familial experience and profoundly impeded his on-going mourning process for the father he still so painfully missed. He watched with distress as his mother transformed from a supportive parent to a passive witness, by her silences giving credence to Samuel's and Michael's homophobic and transphobic verbal attacks. He longed for the mother who had offered him harmonious and clear support of his gender-nonconforming self, coming to realize that the maternal love he had counted on unconditionally before his father's death had now been compromised.

Jesse's trauma grew in severity as he discovered that school, too, was no longer a haven, thus creating a secondary loss. This time, it was the loss of institutional object, the school that had previously been Jesse's home away from home after the death of his father. In middle school, Jesse was teased relentlessly by his peers for his provocative and colorful gender-nonconforming presentation. Although Jesse was very bright and previously had been a good student, his grades began to drop. He started wearing all black, identifying with Goths. Verbal attacks from Jesse's peers, staring, and name-calling persisted unabated into his teenage years. Like other gay, gender-nonconforming, and transgender youth, particularly those who choose not to hide their identities underground, Jesse experienced himself as a "victim of ridicule, violence, and shrill intolerance" (Gherovici, 2010, p. xiii). The ongoing harassment that came his way from the community around him marked Jesse's third trauma, tearing asunder his previously successful academic achievement.

By the end of eighth grade, life had spun out of control. Jesse stopped doing homework; he was explosive at home. He began visiting a neighbor regularly, an older man with whom he felt understood. With his mother's permission, Jesse temporarily moved in with the neighbor. Marlene thought that a temporary removal would provide a respite, cool tempers, and rejuvenate connections. Unfortunately, Marlene had not given thought to the downside of this solution, the potential that, in condoning the respite from the home, she was confirming Jesse's underlying fears that he had lost his mother's love and was being cast out.

In moving in with the neighbor, Jesse's unresolved conflicts about parental loss revealed themselves in yet another way. Jesse again seemed in pursuit of his lost father. Later it was discovered that the neighbor sexually molested Jesse, a likely target because of his hunger for love and his beginning questioning of his sexual desires and identity.

After a time, Jesse returned home, reporting nothing about his sexual activities with the neighbor. Instead, he turned passive into active by posting his availability on the Internet and "hooking up" with a twenty-seven-year-old man who misrepresented himself as an older teen. This man engaged in unprotected sex with Jesse over several months. It soon became increasingly obvious to Marlene that Jesse's time with the neighbor had done nothing to calm the waters at home. To the contrary, Jesse became increasingly agitated. He had fits of rage and threatened to run away.

Marlene began to probe a bit and uncovered Jesse's relationship with his Internet liaison, including the man's actual age, which meant his actions qualified as statutory rape. She banned Jesse from seeing him and reported the man to the police. The man was discovered to be a repeat offender and was arrested. Here was now the fourth trauma—sexual abuse. Jesse first fell victim to a sexual predator who presented himself as a father-like friend but took advantage of Jesse's naiveté, alienation, and hunger for love for his own sexual purposes. In therapy Jesse recalled his time with the neighbor as one of trickery, deceit, and betrayal, with Jesse as object rather than subject. Then Jesse fell into the hands of a man on the Internet who pretended to be a peer, whom Jesse hoped would assuage his angst about his older stepbrother, Michael. Jesse had first been hopeful about Michael, but Michael tormented Jesse. And Jesse's relationship with the Internet man also turned out to be artifice.

Marlene now felt she needed to take action. Fearing for Jesse's safety, and finding him increasingly out of control, she made a decision to send Jesse to residential care despite the inordinate cost. For reasons certainly in conflict with her (inconsistent) support for Jesse's ongoing gender nonconformism, Marlene chose a program run by two brothers, both football coaches. The brothers and their staff offered a behavior modification program for each participant, with the aim of curbing their "bad choices" and moving them toward leading what the brothers saw as healthy, productive, fulfilling lives.

When Jesse arrived at the program, the staff immediately outlined his "person-specific" goal: to make a man out of him. In line with reparative therapies for homosexuality and conservative religious ideologies, the underlying assumption was that gender nonconformity and homosexuality were willful choices individuals could learn to relinquish to lead a healthy, productive, heterosexual life (Nicolosi, 1991). They failed to recognize that Jesse did not need to become a man, but rather to find one—a good-enough father figure to help him heal the loss of his beloved father. What they perceived as "bad" decisions were his "choices" about his gender presentation.

Jesse's long locks were shaved into a buzz cut. When he sat with his legs crossed at the ankle or walked with a limp arm, a staff member would stop him immediately and correct his sitting and standing posture and his hand motions. The staff accused him of being fake, because he expressed wanting to be a girl yet acted like a boy. They said these were just attention-getting and self-destructive choices, which had gotten him sexually molested not just once, but twice. Jesse kept himself emotionally afloat through this gender assault by befriending the seventy-year-old chef at the program, who was supportive of Jesse's gender-nonconforming self. At least Jesse found one benign proxy for his longed-for lost father amidst this sea of repudiators.

Jesse called home for help, begging his mother to take him out of the horrible place where he was being harassed every day for being who he was. Initially, Marlene thought Jesse was resisting the help being offered. The program staff had predicted such behavior and had warned parents not to bend to such "manipulations." It took Marlene six months to realize that Jesse's pleading was not resistance; the program was doing real harm to her son, and she finally brought him home.

Unfortunately, the damage had already been done, marking Jesse's fifth trauma—maltreatment at the hands of a therapeutic community that was supposed to help rather than harm him. As a result of the staff's assault on his gender self, and the program's failure to recognize the raw wounds of his unresolved mourning, Jesse exited the program anxious, depressed, agitated, labile, confused and distraught about his gender self.

Although I listed the trauma of psyche-soma gender mismatch first, I have saved it for last in lacing together Jesse's web of trauma and loss. As Jesse approached puberty, he began to panic. For the vast majority of people, a sufficiently good match exists between birth-assigned gender and their affirmed gender identity. But for some people, such as Jesse, there is a mismatch, and, as a result, the titillating excitement of the bodily changes of puberty is experienced as acute trauma. Prior to puberty most children can easily play at the margins of gender through hair styling, clothing choices, and activity preferences, but, for some, the fun is over when puberty sets in (Byne et al., 2012; Drescher and Byne, 2012; Spack et al., 2011). The young adolescent is left with a reality of new, indelible, highly visible, gender-specific body presentations that imprison him or her in a life that feels unreal and alien. The resulting sense of futility can drive some adolescents to contemplate suicide as they helplessly experience the seemingly unstoppable advent of an unwanted puberty that, for them, marks the death of any chance for authentic gender selves to emerge (Ehrensaft, 2009).

Jesse greeted the changes in his body with horror rather than delight. They predicted his fate as the adult male he might detest becoming. By the time he exited the residential program, bruised by multiple assaults on his gender self, he was caught in a vortex of gender dysphoria, if not panic. He was desperate for a diagnosis of gender identity disorder so that he would be eligible for puberty blockers and then cross-sex hormones.

When Jesse tried to re-enter high school, he could not face the second day of classes. He hated his maturing, male body and did not know how to either clothe or disguise it. Thus marked Jesse's sixth trauma—severe gender dysphoria, brought on by his own pubertal body changes.

According to Toni Heineman (1998), some traumas are accidental, some intentional—a car crash would be the former, sexual assault or physical attack the latter. Jesse confronted both accidental and intentional trauma—the accidental encompassing the death of his father and the agonizing mismatch between his assigned gender and his experienced gender; the intentional trauma of the loss of his mother's support and the hostile response of family and social worlds to his gender-nonconforming self. By fifteen, Jesse showed up for treatment a victim of chronic gender trauma embedded in the trauma of parental loss and rejection.

JESSE/JESSIE'S TREATMENT

My treatment with Jesse was like eighteen months in the presence of a whirling dervish who agonized about the "choices" s/he would make until s/he could slow down to think. S/he was manically rushed in her/his speech and rarely made eye contact. Moments on the verge of explosion alternated with moments of collapse. In the course of therapy Jesse morphed into Jessie and asked to be acknowledged as a she; yet, it was combustion, zigzag, not a linear or consistent trajectory. S/he bounced back and forth between a trany, a she/male, a bisexual, a gay boy, and a "gender smoothie."

Shadows of sexual molestation, exploitation, and both homophobic and transphobic violence were ever-present in Jesse's life. In his trany and gay phases, Jesse reported. "I like hanging out with girls. Nobody will worry about me doing something to their daughters." When he told me about a gang of boys who hurled rocks at him and called him a "fag" while he was walking to the library, he first explained that it happened even though he was just wearing "regular" clothes, instead of his more colorful and creative get-ups. He then announced dismissively, "None of them could even hit me with a rock. If they're going to do it, at least actually do it." The very male power that appalled him was the power he accused his male harassers of lacking—not he, but they were cast as the faggots who were losers (cf. Corbett, 2001).

In a phase when Jesse called himself as a male-to-female trany with a penis, Jesse declared, “God was good in making me a trany with a penis, because otherwise I would have been pregnant by age thirteen, when I started having sex with no protection.” In reality, the threat of pregnancy paled in comparison to the dangers of exposure to HIV infection through unprotected anal intercourse, to which he made no reference.

With futility, Jesse attempted to sweep away the shadows of abuse by posturing with the fearless “male bravado” the residential program had tried to instill in him. It was difficult to sit with Jesse during these early sessions, and I wondered who I was to him. Was I the mother who would jump in to protect him from his own harmful behaviors, the dead father who would have negated his need to construct a false self of male bravado altogether, or perhaps an amalgamation of both?

Jesse came to the decision that he would never be able to afford to have a family, because any money he made would be siphoned into the cost of a cell phone, Internet access (necessary for social networking in the gay and trans communities), electrolysis, surgery, and hormones. I took note of a deeper reason for negating family. Jesse’s fear of the loss of both a parent and the love of a parent, and the introduction of harm into his family of origin, had destroyed his fantasies of an embracing family.

Instead, Jesse declared that becoming a sex worker would be his best future. I listened quietly. Jesse grew silent, distraught, then dissociative and unable to speak. After some minutes, he came back from wherever he had gone, and I asked him if he could tell me what had happened in his head. Jesse explained, “The life that came before my eyes doesn’t look very good.” He looked genuinely frightened, as if a vision filled with mayhem and violence had come alive in the moment, or as if he were actually remembering the life behind him, rather than one unfolding. Gone was the male bravado. I gently reminded him that what he had briefly articulated was just an image, not a fact.

I paused for a moment, absorbing Jesse’s distress. Inside me, a silent interpretation had been brewing over our last sessions, as I had repeatedly borne witness to Jesse’s overvaluation of his soma at the expense of his psyche. As Jesse imagined his future as a sex worker, it seemed time to bring his reverie to his awareness. I said it was striking, given Jesse’s fine mind, that he could only envision using his body, not his intellect, to make a living. Jesse quickly exited his inner chamber of hell, perked up, made eye contact, and responded, “You’re right. Actually, I could make movies.”

We seemed to be making progress as Jesse contemplated himself as more than a body, but maybe not. The next session, Jesse bounded in and announced that porn would bring him closer to God. This was a particularly compelling remark, as heaven, closer to God, was exactly where Jesse imagined his dead father to reside, revealing the ever-present conscious and unconscious ways in which Jesse continued to hold his dead father in mind. Jesse would make people happy, bring them pleasure, and fight for the civil rights of porn artists.

In the midst of recovered bravado stemming from his imagined sexual savoir-faire as a porn star, Jesse began to associate freely. First he imagined himself as pretty/ugly. Then he confessed he did not know how to use a condom, something perhaps his father could have taught him. From there, he went on to quote Kurt Cobain: “I’d rather have people hate me for who I am than love me for who I am not.”

At this point in the therapy, I noticed that Jesse was declaring the fate he had already endured, finding hate where he had expected to find love in his relationships with his stepfather and stepbrother and, to a lesser degree, with his mother. I refrained from an interpretation, thinking it was more important to provide a holding environment for Jesse’s grief and loss. Jesse exuded strong waves of depression, recycling the losses and sexual exploitation of his past, and then turned passive into active as he fantasized himself a wealthy and famous protagonist making a living from sex. Being wealthy would also be a way to identify with his dead father, who had brought the bulk of the family income into the home—wealth that quickly dried up after his father’s death.

Jesse was running in circles, about both his gender identity and his sexual orientation. One week he’d say: “I’m androgynous.” The next week: “If I want to have sex reassignment, then I’m just going to go ahead and do it.” The next: “I’ve never been the kind of person who knew I was a girl trapped in a boy’s body. What I did know from the time I was little is that I wanted to be a princess—I wanted to be like Arielle and all the other princesses like her who were strong and could make a difference. But I also imagined myself being swept off my feet by the prince.” Then: “I’m just a gay boy. I just really like ass-fucking.” The next week: “I’m just a chick with a dick.” And then: “I’m just a woman with a vagina in the rear.”

Finally, catching himself in his vacillations, Jesse described himself as having two different, contradicting brains, one that made him male and gay, another that made him female and straight; one that hated women, one that loved them; one that loved his penis, one that wanted to get rid of it. Although Jesse stated with great clarity that “sexual orientation is what you do with your clothes off; gender identity is what you do with your clothes,” he was like a revolving door gone wild, trying to settle these aspects of self.

Getting a word in edgewise with Jesse was always difficult, but I was able to communicate one consistent response, about both his gender and his sexual identity—let’s slow down and give you some time to explore without declaring. As we attempted to rein in the manic flow of his mind, Jesse chose a focal point to keep him steady: clothes and gender presentation. He did not know what to wear to school. He liked to wear skinny jeans or leggings, but he worried about the bulge of his penis.

Generally, in moments like this, I have noticed that gender-exploring patients take note of my dress and presentation, either identifying with or individuating from my gender expressions. With Jesse, I could feel none of this. It was almost as if he had formed me into a genderless object who would not intrude on him as he crafted his own gender uniqueness. Retrospectively, I recognize that, within myself, my gender had retreated to the background, as an anchor of self, as I sat with Jesse through these sessions. I wonder if I had become a somewhat translucent transference representation of the ghost of the accepting dead father Jesse continued to call forth in his dreams and fantasies, but who had become fuzzy, filmy, and maybe even genderless in Jesse's memory as years had gone by since his death?

In one particular session I succeeded in breaking into Jesse's pressured monologue. I gently pointed out that his preoccupation with his clothes and looks was an outer focus that either reflected or deflected from the inside mess—Jesse's confusion about who he was, gay or straight, girl or boy, trany or gender queer. Jesse stopped in his tracks and left the session in a mute stew. His mother was waiting in the car. As he got in, he slumped in his seat and yelled at her, "Dr. Ehrensaft is right. I hate her."

Although I was attempting to move in slow mode, Jesse rushed into the next session telling me in urgent tones what it was really like to be him. He told me he felt like a girl on the outside but also loved his penis; that, actually, he wished it was bigger. I thought to myself, "Would that possibly be the merging of his mother and his dead father into his own self, a way of holding both and losing neither? Was I going to be moving from translucent ghost to two-headed mother/father transference object who would give Jesse freedom to explore the gender multiplicity of his own self?" Jesse went on: "By the way, how did you like my new hair-color [orangey yellow]? Did you notice?" I thought, how could one not?

Jesse wondered whether he could be a female with a penis and be a top rather than a bottom. Technically, he considered himself a virgin, albeit one who had been molested. He said he liked his penis, and he liked guys, and he liked sucking dick. He did not like vaginas. He thought they smelled fishy, like fish in a lake, "grody."

I wondered where Jesse was now positioning me, a woman with a vagina, as he ruminated about fishy, smelly vaginas. Again I had the strong feeling that Jesse was rendering me a genderless and ephemeral figure as he delved into his own gender conundrums. I seemed to be a neutral pole in the ground around which he could swing freely, neither identifying nor disidentifying with me. This was an understandably defensive response in the aftermath of the assault on his gender by the residential treatment staff who had demanded that Jesse identify with their masculine selves. Unlike Jesse's dead father, his retreating mother, or the intrusive residential treatment staff, I was a person in his life who was there, not going anywhere, no matter what he said or thought. This was a position I had secured for myself by waiting and receiving, rather than telling.

For reasons still unclear to me, this flurried session was ground-breaking. As the weeks progressed, Jesse began to settle into a sense of self as a girl. He changed his name from Jesse to Jessie and began to ask people to use the pronoun "she." Jessie began talking more about her history. She missed her father, but was not sure her father would have supported her as a trany, so maybe it was better that her father was not around to witness Jessie in her gender journey.

The work of Caitlin Ryan and her associates has demonstrated the importance of family support for positive mental outcomes for GLBT adolescents (Ryan et al., 2010). Yet research has not addressed the conundrum for youth when a supportive parent dies and is no longer present as the youth enters the stage of identity formation.

Jessie will never know if her father would actually have supported her transition from male to female. She can only imagine. The positive image she had held of her dead father was no longer sustainable once she went through her gender transition. For the first time Jessie imagined him as potentially rejecting. Perhaps her mother's compromised support colored Jessie's speculations about what her father's responses to her transition might have been, were he alive. Perhaps she defended against hoping for something better, given the ways her family had let her down.

Yet maybe Jessie was using her gender transition as a way to finally accept that her father was no longer there. In posing to herself, and to me, the question that maybe her father was better dead, Jessie was, after a long time, opening the door to revisiting the traumatic loss of her father and the unresolved grief she had held for so many years. I marked this as a turning point in Jessie's therapy, as she integrated her gender explorations with her object losses.

Jessie switched from talking about her father to railing against the residential treatment center: "They treated me like a freak. They stole my vagina money." By this she meant that the program had drained her mother's financial resources and left no funds for puberty blockers, which are exorbitantly expensive, or for surgery, also extremely costly.

Jessie was not sure she wanted a vagina, but she wanted to have the choice. When she called up feeling bombarded by the treatment center staff for her bad "choices" and being coerced into performing as a heterosexual male, Jessie fell into a state of agitated depression. As we embarked on a deeper exploration of her feelings, Jessie could now admit to her distress at having lost a father she was not even sure would want her now. Denied access to ever finding out whether he would have accepted her or not, the clinical risk for Jessie was that she would struggle to establish a sense of herself as lovable and desirable without the positive mirroring of her affirmed female self by her beloved, lost father.

In coalescing around a transgender identity, Jessie made a point of emphasizing that she had been celibate for almost two years—by *choice*. Yet it was clear to me that her abstinence was governed by fear and a desire to purge herself of previous exploitative experiences, rather than a choice to wait, for example, for the right person to come along, or to become mature enough to enjoy sex in a loving relationship. As Jessie lost a positive image of a father who would be there for her through thick and thin, celibacy had protected her from further harm, and at the same time had allowed her to experience her emerging gender identity.

Once again Jessie was eager for a gender identity disorder diagnosis so that she could be a candidate for puberty blockers, cross-sex hormones, and, later, sex reassignment surgery. In the meantime, she went to a health food store and bought over-the-counter soy estrogen, hoping that would help.

The revolving door of gender and sexuality was still spinning, but not as wildly. Jessie wondered whether she was a gender queer attracted to men or a trany attracted to trannies, but she continued to affirm to herself that she was a girl. She wanted to imagine that she could *choose* to sometimes have a penis, sometimes not. She wanted to be pretty. She still found vaginas disgusting, but thought maybe she would want one. She now *chose* to go only into the women's bathroom; she did not want to be raped in the men's room. She was obsessed with men hitting on her. While she affirmed her female identity, all of her sexual fantasies were about gay male sex. She *chose* to post erotic photographs of herself on-line, insisting it was "spiritual" (again, one step closer to her father in heaven). She was furious when her aunt discovered the photos and "busted" her, reporting her findings to Jessie's mother and scolding Jessie, "After everything you've been through, you would *choose* to do this?"

Jessie saw no problem with posting the photos. She explained that she was not afraid of old pedophiles, only young ones, because they are the ones who will have sex with young boys. She sat across from me with pink and purple hair and a tiara on her head as she condemned people who would police her sexuality. With Jessie's transgender transition, life did not get easier at home. Jessie found herself angry all the time. Samuel's animosity grew in response. This time, however, Jessie remembered her early affinity to school as a safe haven. Still in search of substitute figures to replace her lost paternal object, Jessie sought out the staff at her new high school. She poured out to them what was happening at home—Samuel's verbal attacks, Marlene's passivity in the face of the abuse. In turning to the school staff as confidantes and embellishing her story of strife at home, Jessie managed to create splitting in her social world—she vilified her mother and stepfather and pulled for the school to support her.

In Jessie's fantasies, the school represented the idealized dead father, in contrast to the compromised live mother Jessie felt had betrayed her, the interloping stepfather who attacked her, and the de-idealized dead father who might have rejected rather than embraced her. The school was a progressive institution that advocated social justice and promoted ethnic, gender, and sexual diversity. The staff supported Jessie unconditionally, just as Jessie, when once Jesse, had fantasized that his father might have done. Unconsciously maneuvering the school to become her lost good object, protecting her from harm, Jessie was able to instill in the staff a felt urgency to take action. They evaluated whether they should report the family to child protective services and recommend or directly facilitate respite care. This would have meant the third ejection of Jessie from her home. The possibility was eventually forestalled when I consulted to the school and presented a more nuanced account of the conflicts at home.

As I intervened with the school, I was aware of the many roles I was playing and what I may have represented to Jessie: I was a fierce mother tiger who saw that Jessie's removal from home would only re-stimulate traumatic losses, and I was the idealized dead father who assured the school that someone was there to love and support Jessie—even though, in intervening, I might have been usurping the school's position as a good object. Yet, I was also aware that, in intervening with the school personnel, I was offering a more nuanced view of the situation at home, and I was protecting the overwhelmed mother who had failed Jessie as she morphed into a passive bystander.

It was a risk I was willing to take. In the long run, it stabilized Jessie. Our relationship deepened as I interpreted to her the meaning of the split she had created. In her instigation of the institutional splitting between school and home, Jessie may have been retaliating against her mother for betraying her; at the same time, Jessie's actions may have been a desperate attempt to recreate the union of a protective mother and her beloved dead father—the ones who watched over her and did whatever they could to keep her safe and secure. Now Jessie could experience myself and the school taking over that function.

Yet Jessie was not soothed. The school staff's alarm at her family's behavior, as Jessie had presented it, unleashed Jessie's rage at her mother. She stated "My mother just wasn't ready to have a trany. If she was, I wouldn't have been so confused about who I am—a boy or a girl. Trany babies are like mentally retarded babies—parents should be prepared for "whatever." Then Jessie's rage morphed into guilt and sorrow. Jessie felt terrible that she had ruined her family's life. She grew scared she would end up living on the streets; maybe it would be best if she did not live past forty. I found Jessie echoing the common fears of many transgender youth who anticipate or actually face rejection by and ejection from their families. But Jessie’s case was far more complicated. She had suffered severe trauma stemming from both rejection by one and death of the other parental figure.

In the last months of treatment, Jessie became adamant that she wanted surgery to get a vagina. She explained, “The only reason I waffled before is because that horrible place [the residential treatment program] messed with my head.” In the meantime, she grew increasingly desperate to start puberty blockers to stop the spreading growth of facial and body hair, and her mother finally agreed to help Jessie find an endocrinologist.

Jessie now appeared in sessions with long, multicolored hair extensions, bright red penciled-in eyebrows, and a bra with padded inserts. She had switched her employment visions from porn star to fashion model, and continued to speak with no apparent ambivalence about wanting a vagina. Now it was for the clothes aesthetics that she fought the battle of the penis bulge. She explored whether she might be a lesbian, but rejected that possibility as she came to realize that her only sexual attractions were to males. She was at the time attracted to two boys, one fifteen and heterosexual, the other nineteen and gay.

Jessie seemed to be calmer and less disorganized in her thinking. I made a notation in her file: “The dust appears to be settling, the storm somewhat over, as Jessie has worked through some of her loss and grief and is becoming clearer about a transgender identity, without all the deafening noise of trauma to drown out her gender authenticity.” Yet recovery is never so linear. Jessie’s emerging clarity about her identity was soon accompanied by a darkened mood. Jessie grew increasingly frustrated and angry, wishing she were dead. I felt it necessary to do a suicide evaluation, but I found her expressions reflective of her gender conundrums, rather than an expression of true death wishes. Her ambivalence about vaginas resurfaced. She wished she could have been born a girl; then she would have gotten used to having a vagina and would have learned to clean it with Clorox. In the meantime, she was going to have to figure out how to hide her penis, because she did not want anyone to mistake her for gender queer or androgynous—she was a girl. She tried duct tape, but it failed to conceal the bulge, and it was painful. She was lonely, wanted a partner—a mirror image of herself, a transgender girl with a penis. She could now imagine someone could love her, but felt diminished as a love object because she would never be able to afford the surgery that would better align her body with her psyche. She did not fault her family’s financial downturn after the death of her father; instead, she blamed the costly and harmful treatment program that callously had stolen her “vagina money.” Yet this might never have come to pass had Jesse not incurred both parental loss and loss of parental resources—physical, emotional, and financial losses.

CONCLUSION

Jessie was inundated with a cascade of external traumas. She lost a father who had loved and supported her, and then later the love of a mother who had once protected her. She had been sexually molested and exploited. She was harmed at the hands of a mental health facility that, despite an oath to "do no harm," had attacked her gender expressions and identity while unsuccessfully attempting to "repair" them. Although furious about the professionals' treatment of her, Jessie also internalized their message about choice. This became an organizing issue that Jesse/Jessie and I needed to address in therapy.

In our therapeutic relationship, I witnessed in Jessie a manic flurry of confusion between choosing and affirming. Recovery involved undoing the trauma of psychic gender mutilation by family, community, and professionals. Accomplishing that required replacing the trauma-inducing milieu with a safe and reflective therapeutic space (Ehrensaft, 2012). In that space, Jessie and I were able to stop the angst-filled merry-go-round of gender mania set off by the trauma to Jessie's gender self and then exacerbated by the loss of a loving father, the substitution of an attacking father surrogate, and the transformation of a protective mother into an impotent, or at times complicit, bystander. True mourning of a loved one can often be forestalled until the trauma surrounding the loss is dealt with. Such was Jessie's situation.

Once the trauma of both gender and family collapse was worked through and a safe therapeutic place established, Jessie could finally engage in a mourning process for her dead father and more reflectively explore her authentic gender identity and expressions. Jessie was in the midst of this work when our time together abruptly ended after eighteen months.

As a post-script, Jessie's subsequent therapist at the community clinic later reported that Jessie was taking hormone blockers, covered by insurance, and seemed settled in her affirmed female gender identity.

According to Winnicott, adolescence necessarily involves the symbolic act of killing off the parents and taking one's own place as an adult. He warned parents of adolescents: "You sowed a baby and you reaped a bomb . . . somewhere in the background is a life and death struggle" (1970, p. 145). The "bomb" that was Jessie's adolescent experience had exploded in the heat of her gender dysphoria and her real experience of parental death and loss.

The potential for Jessie to have a positive journey into adulthood lies in her ability to feel confident in the path she is taking; the willingness of her mother to make room for Jessie to take that place with dignity, love, and parental support; and her evolving hope and belief that her dead father would have willingly done the same.

NOTES

1. Sarah Cyton with Harriet Malinowitz, “Butch in a Tutu,” in M. Rottnek (ed.) (1999), Sissies & Tomboys: Gender Nonconformity & Homosexual Childhood, p. 221.

2. Gender creativity is a term I adapted from Winnicott’s concept of individual creativity (Winnicott, 1970), defined as each individual’s construction of his or her unique gender self based on core feelings about oneself and chosen expressions of that self (Ehrensaft, 2011).

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Chapter Six

Mourning Childhood Loss in Adolescence

An Indirect Approach to Feelings

Daniel Gensler

In this chapter Daniel Gensler reflects on his well attuned therapy with Susan, a teenager who lost her biological parents after she was adopted and then lost her adoptive mother to illness. His ideas are generative and thought-provoking on many levels.

First, Gensler shows a clinical open-mindedness. He writes from a grounding perspective as a seasoned psychotherapist, informed by the diverse vantage points of theory and technique he has integrated through his psychoanalytic training. He approaches his ongoing therapeutic engagement with Susan free of theoretical rigidities or prejudices. His vivid formulations and intervention choices are informed by his subjective feelings, as well as Susan's, and this makes fertile space for the spontaneous and the creative to emerge. As a result, he provides a compelling example of how an empathic clinician and an adolescent patient can co-construct a productive therapeutic approach.

Second, Gensler's work with Susan helps us think about our notions of how therapy can be more or less effective, as we shift with the rapidly changing social and technological advances of our times. Computers, popular culture, and changing teenage social norms are employed skillfully and integrated into the therapy. When we read about Gensler and Susan IM'ing each other in sessions, what may start out as possibly jarring to a clinician's sensibility becomes exciting as new possibilities take shape.

Finally, while Gensler describes the case of a teenager from an economically advantaged background in the psychotherapeutic culture of New York City, what becomes vivid in this chapter is the work of a masterful clinician modeling what psychotherapy, well conceived and well supported, has the potential to achieve. No matter what the setting, therapists who work with *teenagers who have lost parents will find this paper a wellspring of applicable and practical techniques and directions.* —Eds.

When a child's parent dies, mourning takes a long time. If the child knows that the parent is dying, there is anticipatory dread, fear, anger, and sorrow, depending on the circumstances. After the death there can be a period of numbing and denial, but then ache, loneliness, blame, sadness, guilt, and some chaos as family life changes. Depending on the child's defenses and the family's communication style, these feelings can range from being clear and focused to vague and diffused.

Sometimes the surviving parent engages a child in therapy after a terrible loss; the therapy runs its course and ends. Then life and development can present new stresses that revive the old hurt in a new way. Such predicaments can lead the parent to return the child for another round of therapy, and another, and another.

When there have been several such rounds of therapy, they can differ in important ways. Over time, the next therapist may not be the same person as the last therapist. Further, the child may be dealing with different consequences of the loss, such as changes in family structure (new stepparent, half-siblings, step-siblings, home, school, change in family income, and so forth). In addition, defenses might change, with the child more or less ready to deal with feelings. The move from childhood to adolescence creates new meanings for the loss of a parent, especially when a stepparent enters the picture. A girl whose mother died may have had her father to herself until he remarries. Feelings of betrayal, rejection, jealousy, and resentment are hard to avoid and equally hard to express.

DEVELOPMENTAL AND CULTURAL FACTORS IN COMMUNICATING ABOUT LOSS

Over development, there are changes in the forms of communication used in therapy to express feelings pertaining to loss. Children often express their feelings and understandings through art, play and metaphor rather than verbally. By the time they enter adolescence, teenagers know more than children do that their feelings are potentially verbalizable. Yet some teenagers cannot bear to discuss feelings related to the original loss or to more recent consequences, such as getting a stepparent. Or they can discuss such feelings in a compartmentalized or hypothetical way that keeps their actual feelings unknown, or obscure. Or they enact their feelings in misbehavior.

The forms of communication used to express feelings of mourning also vary over cultures (Parkes, Laungani, and Young, 1999). Ekman and Friesen (1986) have established that the judgment of emotion from facial expression is universal across cultures and countries. However, the meaning associated with that particular emotion varies across cultures (Biehl, Matsumoto, Ekman et al., 1997), with differences in the norms that govern how facial expression of emotion is decoded and interpreted. Other research indicates differences in emotional responsiveness between Chinese Americans and European Americans (Tsai, Levenson, and McCoy, 2006).

Early parent-child interaction is another factor governing the range of emotional expression that becomes familiar to a child. Baby and parent influence one another from moment to moment, and these patterns of interaction become represented, repeated, and preferred. Affect regulation and attachment style structure these patterns of interaction (Beebe, Lachmann, and Jaffe, 1997), and such patterns influence how loss is experienced.

Forms of emotional expression also vary normatively with a child's age and stage of development. Regarding mourning, Christ (2000) presents the idea of a cascade of events which occur over the months and years after a parent's death. During these events a child reconstitutes herself and goes forward. Often this cascade of events influences later development more powerfully than the original effect of the death itself. Christ also examines how normal children cope with loss at different developmental stages. In her study, children nine to eleven years old could not tolerate grief and escaped to school, peer, and sports to avoid it; children twelve to fourteen years old withdrew emotionally from their parents, and avoided information about the dead parent's illness.

COMMUNICATING ABOUT LOSS INDIRECTLY

In psychotherapy, communications about loss can occur indirectly. The commonly heard conversational terms "like" or "whatever" suggest a custom of avoiding clarity, declaration, and specificity. When a teenager in therapy avoids clarity in this way, it is possible to go forward while respecting the need to stay vague, rather than to try to overcome this tendency. From different points of view, this approach could be called respecting a defense (Spiegel, 1996); joining the resistance (Minuchin, 1974); containing unbearable affect until the teenager can bear it (Slochower, 2003); or getting into relation with a teenager's various self-states enough to remain in relationship as the self-states change (Bromberg, 1998). In this kind of approach, therapist and teenager can discuss trivial, associative, random, and mutual interests, using verbal, artistic or electronic media to express them. This approach allows teenagers the space and context they need to suggest or invoke feelings while also keeping feelings sufficiently undefined. This kind of vagueness in expressing feelings can respect the teenager's genuine experience of the loss when that experience is of a vague, ineffable, but painful presence. Intermediate and indirect ways of communication help teenagers avoid dealing with more feelings than they can handle in the moment. Respecting vagueness, and allowing approaches to the expression of feelings that stop halfway, are therapeutic stances that respect a teenager's wish not to comply with adult or therapeutic expectations for verbal expressiveness. Through remaining undefined, a teenager can protect herself from unbearable feelings, and also preserve her personal and generational identity as someone who alludes rather than denotes. A therapist who accepts this lack of definition may simultaneously be colluding with a defense and fostering an alliance. Late in the therapy, to become more defined may or may not become a treatment goal.

I find Winnicott's (1963) ideas about communicating and not communicating useful in thinking about psychotherapy with teenagers, whether or not they have had the experience of loss. Going back to infancy, Winnicott describes how babies first perceive people as subjectively created by the baby as the baby needs them. After a while, a baby can perceive a person objectively as a separate person. With this change come several uses of communication: first, passively not communicating, as when the baby is resting; second, overt communication with objectively perceived people; and third, actively not communicating with objectively perceived people. Winnicott formulated this sequence decades before the more modern attention to the interactional processes underlying how babies learn to communicate (Beebe, Lachmann, and Jaffe, 1997).

In Winnicott's last use of not communicating (actively not communicating with objectively perceived people), a baby has already started to develop what Winnicott calls a false self. With a false self, someone can comply and respond to adults' wishes, rather than to make one's own spontaneous bid or gesture and have it be recognized or implemented by an adult (Winnicott, 1960). Reacting to a child's false self, an adult is not aware of the rest of a child's current experience and needs, though the child does not lose awareness of that very experience and of those very needs. A false self hides and protects a true self. In not communicating, a child is showing a preference not to use that false self to communicate.

In actively not communicating with objectively perceived people (Winnicott's description of a baby's third way of communicating), it becomes important that the part of the self that is not false or compliant (what Winnicott calls the true self) not communicate, and therefore not be found and compromised by an adult who cannot attune to that part of the child. The importance here is that not communicating lets a child preserve its true self. During this kind of active non-communication, there is less communication with objectively perceived people, and the child withdraws into inner experience. The inner experience includes subjectively perceived people who can meet and satisfy the child's needs, as the child used to imagine before learning about communicating with objectively perceived people.

This kind of silent communication is the beginning of what Winnicott called transitional phenomena with subjective objects. A baby or child starts with the illusion of omnipotently creating and controlling the world, and gradually recognizes the illusory, playful and imaginary nature of this experience. In the midst of this process there is no requirement to judge whether experience is perceived subjectively or objectively. In older children and adults, this kind of communication becomes an involvement with symbols, creativity and cultural life.

Winnicott (1963) applied these ideas to adolescents. He recognized the importance of respecting an adolescent's uses of expressions that are intermediate between communicating and not communicating with objectively experienced others. He noted that before teenagers are ready to be found and known by adults through verbal communication, they search for

> "a personal technique for communicating which does not lead to violation of the central self. . . . That which is truly personal and which feels real must be defended at all cost, and even if this means a temporary blindness to the value of compromise" (p. 190).

His ideas are relevant for adolescents who are in mourning, or whose mourning is frozen as time and development move along. Worden (1996) describes the work of mourning in childhood and adolescence. A child needs to accept the reality of the loss of the parent; experience the emotions around the loss; adjust to life without the parent; and find ways to remember the parent. Many factors affect this process, including

- the nature of the death
- the rituals of mourning
- the relation with the dead parent
- the ability of the surviving parent to nurture the child
- the child's relation with the surviving parent before and after the death
- changes in family structure after the death
- peer support, and
- characteristics of the child.

Over the course of mourning, the surviving parent has to adjust to single parenting, the child has to adjust to all the changes in daily life because of the loss of the parent, and the family has to find a way to talk or not to talk about the parent who died.

Many of these factors include a child's different ways of communicating, such as expressing the emotions around the loss, finding ways to remember the parent, talking with the surviving parent, relating with new stepparents, and communing with oneself through thinking, writing, doing art, and dreaming. When a teenager is in therapy, the therapist and teen find a way to interact with a balance of verbal communicating, nonverbal communicating, and not communicating about the loss. As that way of interacting becomes comfortable for the teenager, there is a greater chance to do the work of mourning that Worden describes.

In the following case I illustrate these points in the work with a girl with experiences of loss and trouble expressing feelings with words. Her trouble expressing feelings with words looked like alexithymia, whose features typically include trouble identifying feelings, difficulty distinguishing between feelings and the bodily sensations of emotional arousal, and trouble describing feelings to other people (Taylor, Bagby, and Parker, 2007). In her case, however, the trouble with emotional expression was not a rigid trait. Rather, it was more or less present depending on the kind of relationship she was in. Over the course of our therapy she and I were able to take advantage of this kind of flexibility through our relationship in order to make emotional expression easier for her.

CASE

Susan was fourteen when we first started to work together. I was her third therapist. She is an only child, adopted in infancy. She is sixteen at the time of this writing, still in weekly therapy. We also have had family meetings, every two or three months at first and every six months more recently. I see her father and stepmother either with her or without her; we arrange it beforehand. The trigger for the referral for therapy with me was the imminent death of her maternal grandmother (the mother of her adoptive mother), who was dying rapidly of cancer.

Susan is a quiet, smart, petite, pretty girl who attends a private school in New York. She was born in Vietnam and given to an orphanage at six weeks. At seven months her parents adopted her and brought her to New York. When she was seven her adoptive mother contracted cancer, was sick for two years, and then died when Susan was nine and in the third grade.

In the process of therapy, we learned about Susan’s experience of the loss only occasionally, not every time we reviewed it. Usually the review was at my instigation, not hers. Often she said she did not remember and moved on. Nonetheless, over the course of time she recovered and reviewed a number of memories with me. Before her mother got sick, Susan remembered folding the laundry with her mother and with a former housekeeper. She was sitting on the couch with her mother when her mother first told her that she was sick; her mother also told her that she was going to get better. The way she explained it, the good guys win; with her illness, the bad guys were bad cells in her body and the good cells were going to win. Susan believed her mother; she knew that her mother was sick but did not think she would die.

When her father stayed late with her mother at the hospital, Susan slept at a friend's house, or stayed at home with a woman who used to babysit for her, or with a friend of that woman. She remembered their names. She remembered visiting her mother in the hospital, as well as a period when her mother came home for a while and there was a hospital bed in the den. She remembered her mother vomiting. When they had to drive her mother back to the hospital, Susan remembered her mother telling her father, "be careful, the bumps hurt."

One day when she came home from school, she saw that her grandparents were there and figured that her mother had died. Her father took her to her bedroom and confirmed that terrible news. He cried but Susan did not. She felt like a robot on autopilot—"who knows, maybe I'm still on autopilot." She went to the funeral and remembers a lot of people talking. Her father asked her if she wanted to say something and she did not. She remembers no review of memories afterwards. Susan vaguely knew that her mother's ashes were stored somewhere in their country house, but this was never discussed. In a contradictory, dissociated way, Susan also had the experience of not knowing what became of her mother's remains.

As her mother was dying, Susan was sent to psychotherapy because of mood swings, anger, and dissociative episodes ("it's too much, I can't handle it, I go blank, I separate from myself, I have to ground myself"). The therapist, who was a woman, had the chance to meet her mother, too. At the time of her mother's death Susan could not say how she felt about her mother, except that she thought that she had loved her mother. Although she said the therapist was nice, Susan was nervous and barely participated in this therapy. Later she called it "fake therapy." It lasted a year.

Just after her mother died (which was five years before she started therapy with me), Susan was afraid that something bad would happen to her father. Around the time she started therapy with me, she wrote a song about her fear that her father could die too. She shared it with no one at the time:

> "just like before, I never meant to lie, I just had to be sure that you would survive, but the next thing I knew, you left me alone with nothing but pictures, and my heart torn."

She showed me this song two years into therapy, when she was more able to realize and to review with me the feelings she had after her mother died.

A year after her mother died, when she was in the fourth grade, Susan's teacher took her into an office and asked her how she was. Susan did not want to talk. Her teacher called her loss an elephant in the room, something everyone knew about but no one mentioned. After getting Susan's permission and her father’s permission, the teacher told the class that Susan’s mother had died. One girl asked her how it happened.

In her first therapy, Susan had asked her therapist, "is it OK if I don’t like my dad’s girlfriend, whenever he gets one?" Two years after her mother died, when she was eleven, her father met Mary. They married when Susan was almost thirteen. I will refer to Susan’s father and stepmother as her parents. With her tendency not to speak of feelings, she did not speak about her biological parents. However, her later interest in attending a meeting of Asian adoptees suggests the feeling of being attached to them and identifying with them as Asian.

In the seventh grade, after her father and Mary married, Susan felt distant from Mary. When Susan got her period she had great trouble finding words to tell this news to Mary. She was spending much time on the internet, instant messaging with her friends. Susan re-entered therapy at that time with a second therapist, also a woman. At the time she said, “nobody knows me, I don’t know how to talk about myself.” She did not speak much in this therapy either, avoiding any reference to her adoption or to her mother’s death. She did not like her second therapist. After sessions when her dad would pick her up, she was mad and wanted to cry because she did not want to go to therapy. She wanted to talk about that with her father but couldn’t because she didn’t want to upset him. She didn’t talk about it with friends either. At the end of the school year she refused to continue, saying she needed to see a male therapist instead.

I was Susan’s third therapist. She came to me at the age of fourteen, at the start of eighth grade, because her parents were concerned about her silence with them. She spoke only when spoken to, and answered briefly. She could think about her feelings without difficulty when she was alone, but “went blank” when someone asked her how she was feeling (she could not focus on the question and could not answer it). She was rejecting toward Mary and told her not to hug her. She was also lonely at school and was having trouble with her two best friends (one would reject her and the other would insist that Susan always agree with her; then the roles would switch).

The trigger for the referral for therapy with me was the imminent death of her maternal grandmother (the mother of her deceased adoptive mother), who was in a hospice dying rapidly of cancer. Susan had been close to her grandmother and visited her twice at the hospital, but did not verbalize feelings about her dying. Her grandmother died between our first and second sessions. Susan made a slide show of pictures of her mother and grandmother, which helped her mourn. Months later she made an abstract sketch that reminded her of her grandmother, but she could not say how.

Susan found that Mary, unlike Susan’s father and mother, was expressive and inquisitive, and Susan often felt overwhelmed by her expectation for verbal responsiveness. By her father’s report, neither her father nor her mother had been good at talking about feelings. After her mother died her father had become even more silent. Currently she thought that her father and Mary knew little about her experience of life, both positive and negative.

Susan and I found a way of getting to emotionally meaningful topics indirectly. We would speak in a free-associative, light, random, mutually directed way. For example, she was a little compulsive, and would comment jokingly on something out of order in my office. Or we would talk about something neutral or peripheral. There were silences, sometimes awkward. She told me that she liked that I spoke quietly. I would disclose something about myself or my thoughts and feelings, with regard to the neutral or peripheral topic, without asking her for her comments. Usually we would get to something she cared about. For example, she read me portions from her diary, writings about sad, lonely, confused states of mind. I could not learn why she chose these portions rather than others; when I asked, she would tell me she didn’t know. We could also talk about the indirect way we were conducting our conversations. That was comfortable for her, and she seemed to enjoy coming to sessions. But she could not answer direct questions, explain what she meant, or initiate talk about her feelings. In response to my questions about her feelings about her friends, for example, she would reply, “maybe” or “I really don’t know.” Later she told me she knew her thoughts, but that they slipped away when she tried to speak them.

Once I noted to her how competent she was at picking up social cues and reading other people’s intentions and feelings. She told me that she knew her parents wanted her to open up more about her feelings. She found her father too slow in his responses to her, saying a few words and then stopping to think about what to say next. She would lose her focus with him, or feel impatient with him, or wonder if he was being fake as he chose what to say rather than to say it spontaneously. In fact she may have been misinterpreting his slow pace in finding the words to express himself, wrongly construing his slow pace as coming out of the kind of inauthentic expression that she disliked in herself and tried to avoid. He rarely spoke about her mother to her; when he did, he would become upset; and so she found more reason not to speak with him about her mother in the wish to spare him this kind of upset.

She also found Mary confusing. She said that the looks on Mary’s face made her uncomfortable, and made her wonder if Mary was disapproving of her. She wished her parents would accept her as she was, and not push her to express herself more. She mistrusted people who said, “I know what you mean,” doubting that they actually understood her when she hardly understood herself. She found Mary’s compliments to be fake and wondered why Mary was making them. She thought that Mary asked too much, cared too much, and tried too hard. Susan did not like how, if she said, “I guess so,” Mary would press her to say more about what she meant. She and her previous therapist had wondered if she had more trouble trusting women since her mother died; in Susan's mind this was possible, but only speculative.

After a while she became more able to speak with me about emotional matters. She let me read certain passages from her journal. Struggling to find the words, she described an experience of being only "partially present" in her mourning of her grandmother, and feeling similarly in other places in her life. At this time there had been little discussion of memories of her mother's death. She also wished that she knew what she wanted to do when she was with her friends, beyond letting them boss her around. She thought she could speak about this openly with me, and not with her former therapist, because I was a man, though she did not know why this was important.

After a few months of therapy she told me that she did not like how her babysitter folded the laundry, compared to how the old babysitter (whom she had when her mother was alive) used to do it. She also remembered how she liked it when her mother would squeeze her foot hard when it felt tingly. She could go no farther regarding missing her mother and her mother's love, but we both felt this to be a connection, felt with some anger, to the loss of her mother. Since her deceased mother, like her father, was not particularly expressive of feelings verbally, the warmth and love Susan felt for her mother had come out most easily in shared activities.

Susan started to loosen up in therapy and in her life. For example, she let me see how creative she was. She started to doodle in sessions, showed me her sketchbook, and drew a picture of her apartment. She found a boyfriend for the first time, a student at a different school. She told me that she never had a chance to talk with her father alone because Mary was always there. She felt a certain bond with her father because they were both so silent and unexpressive, compared to Mary's talkativeness. At this time, she could not say that she resented Mary for that. Yet she started to tell me some dreams that were full of shooting and killing people. She also told me that she liked horror movies where people got killed. She could agree with my speculation that this had to do with some angry feelings; but it was just a speculation. She became clearer about her complaints about her parents, without differentiating between anger at her father and anger at Mary. They repeated her own ideas back to her as if the ideas were theirs; they were annoying in reminding her to do things she did anyway; they were confusing; and their questions concealed criticisms or suggestions. For example, when they asked if she could study while having the music on and instant messaging, she thought that they were really trying to tell her not to do so.

She started to feel guilty that she didn't feel like doing what she was "supposed to do" in therapy, namely, to look at why it was so hard to talk with her parents about feelings, such as feelings about her mother dying, her grandmother dying, or about having been adopted. By this time it was clear that she could express herself more easily with me than at home.

She told me that she had cried with a friend recently. She had been telling him about what she had already told me, that she would refold her clothes the way she likes, not the housekeeper's way. She also remembered how much fun it was to go through her clothes with her mother. She could not tell me more about this, but indicated that there was more to tell. She knew that the topic was important (memories of being with her mother and feelings about the comparison between being with her and being with Mary).

Then she asked whether we could spend a session instant messaging to each other instead of talking. She thought that communicating by instant message might help her tell me more. I asked her why and she just said, "I don't know." I agreed to do it and told her I did not have much experience with it, and she said she would help me set it up. The next session she brought in her laptop computer and helped me download instant messaging software into mine.

We spent most of the session instant messaging (IM-ing) with one another in what is called a chat session.[1] But by then, a week after the previous session, she did not tell me about fond memories of folding laundry with her mother. Rather, she told me about anger at Mary. Specifically, she told me in the chat session how mad she had become with Mary recently when Mary had been angry at her father. There had been something wrong with the family dog, who was limping. Mary had pressed Susan's father to do something for the dog, he was slow to respond, and Mary got annoyed with him. Susan told me all this by typing words and occasional emoticons (symbols that represent feelings), usually when she intended to signify humor.

In the IM chat format, I responded in two ways, one that was specific to the incident and another that was more general. Specifically to the incident, I noted that in addition to Mary's pressure, which Susan resented, her father had a hand in this too. For example, his slowness provoked Susan, as it usually did. More generally, I thought that she was mad at her father for marrying Mary, and that maybe she was taking out on Mary her anger over her mother's death. Without much conviction, she speculated that I could be right about her anger over her mother's death. She confidently agreed only that she was mad at Mary, but thought that it was wrong to feel that way.

At the end of the session we closed our laptops. I asked her how the experience had been for her. Typically, she said "I don't know" and asked me the same question. I told her that I had liked it and that I also had found it strange. She asked me what I meant and I explained that it had been fun first of all to do something with her that was new for me, and new for us. I also told her that the IM-ing had the appearance for me of communicating about something important, with both of us involved in the communication. But there was something different, too. On the one hand, I had learned her thoughts and we had done something fun together. On the other hand, I had not felt that I had spent time with *her* as I usually did in sessions, other than to recognize that we had been sitting next to each other and typing. She still didn't understand. I tried again and told her that I thought that she had shared her thoughts with me, but that there was a part of her that she had not shared, maybe the part of her that felt uncertain, nonverbal or ambiguous in her feeling about the incident she was IM-ing me about. When we spoke in oral communication, we were always aware of the trouble she has in communicating feelings; when we were instant messaging, there was no reference to it. We were acting as if we were communicating while ignoring the way she has trouble communicating. Yet cyberspace also enhanced our ability to communicate, offering a special place in which it was more possible for her to access and share her emotional life.

We talked about this further. Had the format of IM-ing driven away the trouble communicating about feelings, or just masked it? When Susan was alone or writing in her journal, she was able to be more clear about her emotional life. Had the chat medium allowed me to get inside her mind, leading to the feeling of intimacy and to more effective emotional communication? Or was there something contrived, represented for me in the thought that I hadn't felt as if I had spent time with her, during the IM-ing; that we had bypassed the rest of her as we got more direct access to her thoughts and feelings; and that that was what I had been missing. I added that though I had said "contrived," I didn't like the word; I thought that what she had said to me in the chat session was genuine, but I missed the rest of her. I also found some way to refer to the idea that perhaps the intimacy of IM-ing fulfilled a longing for exclusive closeness with someone; a different feeling from having to share her father with Mary. Typically, all she said was, "hmm, interesting," and the session ended.

Privately I thought to myself that I was missing the rest of her, as she missed her mother. The instant messaging, which deleted much of her bodily and affective presence, had given me an experience simultaneously of having her and communing with her, and of not having her and losing her. She also had once told me that she found it helpful to write down her thoughts, when she was in private, because she would worry that she would lose them, or that they would in fact get lost if she did not write them down. Knowing that they were written, she felt freer to go on to some other thought, secure in knowing that the first thought would not get lost and was there to return to. The chat session had given me a taste of her experience of having and losing.

In a subsequent family session, we discussed the idea that if she could mourn the loss of her mother more, she might accept Mary more. We also spoke about bringing in photos of her mother. In the last session before she went off to overnight summer camp, Susan brought in photographs of her mother. We reviewed them and discussed related memories. This review of pictures was not her idea; it was a combination of mine and Mary's. Susan was noncommittal about how she felt about reviewing these pictures.

At the midway point Susan was enjoying camp very much. However, just after seeing her father and Mary on visiting day, she felt lonely and upset with thoughts that her parents had not changed and were not going to change. She also wished she had more time with her father, without Mary around. Shortly thereafter she told a boy at camp, “I’m afraid I’m going to do something stupid,” and let this boy read passages in her diary in which she alluded to suicide. The boy told the camp director, who called Susan’s father.

In hindsight I wondered whether Mary and I had taken control away from Susan by reviewing those photos just before camp started, exposing her to feelings of longing and thoughts of comparison between life before her mother got sick, and life now. I wondered if she could not bear those thoughts and feelings without the safety of controlling their timing and context, and that similar feelings had re-emerged on visiting day.

Father, Mary and I discussed options, including Susan coming home early from camp, using psychiatric medication, or seeing me more frequently. Once visiting day was over, however, Susan was feeling herself again and did not want to come home early from camp. Upon her return she saw me twice a week for a little while before returning to weekly sessions. She could never talk about the feelings or the content of her suicidal thoughts.

When she saw me after camp, she was able to tell me that she wished her father would ask to spend more time just with her, without Mary, but that he didn’t; that if she pressed him for more time just with him, he would ask Mary’s permission; that in any event he’d feel guilty to leave Mary out; and that if he and Susan did something together he would be too awkward for her to enjoy it, and so it wouldn’t work anyway. She was able to tell me clearly that at times she wished her father hadn’t married Mary. About the suicidal episode at camp, she promised not to kill herself because she couldn’t put her father through another loss. She let me read something she wrote in her diary: “maybe when Mary tries to be motherly, I don’t want it because it’s not from my mother and I’d miss it from my mother, even though I don’t remember my mother being that way.” She worried that if she talked more openly with her father about such feelings, he would get teary, and then she and he could not handle the subsequent awkwardness.

We learned more about their awkwardness. Her father did not initiate hugging her; and when she hugged him, it felt to her that he was waiting for her to stop the hug, and this made her feel awkward or unwanted. She also felt guilty to want to hug him when it made him so uncomfortable. He would come into her room hoping to have some time to talk, but then he did not know how to start to talk with her, and would just sit awkwardly on her bed. She did not know what to do with him when this happened, and eventually he would leave.

We prepared some topics to discuss in a family meeting, including her father’s tendency not to hug her. In the meeting, her father wondered why he avoided hugging Susan. He wondered (in a way that was similar to Susan's) whether he felt awkward with her because of her increasingly adolescent body; because he was generally not comfortable with showing affection; because hugging her reminded him painfully of hugging her mother, who died; or because he was afraid Mary would feel left out. In contrast, Mary said that she would be thrilled to have him feel more comfortable hugging Susan. She also said that she was tired and annoyed at being used as a foil in a problem that at least partially did not have to do with her. After this meeting Mary and Susan's father entered marital therapy, a positive and useful step.

Susan transferred to a new school that fall, at the beginning of ninth grade and was socially happier there. Everyone had a laptop and she showed me hers, with desktop-wallpaper images of her two dogs. She showed me other creative expressions, including a paper she wrote on her laptop about a utopian world, and an interesting essay about herself and her community. She showed these to her parents too. She became popular, got a best friend, and liked a boy. She felt able to participate in a number of social groups, enjoying crossing between them. Her best friend was a girl who had also been adopted from Vietnam. Susan went to an Asian cultural event with her, and for a while she and this friend thought of traveling to Vietnam. There was no other reference to her Asian roots or to her adoption. She enjoyed coming to the same conclusion at the same time with someone, whether with her best friend, the boy she liked, or me. She was talking more with Mary, and referring to musicals and books about children whose parents die. She was playing basketball and enjoying learning more about the New York subways.

She showed me more of her drawings; a blog that she had started; and a website where she was creating emotionally evocative images by combining clip art from drop-down menus. She was becoming more creative and thoughtful. For example, she described memory as something on a high shelf, covered by fog, something that you could get to by a chain of associations or (mixing a metaphor here) by drilling down to it. She called her creativity "a cave where things keep coming out." She showed me a moving song she had written about her mother, with lyrics about feeling guilty that she did not remember her mother more. She went shopping with Mary, but she still had trouble feeling connected to her.

She was generally happier and more open, though still mostly silent at home. She decided her father would never stop being awkward. Through analyzing a dream of hers, she let me know that she had begun to be curious about what happened to her mother's body after she died. The fact that she did not remember that her mother had been cremated indicated how massively she and her father had avoided the subject. But she decided not to ask, because she dreaded having to get the "sympathetic look" from Mary and the hurt look from her father. She went into more detail about her frustration with her father:

> "he tells me to talk with my teacher before an exam and when I say I will, he says, 'are you sure?' and I'll get annoyed because I just told him I would, and he'll get awkward and act like I didn't understand why he had said, 'are you sure?' When he leaves I'm so frustrated that I cry, and then I get over it."

She could also consider how she felt about using words to refer to feelings without believing that the words truly corresponded to her current feelings. She thought that doing so would be "mendacious" (a word she had just learned in school).

DISCUSSION

This case is about a teenage girl with multiple losses in childhood, including her birth mother and then her orphanage in infancy, and later her adoptive mother and her adoptive mother's mother. She could not find a way to talk about the adoption beyond speculation and uncertainty. She had little to say about her grandmother's death. We kept working on her reaction to the loss of her mother when she was nine years old. She had trouble using words to communicate feelings in direct conversation, even though she could write in her diary about her feelings.

Susan wished that she could have a more direct and exclusive relation with her father. The fun and intimate feeling in our therapy sessions partially satisfied that oedipal longing. But I chose not to make that connection to Susan, with concern that doing so would turn the real feeling into an empty speculation. In general she had trouble speaking directly to me about her feelings, and found it easier to use indirect, electronic, written, and artistic expressions. Sharing ideas through electronic technology (instant messaging, website sharing, and blog sharing) was similar to using more traditional media (showing me passages from her diary, her sketchbook, and her essays) and using indirect approaches to topics. Susan was using kinds of communication that were intermediate between thinking to herself about emotional matters and speaking to someone else about them. She felt safer and more capable of addressing such matters with the affect held at somewhat of a distance.

Memories of her mother emerged only in this context. Direct inquiry led nowhere except for speculation ("maybe, I don't know"). She had reviewed her mother's death in two previous therapies. Its meaning during the time of the therapy with me was not just about what happened when she was nine years old. The meaning of her mother's death also took shape in the present, as she was dealing with adolescent wishes for autonomy and love, with feelings about her father's love and attachment to her stepmother, and with oedipal wishes for a more exclusive relation with him. She was also discovering the uses of her creativity for self-expression, and she was learning to live more comfortably with her balance between communicating and not communicating about emotional matters. The memory of her mother's death was obscured by time and by her characteristic way of repressing the communication or experience of feelings. There was also a combination of sad longing and guilty resentment to be expected to think and talk about her mother's death, during therapy sessions. She could not easily speak about her feelings of loss directly to me without working around to them, referring to them speculatively, feeling doubt about them, and so forth.

Speaking about feelings of loss became more possible as she found a way to speak about her feelings in general. Susan knew many of her feelings but found them too confusing, intense, or dangerous to verbalize more easily. She needed media for emotional communication that felt under her control. When Susan reviewed the photos of her mother with me and her parents, she may have been faced with feelings of longing for her mother at a time when she was not ready to face those feelings. I believe that during visiting day at camp, she was overwhelmed with the contrast between life at home with her father and stepmother, compared to memories of life with her mother years ago, and she became briefly suicidal. Indirect, creative, artistic, written, or electronic communications helped her to feel more safely in control of her feelings, including feelings of longing for her mother. Feeling more safely in control, she could share such feelings. Susan could also feel in a special relation with the experience and the product of creating these expressions. She was getting to know and own her own brand of creative expression, one that felt both like self-communion and like intimacy with another person, without feeling fake or inauthentic.

Different points of view are helpful in understanding Susan's way of expressing feelings. Looked at culturally, it is possible that living for seven months in a Vietnamese orphanage left her with very early procedural memories of a cultural way of inhibiting the expression of emotion. Looked at systemically, her adoptive parents' inhibition of emotional expression also had its influence. Looked at through an ego-psychological lens, Susan was using defenses such as undoing, intellectualization, inhibition, and dissociation, to protect herself from experiencing intense feelings of loss, longing, resentment and jealousy, feelings that could otherwise disrupt her stability and even lead to suicidal ideas. Looked at developmentally, it was not unusual for a girl her age to avoid information and emotional expression about painful feelings. Looked at through a Winnicottian lens, over the course of therapy she moved from active non-communication intended to preserve a true self from being overwhelmed, to an intermediate area of communication that used indirectness, symbols and creativity, without needing to validate what they actually meant, or what feelings they actually referred to. For Susan, intermediate areas of communication included electronic media such as instant messaging, web site sharing, and blogging, as well as traditional media such as art, writing, and metaphor. In this intermediate area of communication, it was crucial not to require her to elaborate, to say what she really meant, or to explain what the symbol actually indicated. Considerations of reality and actuality would have pushed such communication into a false-self realm that would have complied with my wishes or her parents' wishes, for the sake of satisfying our need to think that she was speaking with us about her feelings. But making her try to say what she actually meant or felt would also have undone the integrity of the experience of having tried to communicate from a true-self position. Further, pressure to verbalize her affect before she was ready would also have ignored her wish to be like her father in his unexpressiveness. She also feared that openly expressing her feelings would injure him. It would also have ignored her likely identification with her deceased mother, who was also described as relatively unexpressive of emotions. Finally, it would have ignored her adolescent wish to feel and think of herself as different from her stepmother.

In conclusion, teenagers know that art, play and metaphor refer to experience that is potentially verbalizable. They know that they are no longer children, who play and may not communicate feelings primarily through verbal expression. Yet it is still problematic to verbalize painful experience before a teenager is ready to do so, in therapy or otherwise. Adolescents in therapy after painful losses need to discover a balance between verbal expression, nonverbal expression, and non-communication altogether, as they look for ways to express themselves that feel like a genuine creation of their own. Susan was able to use such a process to verbalize, hold in mind, and share memories of her mother with me, allowing her to process her loss a little more. Therapy can support this process, unless the expectation to focus on verbal expression overlooks teens' fuller selves as they work through painful experiences such as mourning and loss.

NOTES

Earlier versions of this paper were given at the spring meeting of the Division of Psychoanalysis (39) of the American Psychological Association, New York City, April 2011, and at the "Where the Wired Things Are" conference in New York City, October 2010. Thanks to Dodi Goldman, PhD, and to audience discussants for their comments. Thanks also to the editors of this book for their helpful suggestions.

1. With the rapid development of social technology, this use of instant messaging would now more likely be replaced by chatting through Facebook.

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Chapter Seven

Revisiting, Repairing, and Restoring

The Developmental Journey of a Bereaved Adolescent

Norka T. Malberg

We are privileged to get an in-depth view of how Norka Malberg expertly conducted a four times/week psychoanalytic treatment with a fifteen-year-old girl whose development had been disrupted and "frozen" at age eight, after she lost her father. Pam began her three years of treatment at the Anna Freud Centre in London depressed, with sleep disruptions, frequent potentially deadly accidents, difficulty attending school, poor peer relationships, and recurring panic attacks and dissociation.

Malberg joins Pam in her pain and takes her from her stuck position in a latency stage of development to become an adolescent capable of moving on. The focus of the paper is on the complexities of Pam's experience of grief with a mother, who was unable to help her, and the development of a meaningful therapeutic alliance that facilitated her process of internal and external development. In the transference Malberg is seen as both the mother who was incapable of providing adequate care, with all the conflicting feelings that entailed, and as a safe, containing mother, who elicited feelings of vulnerability and fear. Malberg's challenge was to help Pam feel and reflect yet not disintegrate.

Using her psychoanalytic lens, Malberg draws from contemporary literature on attachment, loss, bereavement/mourning, and grief. As the therapy unfolds she vividly describes her induced countertransference of maternal feelings as she seeks to contain Pam's sadness, fear, pain, rage, and loneliness. As a skilled and sensitive clinician, Malberg states her own feelings and reactions and invites Pam to join her in thinking about them, ultimately helping the teen modulate her own affect and memorialize her lost relationship.

The untimely loss of a still-needed parent unleashes many intense feelings in a child, and Malberg has described her therapeutic role in creating a safe place for Pam to revisit her early trauma, and repair and restore her relationships with both of her parents. In describing her work, Malberg acknowledges

> *the importance of collaboration with others, including collateral work with Pam's mother, communication with her medical doctor and school personnel, and finally supervision, where Malberg found her own safe place to reflect and take care of herself.* —Eds.

Pam, a robust and rather tall fifteen year old with ginger curls cascading over her shoulders, shyly entered my office. She sat, looked around, and spoke of the smallness of my consulting room, but added that it had a beautiful view. She wondered if the view helped me cope with the somewhat claustrophobic feeling of the room. I replied that I did not think the room was so small but that perhaps it felt that way because of the uneasiness of this first encounter. Pam smiled and said human beings get used to what we have to, and we learn not to wish or hope for more, or at least pretend to avoid the pain of not having. I wondered if she could give me an example. Pam replied, "Well, take me as an example. I am really here because I could not cope anymore with the pain of having lost my dad seven years ago." A silence ensued, and Pam, as she would many times during our work together, looked out the window. She commented on how rainy it was, and how scared she was of falling on the street and hurting herself.

In "Pathological mourning and childhood mourning," Bowlby (1963) speaks of four variants of pathological response to object loss in bereaved adults: anxiety and depression with persistent, unconscious yearning to recover the lost object; intense, persistent anger and reproach toward objects including the self: becoming absorbed in caring for someone else who has also been bereaved, sometimes compulsively; and denial that the object is permanently lost, frequently resulting in a split in the ego. Bowlby notes that these responses can also be present in childhood mourning, and warns about their pathogenic potential for the child's object relations.

Contemporary attachment theory highlights the importance of "good enough care" and containing—and how their presence or absence influence the way young children manage trauma. This is especially relevant in the context of emotional regulation—the process of modulation, modification, direction, and control of intense arousal and distress, and developing patterns for coping with stress. Following my first encounter with Pam, I struggled to make sense of her presenting difficulties. I realized that my feelings of being puzzled and somewhat lost might be a countertransference response to Pam's feelings of ambivalence and fear regarding psychotherapy. Many of the themes expressed that rainy, dark afternoon would be revisited during the next three years of our analytic work together. The trauma of Pam's early parental loss had cast a painful shadow, resulting in developmental inhibition in the organization of her precarious ego functioning.

This clinical paper seeks to illustrate the complexity of child and adolescent mourning by looking from a contemporary psychoanalytic developmental lens at my four-time-a-week psychoanalytic treatment of Pam, who had lost her father to a year long illness. I hope to convey the uniqueness of the subjective experience of grief and the importance of allowing the different developmental narratives, with their multiple meanings, to emerge and transform, parallel to the development of the therapeutic alliance and the young person's own developmental process. I will explore the impact of the death of Pam's father on her psychic development and functioning. Also, I'll describe the effect of Pam's mother's psychopathology, and her incapacity to protect young Pam from environmental impingement, on Pam's symptomatology and her sense of being stuck. By allowing a disorganized state of bereavement to emerge in the room, Pam and I were able to work through the painful process of mourning by modulating affect, habituating to change, and memorializing the lost relationship. This occurred parallel to the process of revisiting, repairing, and restoring in the context of the therapeutic dyad.

THE BEGINNING OF OUR JOURNEY TOGETHER

> "We assume that the process of mourning for a loved person will last while the emotions of the mourner are concentrated on the loss, as well as on the necessity of withdrawing feeling from the inner image of the dead. So far as this means withdrawing from the external world, the task of mourning interferes with life itself. So far as it signifies a reunion with the dead by means of reviving and reliving the memories concerning him, mourning is known to be as absorbing and fulfilling as it is painful" (Anna Freud, 1967).

Pam, from South London, was referred to a child psychiatrist by her school's guidance counselor. The counselor became alarmed after Pam, usually a compliant and quiet girl, had gone into a rage and "went after" a classmate with a pair of scissors in a rage. Jack, the class clown, had made fun of her because she was wearing a "funny old shirt." Jack was unaware that the shirt had belonged to Pam's deceased father. Pam, in a state of total despair, had sobbed for over an hour and then slept for more than two hours in the counselor's office. Pam confessed that she never got more than three hours of sleep a night and often slept in the afternoon after school, before her mother came home from work. The guidance counselor conveyed sympathy over Pam's loss, assuming her father had died recently. Pam responded with hysterical laughter and told the counselor that he had been dead for seven years.

Pam's mother, Mrs. H, was appalled at first by the referral and confronted the guidance counselor, saying Pam had never given any trouble at school and was now being punished. However, once she found out the details of the episode, she became more agreeable. After a few sessions, Mrs. H, became infatuated with the psychiatrist, a woman in her fifties, and called and wrote emails professing her love for her. In response, Pam refused to return to my colleague's office for treatment following a brief diagnostic period. She felt ashamed and angry toward her mother.

A few months later, Pam experienced a dissociative fugue in the middle of the street and was hit by a passing bike. After taking care of Pam's physical injuries, the emergency physician suggested a referral to mental health services to rule out suicidal ideation. Following Pam's recovery from her injuries, Mrs. H contacted the psychiatrist in a more appropriate manner, and the referral was made to me for psychodynamic treatment.

The referring psychiatrist felt that psychoanalysis, four times a week, was needed to contain Pam's high levels of anxiety. The referral read, "[T]he only way in which Pam's treatment has a chance of being successful is if the parent worker manages to engage and contain her mother, to help her recognize her own need for psychotherapy and understand Pam's needs as separate from her own. Otherwise . . . she will interfere significantly in the treatment and sabotage her daughter's progress in any way possible."

Pam came to see me after two phone conversations and three missed appointments. I was about ready to give up, a feeling I would experience quite often in the next three years. Pam presented with longstanding sleep difficulties, recurrent panic attacks, a history of frequent accidents (e.g., falling in the street and stumbling into things), and a perception of the world as dangerous. This fuelled her difficulties attending school, and forming and maintaining age-appropriate peer relationships. After the September 11 incidents in New York, Pam felt the world was finally confirming what she had always thought—that danger is everywhere, and life can end tragically and suddenly at any time. Pam said she had been depressed since her father's death and had never been able to "let go."

Pam seemed frozen at the age of eight when she lost her father. She had the demeanor and tone of voice of a much younger girl. She was well-spoken, but in the room she often mumbled and moved her rather developed body the way an awkward preschooler would. She covered up her grown-up sexual body with loose dresses and large shirts. She often sat hunched, and would cross her legs and arms as if covering or protecting herself from my gaze. Pam often stumbled on the way down the stairs and held the railing in a childish way. In response, I would often feel like holding her arm and felt concerned for her after her departure.

I was also able to see a different side of Pam—one that had allowed her to function in school up to that point. Pam loved books and writing, and knew interesting facts in history and science. She found the school's library a safe place and had developed a wonderful relationship with the school's librarian, an older woman from India who had seen Pam's strength as a writer and had encouraged her to write as a way of expressing her difficult feelings. Three months prior to Pam's referral, the librarian had left the school to go back home to India to take care of her ill mother. This had been a terrible loss for

Pam, and she wrote a wonderful poem for the librarian in which she acknowledged openly what the loss of their relationship meant to her.

Pam displayed a wonderful capacity to reflect and think with me about difficult realities in quite a manner-of-fact way. She related to me with warmth and humor. However, in her daily life, she would often find herself overwhelmed by sudden states of fear, sadness, and despair, responding by becoming phobic and retreating into a deadly stupor in the safety of her dark room, surrounded by her stuffed animals, like an infant in the womb.

Psychoanalysis, I thought, would provide the level of continuity Pam needed to access thoughts and feelings that had been repressed and turned into symptoms. It would also provide the possibility of building a strong treatment relationship that could enable her to explore her internal representations of the world and the ways in which they influenced her coping and responding to internal and external stressors. I was mindful that Pam could potentially experience me as an engulfing mother in the transference. This led me to focus on our nonverbal communications and sudden shifts in feeling states, and the need to name them to promote mutual regulation. I became aware of the multidetermined complexity of Pam's bereavement and her need to revisit the narratives she had constructed around the traumatic loss of her father in the context of her remaining primary caregiver who often failed to contain and buffer her.

Initially, because Pam's mother had become infatuated with the previous therapist, it was decided I would have very little contact with Pan's mother. However, as my work progressed with Pam, my communications became more frequent and regular with her mother. During the second year of Pam's analysis I saw her mother once a month, and I would often speak to her on the phone when Pam did not show up for sessions. In retrospect, I feel that this was very important for Pam, who feared the strength of what she called her mother's "poisonous madness."

RETELLING THE STORY: LIFE BEFORE AND AFTER FATHER′S DEATH

Pam's conception and birth, and the narrative of her early life while her father was alive, were fraught to say the least. Information presented here was reconstructed over the years I worked with Pam and her mother. Pam was born out of wedlock. Her father had been married but had had a passionate extramarital affair with Mrs. H. Mrs. H had been in a relationship with another woman for many years but had fallen in love with Pam's father at first sight. Parallel to this, Pam's father's wife was having her own affair with a much younger man, a friend of her husband. Mrs. H and the father's wife were pregnant at the same time. The father discovered his wife was having an affair, but accepted John, Pam's half-brother, as his own. The father separated from his wife shortly after John's birth. He moved in with Mrs. H and Pam, and he lived with them until his death. Unresolved issues of paternity and marital status infused both children's earliest months with tension. However, by the time the children were toddlers, both mothers put their differences aside for the sake of the kids. Despite this, Pam's father never fully recognized Pam. She was given her mother's maiden name. I later discovered that this had fueled Pam's ambivalence and envy toward John, whom she perceived as the "claimed" child.

Pam and her parents lived near her father's family of origin in London; the mother's family lived in Australia. Pam kept in touch with her mother's family and dreamed of going to visit them some day. Pam had many fond memories of her life when her parents were together and of weekend excursions to museums with her father and John. I often wondered how the existence of the parental couple in Pam's mind shaped Pam's ever-unfolding oedipal narrative and the identifications and the desires it held.

Pam's father was diagnosed with colon cancer when she was seven. He struggled with the illness for a year. Pam and her mother were convinced his family doctor had neglected his care and could have detected the cancer much earlier. As a result, there was a sense that father's death was untimely and unjustified. This fueled Pam's belief that the world was unfair and that she was destined to lose anything she cared for.

Pam's father died in the summer, but she had memories of his thin body being protected by a sweater during the last days of his illness. She often wore this sweater to sessions during the initial phase of our treatment.

Pam was allowed to be an active participant in her father's wake and funeral. She recalled how she and John helped each other during the process, holding hands and staying close. However, due to two years of property disputes between the two mothers, John and Pam lost the comfort of the bond their father had encouraged between them. Pam remembered crying and missing both her father and John.

During this period, Mrs. H's mental health began to deteriorate. By the time Pam turned ten, her mother had fallen into a major depression. According to Blum (2003) a surviving parent, traumatized, bereaved and in grief, may foster psychopathology and fixation to trauma by avoiding talking about painful memories. Under these circumstances, discontinuities favor the maintenance of contradiction and confusion, which contribute to cumulative trauma.

Pam remembered having to ask neighbors to take her to the supermarket and sitting by her mother after school, making sure she was alive and all right. Mrs. H suffered from diabetes and migraines, which often incapacitated her and gave her valid reasons to stay in bed. She would hold jobs for several months, but then lose them due to illness. Pam expressed her concerns about her mother to her doctor during a regular visit, who then gave her mother anti-depressants.

Things got better for a while. Pam felt maybe it was all right to be sad then and miss her father. I often wondered whether Pam's mother's somatization and experience of chronic illness may have helped bring about Pam's sense of lack of ownership over her own body. The toddler, in the process of mastering an emerging mobile body, also builds the psychological capacity to stand alone. Pam's toddler journey, in her mind, had been guided by the love and supportive hands of her father who was now gone. Without him, she had felt unsteady and unsafe in the following years.

Nagera (1970) reminds us that, as a result of developmental needs, school-age children who have lost parents tend to keep the lost parent alive, although they know the parent is dead and will not return. This delayed "letting go" of the lost parent results in a strong investment in a fantasy life, where the lost parent may be seen at times as ideal. When the surviving parent presents as unpredictable and fragile, memories of the lost parent may provide the continuity required for a coherent, yet precarious, development of the sense of self.

By age twelve, Pam was experiencing sleep difficulties, the result of years of constant evening interruptions due to her mother's drinking and socializing in their apartment followed by frequently sleeping next to her mother in vigilance. During these times, Pam would lock herself in her room until the morning hours, reading and, in her own words, "evoking happy memories of [her] father and longing for his return."

Mrs. H tried to commit suicide twice during Pam's latency years, once shortly after the death of Pam's father, and again when Pam was thirteen, both times with overdoses of alcohol and pills. The second attempt resulted in Social Services visits to the home, but nothing ever came of these. Pam often described how good her mother was at "being normal" when she had to. Pam felt that her voice and needs as a neglected child had never been seen or heard. Indeed, Pam felt left by her father in a world without parental containment and protection, and this interfered with her ability to integrate the loss of her father into an evolving narrative.

During the initial stage of the analysis, Pam's mother was complying with her psychotropic medication and seemed to be managing her diabetes well. She had been employed steadily for two years and was in a stable relationship with a female companion. Pam lived with her mother and often enjoyed the company of her mother's partner and her two children, who lived with their father but visited many weekends.

Pam was very close to her mother's friends and often spoke of her concerns for them. She was particularly fond of a neighbor in her thirties, a victim of domestic violence. Pam often asked me for consultation on how to help her and seemed to feel a maternal function in relation to this woman;

Pam worried about her and protected her as she did her mother. Pam had no friends her age and seemed isolated at school. She often spoke of feeling out of place everywhere, as if she did not belong in the grown up world or the kid world. She was in an “in between” state where she felt lost, unclaimed and afraid most of the time.

PAM’S NEED TO “FLY AWAY”

> “Although such aggressive thought and action, concerned as they often are with events of the past, seems pointless enough to the outsider, I believe their function, of which the subject is not usually fully conscious, is always to achieve reunion with the lost object . . .” (Bowlby, 1963).

The incident that prompted the school counselor to refer Pam occurred close to the sixth anniversary of her father’s death, a year before our treatment began and two months prior to the seventh death anniversary. Pam spoke of the impact that the anniversary date always had on her. Her sleep was disrupted, and she kept the lights on, as she had for months after her father’s death.

Pam filled the first two months of the analysis with stories of neighbors and endless angry monologues against Americans, Muslims, the British government, and her school principal. She conveyed her sense of the world as an unfair, abusive place. She would bring cards and all sorts of latency-age activities—coloring books, collections of soaps, other items. I would often comment on how important it was for Pam to keep me interested and alive. She would reply by making fun of my tendency to draw conclusions too quickly.

Despite all the “noise” in the room, I became aware of Pam’s tendency to disconnect from me rather suddenly and unpredictably. The room would feel silent and lonely at these times, and I would stay silent and wait. I understood these moments as Pam’s need to tune me out so she could reorganize. Later on in treatment we would name these moments “flying away.”

Putnam (1993) enumerates the protective functions of dissociation: automatization of certain behaviors; resolution of irreconcilable conflicts; escape from the constraints of reality; isolation of catastrophic experiences; cathartic discharge of certain feelings; and alteration of a sense of self, so a traumatic event is experienced as if “it is not really happening to me.”

As the anniversary of her father’s death approached, Pam’s affective state began to shift. The mood in the room began to feel oppressive and subdued. She would share random thoughts and memories about her father and her early childhood and then stare out the window and comment on how lucky I was to have such a beautiful view. I understood this as her response to overwhelming, painful, conflicted feelings over the loss of her father. I would comment that the anniversary of his death was a painful reminder of how, as she got older, every year the memories seemed farther away. Pam seemed to fall into a deadly stupor in response, staring out the window. During these times, I believe, Pam experienced dissociative states because of overwhelmingly painful affective experiences.

After several sessions of my staying silent and bearing those moments of fleeing, I began to feel the urge to keep Pam alive by asking questions. I came to understand this as the emergence of my maternal feelings in the countertransference when I faced Pam's intense sadness and loss. I felt protective toward her, concerned for rapidly deteriorating states of mind that led to increasing difficulties attending school and engaging in age-appropriate activities. Pam began to report frequent phobic reactions in crowded trains and buses. She spoke of walking long distances after thinking someone in the bus was a terrorist.

Pam traced her phobic symptoms to the day of her father's funeral. The following excerpt, from two days before the death anniversary, illustrates how Pam and I began to remember and make sense together of an experience that had paradoxically organized and informed both her capacity for continuing in the absence of a predictable, containing parental mind, and her lack of sense of self and agency:

> Pam walked in with her usual bag. I commented on how full it looked. She agreed and produced a stuffed bear, which she told me had belonged to her since she was little. She said it was her best friend and thought it was time we met, since we were the two people with whom she spoke the most about difficult things. She told me her dad's anniversary was coming up in a few days and that she had been feeling scared, as she usually did this time of year.
>
> I wondered if she could tell me more about this feeling. She said she remembered feeling like this after her dad's funeral, when she was afraid he was going to come back as a ghost. She said she used to feel confused, because she thought she wanted to see him but she did not like ghosts. She spoke of how innocent and naive she was, thinking that it was OK her dad had died, since she had thought he would come back, like Jesus. But then she saw how they put his body deep into the ground, and she asked her half-brother, "How is he going to get out of there to come back?" John had said he was not—that his body was going to stay there—and he had started to cry. Pam said she was angry with herself for being so stupid. She had not cried or said goodbye because she was convinced her father would be back.
>
> I commented, "You were eight years old." Pam replied, "I should have known better, but I did not have a mother like John's. My mom was too busy crying and making it all about her, like she always does. My dad left me alone with her and did not come back; he did not come back for me."
>
> After a long silence, Pam added, "Sometimes, I am so stupid I think I am going to see him again." Pam looked out the window and commented how much her dad liked sunsets.

This session marked a beginning. Together, Pam, Bobby the bear, and I went down a path that would, at times, feel dangerous, filled with the helplessness that dwelt in Pam's inner world. By staying with the feeling of sadness and resentment toward the lost paternal object, not running away from the difficult feelings in the room, I had accepted Pam's invitation to be with her in pain. I allowed Pam the experience of sorrow in a holding environment. This, I believed, was an experience she had never been afforded; its lack had impinged significantly on her development of a sense of self distinct from the experience of mourning.

On her way out of the consulting room that day, Pam told me to be careful, and not to fall down the stairs. She said I should not wear long skirts—I could trip and hurt myself. I was left anxious and worried for Pam's well-being and safety, a feeling with which I had become very familiar. I understood this emotion as Pam's projection onto me of her sense of the world as dangerous and persecutory, but also as her struggle with her aggression and resentment toward the abandoning object—in this case, me. And this was our last session of the week.

As our work progressed, Pam struggled to revisit memories of her father. Reorganizing them into more mature concepts and emotions as she felt safer and contained in our therapeutic relationship was challenging. Pam continued to succumb to sudden dissociative states—flying away—when she felt overwhelmed by painful and helpless feelings elicited by her memories. These defensive maneuvers were, in Pam's words, "the only way [she knew] to keep [her]self glued together." Understanding her need for her defensive structure, I would choose to stay with her in her emotional state, and try to mirror her emotions, while attempting to reflect verbally her unspoken thoughts and feelings, mindful of the fragility of her ego functioning.

Our interactions during this period resembled those of a mother with a younger child. I waited carefully, trying to understand Pam's cues. She would reply with a smile or a few seconds of a fixed stare. I often found myself mirroring her body posture and lowering my voice. There was a feeling in the room of what Beebe and Lachmann (2005) have named "interactive regulation," a back and forth co-construction of both inner and outer unfolding processes.

Parallel to what felt like developmental restoration, Pam began to revisit the narrative of her life with her father from a safe distance. She delved into her memories and engaged in magical thinking by giving life to Bobby. This excerpt from my clinical notes illustrates this dynamic:

> Pam continued to bring Bobby to sessions, in her bag, along with favorite story books from childhood and other keepsakes. . . . She arrived with a bag filled with photographs. She told me her father loved taking pictures and that he had

> left her the bag he had always carried around. Inside, he had left a book with pictures for her.
>
> Pam knelt next to me and placed her hand on my lap. She showed me every picture and told me the story behind it. One picture in particular seemed to make her beam with pride. Her father had a three-year-old Pam in his arms; John held onto his father's pants adoringly. Pam declared triumphantly, "I was my daddy's girl! He loved me so much!"
>
> She proceeded to tell me she would be going the next morning to the cemetery with John, to say hello to her father. She was excited to see John, whom she had not seen since her accident, when he had come to check on whether she was all right.
>
> Suddenly, Pam remembered Bobby had been in her bag the whole time. She took him out and apologized to him. She turned to me and said, "You probably think I am crazy talking to a stuffed animal, but he is my friend." Pam told me she used to fill her bed with stuffed animals after her father's death. She did not want to feel alone. She wanted to smell his cologne, which she had put on all of them.
>
> I was confused about what to say about Bobby's presence and the role that Pam had given him in the room. I accepted the invitation to pretend and invited Pam to tell me more about the day her father had given Bobby to her.
>
> I briefly commented on Pam's constant concern about my opinion of her state of mind. In response, she spoke for a few minutes about her concerns about becoming like her mother. Then, after acknowledging this fear, she quickly shifted the conversation.

In another session, Pam started to show me small golden objects on her necklace—her father's wedding band, three crosses given by three family members, a medal of a saint her mother had given her after her accident. Finally, she showed me a ring John had given her. She said, "[These] . . . objects help me [to] carry people with me, so I don't feel alone or miss them so miserably; but it does not work very well lately."

After a short silence, Pam talked about how much fun she used to have with John and her father. She felt that, when her father died, so did her childhood. She sometimes still thought he would come back, but then it would become confusing, because she felt angry and sad at the same time.

I recalled how Pam had told me about feeling caught between being a grown up and a child, how difficult it was feeling that way. I wondered if that came from being stuck between feeling angry and sad. Pam said that made sense—how could she hate someone who had taught her how being loved and happy felt, but also forgive him for leaving her alone? Why hadn't her father gone to the doctor sooner? Why hadn't he taken better care of himself? Pam became tearful for the first time since the beginning of our work. She told me she did not like feeling this way. She looked out of the window and commented on how early it was getting dark.

Judith Armstrong (1994) has described trauma as disrupting the developmental consolidation of self across behavioral states, rather than creating developmental arrest. She describes trauma as “a developmentally complex difference . . . a case of growing up strangely.”

When faced with what I understood as Pam’s dissociative defense on this occasion, I chose to acknowledge my affective state, and I invited Pam to join me in doing so in the context of remembering the experience of trauma. My affective state during moments Pam “flew away” helped me name her feelings and think with her about them. I felt frozen and lost during those moments, without the right words to say. Other times, I felt an urge to fix Pam’s life, to call Social Services, to find her a new school, to make things right. I believe I experienced what Fonagy (1997) calls “failure in mentalization.” My job was to recover my capacity to put feelings into thoughts and give voice to what I thought was Pam’s experience. For instance, I spoke about times when feelings got so difficult in the room that Pam needed to go away in her mind. I wondered if she felt she needed to fly away from me, from the painful memories, and from the reality of feeling so lonely.

Pam turned around and said, “That is what happened that day when I stood still in the middle of the road.” She told me it had happened again a few weeks prior, when she was waiting for the subway she had just “gone away.” I wondered if she remembered where her mind had gone to. She said she just went blank, and then suddenly woke up. I wondered if Pam remembered the first time this had happened. She stayed silent for quite a while, and then replied, “A long time ago, and many times after, sometimes there are things that are best not to hear or see.” I agreed, and said that, in here, she could fly away, and that I would keep her safe and try to put words to feelings. Pam smiled and replied, “Perhaps there is a part of me that has never come back. My father took it with him.” Much to my relief, Pam then reported that, since she was able to fly away in her sessions, she had not experienced these moments in the street. I wondered if Pam had picked up on my own anxiety and had taken care of me, the way she had taken care of her mother for many years.

As our first Christmas break came near, Pam’s anxiety became visible. I felt guilty and worried. I found myself finding excuses to not take my usual two-week holiday break, even though I had psychiatric and therapeutic backup for Pam. She overheard a conversation between the receptionist and a colleague and concluded that I was going back to the United States for Christmas. She came to our next session announcing her knowledge: “Ah! I know something about you! Finally!” She was worried about my safety. She spoke in an uncontained fashion about terrorist plots and how the Christmas season would be a perfect time to kill stupid Americans going home.

I struggled with the intensity of Pam’s catastrophic fantasies, and I said how inconsiderate it was for me to leave at such an important time in our work, as we were getting to know each other. Pam dismissed the value of our relationship and added she would not be surprised if I died, since everyone she liked had died. I reflected on how awful it must be to feel that way and was reminded of Pam's guilt over not having said goodbye to her father properly. She agreed and said she would feel less guilty since she had warned me about the dangers of going on planes.

REVISITING: RE-EXPERIENCING AND SURVIVING SORROW AND RAGE

A week before Christmas break Pam arrived with a cookie box in her hands. It was filled with keepsakes and linking objects (see Volkan, this volume). She looked out of the window for a while, and then said she had thought of all the things we had been remembering about her father. She wanted me to get to know him better. She placed the cookie box on a small table so we could both look at it. She showed me her father's eyeglasses, which she kept as he did, carefully placed inside a protective plastic pouch. She told me she was very tidy and careful, as he had been. She showed me cards from her mother to her father with loving comments. She gave me two pictures of her and her father to look at. She said, "We used to be very happy." She showed me two small toy trains and told me her father had given John a large train set. They had played with it all the time. When her father died, John gave her three little trains. Pam showed me her father's taxi license. Finally, she took out a small Christmas gift tag with her father's handwriting and told me this was the last thing he wrote to her: "Always in your heart." With tears in her eyes, she showed me the program of his funeral. She fell silent and looked out the window. I felt overwhelmed with sadness.

Pam looked at me as if waiting for me to put words to her pain. I said she had shared something very precious, but it was also very painful, and that I felt moved by her bravery. I said I could tell that, although her father had died many years ago, it felt at the moment like she was trying to make sense of something with me, perhaps trying to make her father's death real. I said I thought she was saying that the memories of her father seemed to make her feel stronger and worthy. I wondered if the real struggle was about how to move on with her life as a teenager when all her memories of her father and her were of a younger Pam. She replied, "It is like I am stuck or something, because I am afraid of how I would feel if I really let him go, what I would have then? My crazy mom? Can you understand? Do you ever feel like that? Like things are not real, like you are not real?"

Pam became tearful. She told me she was going to miss me. She had had a dream in which she was spending Christmas with me and my family. In the dream, her father had come to fetch her from my home, and we were all happy. Pam said she had woken up feeling angry instead of happy. I wondered what she thought that was about. She replied, "It is about things I want and I can't have! The story of my life. . . ." I commented that there are many ways we can keep people alive in our minds and with us, even if they are gone. Pam smiled sadly and added, "But it sucks." I agreed. The potential threat of losing me had activated Pam's capacity and need to mourn in the presence of a safe and containing therapeutic mother.

Pam arrived at our first session after Christmas an hour early. She said hello to me as I greeted my previous patient in the waiting room. A slightly younger boy, he had looked at her angrily and claimed me by holding onto my sweater. Pam wondered what the problem had been with the silly boy. She acknowledged her early arrival. She had been counting the days to come back and tell me about her holidays. In a rather young and undefended voice, she told me she had missed me. Only by using her "baby voice" could she safely express her longing for me. She had been worried when she got the call informing her I was coming back two days later than planned; she thought I might have had a bad accident, or gotten sick or depressed.

Pam wanted to know how many kids her age came to the mental health center, and the rate of success. She spoke and spoke and then looked out the window. I wondered what had happened that Pam had flown away. She said she had had recurrent nightmares following our last session, in which angry dogs were chasing her; then a big flash of light would blind them, and Pam would wake up scared and exhausted. Her mind would not stop. "Please help me, Norka," she pleaded. "I don't want to be like my mother. I want to be normal, like my dad was."

Pam's first dream about angry dogs came after an argument with her mother. I asked her how she felt when she thought of the dream in session. Pam spoke of feeling paralyzed by fear and then began speaking about daily events and refused to explore the dream further. Unlike previous times, when this dream had emerged Pam was able to think with me about the angry dogs. She thought they had something to do with her worries about the world being unsafe and her fear of not noticing danger. I understood the dream to represent Pam's primitive anxieties around merging with objects of desire. Over the holidays, she had missed her therapist. I wondered, was she unconsciously thinking about whether she was bisexual, like her mother?

Pam recalled being worried about her mother, especially after her father had died. She told me that recently her mother had been missing a lot of work, and Pam was worried her mother was getting depressed again. She was angry that her mother had refused to see the psychiatrist and wouldn't get involved in parent work. She recalled feeling ashamed about her mother and therefore never having friends from school to her home. She did not want to go back to school the following week; her fears and sleeping problems had depleted her, and she felt unable to cope. Pam said others saw her as happy and mature, but she was, in fact, depressed and scared.

Together we were able to acknowledge, for the first time, Pam's sense of grievance and her longing for a containing and holding object with which to connect. After the session, I was left wondering what Pam needed from me and how much she could explore painful feelings in the transference without her fear of disintegration becoming a reality. Despite Pam's reflective stance in our work and the evidence of a strong therapeutic alliance, Pam's external functioning continued to deteriorate. She stopped going to school and began to stay in bed until it was time to come to our sessions. I felt helpless, unskilled, and anxious after each session. Pam had refused my suggestion to have a psychiatric consultation to explore the possibility of medication; in her mind this would make her "crazy like her mother." I felt alone and responsible for Pam's survival. I was experiencing what Pam had endured in her relationship with her mother.

However, I was not alone. I began to collaborate more actively with other professionals in Pam's life—her school counselor and family doctor. Pam was aware of these exchanges and found it interesting we could "play nice," in her own words.

THE MIDDLE PHASE OF THE TREATMENT: RESTORING THE NARRATIVE

Pam continued to share memories of her father through stories and objects. During the middle phase of our work together, she decided she wanted to write a narrative of her experience from her point of view. I understood this as a move forward in her capacity to integrate her past and present, and as reflecting her need to create a coherent narrative from which to think about her emergent sense of agency over her thoughts and feelings. She reported a decrease in day dreaming and was able to reflect with me on feelings she previously had wanted to escape by looking out the window. Pam now showed increased capacity to acknowledge difficult feelings; when overwhelmed now, she could retrieve a soothing memory.

Pam's memories became more vivid, and she was integrating positive and negative aspects of her father. She remembered how, when she had been afraid of going on trains, her father would be stern with her and make her: "He could be really mean sometimes, you know, but then he would be nice and say sorry and say, 'See, you could do it!'" She was writing her autobiography, and she titled the first chapter "A Happy Little Girl." It described how the young Pam had lived happily with her father and always felt safe when her big dad, with his big hands and big muscles, was around. Pam's writing about her father was moving and had a realistic feel none of her previous descriptions had. She spoke of a father who got angry, and one who was unfair to Pam at times, preferring John because he was a boy. It was a story of mutual enjoyment where her father’s human nature was nevertheless depicted realistically. Pam paused and reflected on how good it felt to think of her father as a real man, with good and bad, though she had felt guilty the first time she read what she had written. John had helped by adding details and remembering with her. Her first chapter concluded, “He was not perfect all the time, but he made me and moms feel special; and like we were really important to him.”

Pam told me she had started chapter two. It was about her father’s illness and death. She described how awful her father had looked, how his skin had felt dry and dead from all the treatments. She remembered feeling scared by his touch toward the end of his illness, thinking his eyes were not the same, and how he was angry all the time. It was like he was gone before he died. Pam said she understood this differently now that she was older, and that writing about it was helpful. I invited Pam to imagine what an eight year old would have understood; she was in a different position to understand the experience now. Pam agreed.

Pam’s writing became quite prolific. In a poem she decided to enter in a local competition, she described herself as an “emotional vacuum,” a container of others’ sadness, fears, and anger. She thought with me about her compulsive need to write and rewrite this poem. I said I believed she was trying to get in touch with difficult and confusing feelings that had lived inside her without words for a long time. In response, Pam began to open up about other ways in which she felt she had survived her feelings for the last seven years. She spoke of her multiple collections and how she would look at catalogues and make lists of things she wanted. It was about the longing, we concluded, wanting and missing something she once had, but had lost.

IN NEED OF A COMPASS ON THE WAY TO THERAPY: WANTING TO BE FOUND

For Pam, losing her father meant losing an emotional compass, a place of safety. It also meant losing her generational place; she had become her mother’s caregiver after his death. She had also lost the promise of more available opportunities to feel claimed by a family. This became more evident during the beginning of our second year together, with the death of Pam’s paternal grandmother, and also John’s admission to a prestigious local school. From my notes:

> Pam brought a small book with her to the session. She said this one had also been given to her by her dad, but somehow she had forgotten to bring it before. The story depicted two little animals who found an attic filled with things from the past. To go to the attic you had to go through a labyrinth. The little animals

> had dressed up and made a beautiful show for the grown up animals, who praised them.

Pam spoke of how much she liked this story. I reflected on how important it was for children to feel seen and admired. She agreed and remembered being loved by her father and his family that way. Pam became pensive and sad. I wondered about this. She replied that John had been invited to the funeral, but she had not. Pam began to cry. Together we thought of how hurt she felt, and how betrayed by John. She was angry and envious that her father's family had kept John close and let go of her. She became enraged at the thought of John attending a prestigious school while she was asked to attend classes at a school where they stabbed people. For the first time, Pam was able to stay with her pain and rage in the room, without flying away.

Following this session, Pam did not return to therapy for three weeks. She stayed at home with her mother, in isolation. I sent her a letter, waited, then a phone call. I managed to speak to her mother, and then to Pam, who agreed to return to treatment after an hour-long conversation. She expressed her bewilderment at my persistence; she could not understand why I would still want to see her. When I expressed my belief that she perhaps felt that I, too, wanted to run away from pain and anger and leave her feeling the way she felt, Pam angrily commented, "You don't know anything. If I feel like that again, I am not coming back."

For weeks after Pam returned, I would hear complaints about how the frequency of treatment was affecting her performance at school. Another side of Pam began to emerge. She dressed in more adolescent fashion; she shared sexy songs she would write for fun, and spoke of her dislike of babies. The theme of babies facilitated discussion of Pam's conflict letting go of her infantile self and accepting her sexual body and sexuality. Important questions emerged: Would her father like who she had become? What kind of woman would she like to be? Pam began to conceive the possibility of a different life for herself and imagined what her father would say about it. She began bringing puzzles to do with me. As we worked our way through them, she continued to remember times lost and she grieved the life she thought she would have had if her father had lived. In my mind, Pam was rewriting an oedipal narrative in the context of her longing for her father and the containing and facilitating presence of a therapeutic mother. As a result, an adolescent Pam began to emerge in the consulting room.

Pam began to bring in dreams in which she fell down the stairs or saw herself in a coffin. She began to share her belief in the power of "bad thoughts," how they can cause bad things to happen. She spoke of having seen her father's spirit the first time her mother tried to commit suicide. We explored these beliefs and the function they had served for the younger Pam. We acknowledged all that had been lost when father died. We reflected on ways Pam had managed to keep alive within herself the good things her father had left her. We mourned all she wished had not been "killed" with his death. It was "like the world had become dangerous and scary that day and never regained its color. It continued to be grey and scary, like [Pam's] dreams."

Pam had been able to repair her relationship with John. They managed to find a time to visit their father's grave, and for the first time. Pam had managed not to cry inconsolably. Instead, she enjoyed being sad with John, remembering their fun times with their father.

THE LAST PHASE OF TREATMENT: "I HAVE TO GO, I AM TOO OLD FOR THIS!"

Pam left a message on her paternal grandmother's answering machine four months after her death, on the day of her grandmother's birthday, pretending she did not know about her death. I felt sad and troubled and chose to reflect out loud, speaking of the powerful pain that comes from being unseen and silenced.

In response, Pam told me that, in her mind, life was filled with deceit and silence. She began telling me that her father had had an affair with another woman when Pam was four. She remembered being upset at his departure from their home and happy when her mother took him back. She remembered thinking, later on, that perhaps he had died as a punishment.

During this period of the analysis, Pam's conflict over what her emerging sexuality meant to her was central. Growing into a sexual, grown up woman meant loss and exacerbated Pam's perception of the world as dangerous. She thought of herself as the result of her parents' illicit sexual relationship, and how she had been exposed to her mother's sexual adventures over the years. Not only was staying young a way of satisfying her longing for her father, but it also meant not becoming an out-of-control sexual woman, as she perceived her mother to be.

Pam's relationship with John became ambivalent. Her implicit belief they might not be related created conflicting and dangerous feelings in Pam. Despite these conflicts, Pam began to imagine the possibility of a different life. She fantasized about moving to Australia and becoming closer to mother's family. She began bringing a sketch book and enjoyed drawing pictures of her dream apartment, with only one room, where she could live with Bobby, her stuffed bear. He would be her baby forever. Pam began bringing brochures of schools where she could finish her education. John began to take an active role facilitating her return to school, which Pam found holding and rewarding, an opportunity for repair and restoration of their ties in a safe, age-appropriate fashion.

The ninth anniversary of Pam’s father’s death was near. Pam spoke of going with John to the grave. She told her father’s family that she knew about her grandmother’s passing. They explained they felt bad but did not want any dealings with Pam’s mother. Pam expressed her rage toward her mother and remembered how embarrassed she used to feel when her mother would pick her up at school, wearing weird clothing and behaving inappropriately. In response, I spoke of Pam’s sense of having being cheated of a father, a normal mother, and the opportunity to receive a good education. We were able to explore her feelings of shame and rage over her broken life.

Pam began to skip sessions and often sat in silence when she came. She frequently arrived ten minutes before the end of the analytic hour. I understood this shift as a response to an emerging loyalty conflict Pam experienced between her mother and me. Mrs. H had begun to complain about our sessions getting in the way of Pam’s schoolwork and socialization. I felt torn between my wish to protect the analytic frame and my wish for Pam to attend school regularly and have friends. Pam and I spent what seemed like endless sessions discussing the possibility of termination vs. reducing to twice weekly psychotherapy.

After much thought, we decided to reduce our sessions to twice a week. Pam began to attend sessions regularly again, but declared that we would see how we did as she was “very busy these days.” I continued to have regular contact with Pam’s guidance counselor, who had begun to have more regular contact with Pam again and monitored her progress. Pam seemed aware of this relationship and would refer to it by saying that I had her permission to think with the guidance counselor about whether the therapy “helps.” Pam enjoyed her newfound sense of agency and the feeling of having something in her life she could control. She also liked having two adults supporting her.

Pam seemed to have integrated the memories of her father into her emerging adolescent identity. She was able to claim her pubertal body and her status as a seventeen-year-old student and photographer. She established a friendship with a girl in her photography club at school and seemed very pleased with how understanding this girl was about Pam and what she called her “unconventional lifestyle.”

Pam often spoke of how fed up she was with her mother and her neediness, and how Pam feared she would never be able to leave her. Instead, once again, she began to leave me, arriving late and missing sessions every week. She explained that coming to sessions was sometimes too painful and exhausting. She spoke of always needing Bobby when she was at sessions but not needing him as much outside anymore.

Since Pam was still experiencing panic attacks and sleep difficulties, I was apprehensive about her ending treatment. Although I felt hopeful, I was also concerned about the fragility of Pam’s new developmental gains. After a few weeks it became clear that Pam was ready to let me go. In the transference, I had become the mother she could safely leave while holding onto her story and painful memories. We decided to end our work right before the summer break, to give us enough time to say goodbye.

Pam came to a session a month before our ending with a book of new photographs. She sat in a chair next to me and showed me pictures of students in her new school, her home, neighbors engaged in their daily lives, people waiting for the bus, parks near her home, and trees on a dark and stormy afternoon. We were able to acknowledge that the photographs contained Pam's hopefulness for the future, but also her remaining belief that the world is not safe at times. I spoke of Pam's emerging capacity to be in touch with her feelings in a more mature and contained fashion. The camera lens had allowed her to look at the world from a safe distance. She could now see the ordinary, good, and hopeful side of the world, as well as the fear and pain symbolized by the dark and windy trees. Pam looked at me with pride. She heard my words as praise from someone who could love her and see her despite her decision to say goodbye.

On the day of our goodbye Pam arrived ten minutes late. She wore a new outfit, with high heels, beautiful curls adorning her face. She looked apprehensive and shy. She sat in silence and then produced a piece of paper, a homemade card. Inside, there was a poem that described how she had been an "emotional vacuum" for many others, but now had found an emotional depot in me. She read the poem with pride and eloquence. She expressed her wish for my happiness and her wariness that, in her absence, I would become burdened by all the painful memories she had shared and was leaving with me. She thanked me for never giving up on her and promised to remember the good and the bad we had gone through together. Pam acknowledged she still had lots of things to work on and that her mother would never be normal, but she knew she could move forward and carry her sadness as part of who she was. She told me Bobby had stayed home as he had found it difficult to come and say goodbye. I said that I was saying goodbye to the grown up Pam, the one who wore high heels and was preparing for college. I commented that her fears of the dark and her worries about growing up were still there, but now, I said, she had chosen to leave that safely put away, as Bobby was, to come say farewell.

We agreed on a follow-up session in three months. Pam did not show up. I was left, as I had been before, "not knowing," with concerns over Pam's well-being. However, this time, I had the knowledge that Pam had left experiencing a more cohesive self and an emerging sense of agency over her life.

CONCLUDING THOUGHTS

The untimely loss of a still-needed parent unleashes intense panic, disorientation, feelings of helplessness, outrage, and profound separation anxiety in children. In her 1986 paper, “On Trauma—When Is the Death of a Parent Traumatic?” Erna Furman reminds us of Anna Freud’s (1964) comment: “I shall remember not to confuse my own with the victim’s appraisal of the happening.” Furman highlights the negative impact of a parent’s lack of capacity to provide a holding environment for the child in the midst of early parental loss. Anna Freud also grasped the importance of the therapist’s awareness of her countertransference and the dangers of allowing knowledge of trauma to cloud the capacity to “be with” the child patient and follow his or her narrative, with its multiple emerging meanings.

A developmental psychoanalytic lens invites us to explore the impact of the before, during, and after in regard to the internal and external experiences of trauma, and their interaction. Pam managed to survive psychologically despite unthinkable loss in the absence of a containing and predictable parental—that is, maternal—mind. As a clinician I was faced with the challenging task of attempting to restore the developmental pathway that was disrupted by early trauma in a child who did not yet have a secure base.

The challenges presented in this case affected my therapeutic technique as well as my role as a child and adolescent psychotherapist. Lessons learned from three years of work with this courageous young woman related to issues of transference and countertransference, the importance of the developmental lens, and the value of working with a professional network.

Issues of Transference and Countertransference

Pam was a charismatic and warm young woman, easy to relate to and like, but also needing parenting. Because of this, she would usually awaken in me a need for action both during and outside sessions. For instance, though she presented with a chronic sleep disturbance affecting her overall functioning, she refused medication. In response, I would often feel helpless and frustrated, as I did when I saw her after a week of school absence and I thought of how the school environment would have been a source of safety and predictability for her. As the treatment progressed and I became more actively involved with Pam’s mother, the issue of medication was addressed. Over time I was able to help Pam’s mother “help” her daughter.

Another challenge involved Pam’s demands in the transference. At different times it was difficult to separate my own feelings (as informed by my knowledge of her early trauma and on-going deprivation), from what represented Pam’s own needs and wants. Developmentally, Pam needed me to be a soothing maternal presence when the pain of early loss invaded our consulting room. At other times she needed a playful therapist with whom to explore her capacity to symbolize and integrate her feelings in a safe and predictable relationship. My knowledge of Pam's external reality often intruded on my capacity to wait and "be with."

The clear frame and the intensity of the analytic situation held both me and Pam and allowed us, in her words, to "take our time, to look, think, and feel." Although both Pam and I had the wonderful opportunity to work four times per week, I believe the analytic frame can also be applied to clinical work once and twice a week, particularly the developmental psychoanalytic lens and the clinical focus it provides.

The Importance of the Developmental Lens

Understanding the impact of early parental loss from a developmental lens proved very important in this case. Although Pam presented the physical appearance of an average fifteen year old, in many ways she seemed frozen at the age of eight. She used latency defense mechanisms of denial in fantasy and sublimation, when faced with anxiety-producing situations that emerged from her external world (with peers and school), and her internal world (with conflicts over on-going unmet needs, fears over loss of the remaining parent, and her emerging sexuality). Keeping this in mind helped me, not only in terms of meeting Pam where she was, but also in terms of my understanding some of her material. It helped me avoid jumping to clinical conclusions that could have pathologized Pam in a way that disregarded her history of trauma. For example, in many ways her "flying away" moments seemed to be an adaptation to the need to maintain herself functioning in the midst of unimaginable environmental toxic stress and unresolved grief, without greatly needed environmental support and containment. Pam was able to function marginally adequately for a long time, but with the emergence of adolescent turmoil, alongside her unresolved grief and fear of loss, this created a perfect storm, resulting in what Pam feared the most—feeling she was losing her mind.

As Pam's therapist, my role was to help her create a safe environment, where she could revisit her early trauma, and actualize and repair her relationships with the lost parental object and with her living parent. She was able to restore a sense of developmental balance by naming difficult thoughts and feelings, surviving the experience together, and exploring new possibilities—new ways of restoring her broken developmental path. I believe this was accomplished by my providing timely interpretations in the transference (about our relationship in the here and now); by surviving and naming difficult feelings, such as anger, frustration and fear; and by providing a secure space where Pam's thoughts and feelings were the primary focus and priority.

Working With the Professional Network

My work with Pam was facilitated by my maintaining relationships with other professionals. Working with Pam's primary physician, who held a lot of the family history and had a strong, on-going relationship with Pam's mother, was central. We became a benign and functioning parental couple for Pam. Also, my working with the school, the guidance counselor, and the librarian were important supports for this young woman as well.

This type of case had the potential for creating splits between service providers; acknowledging and avoiding this possibility was crucial in working with other professionals. Having regular phone calls and occasional provider meetings was of the utmost importance. Of course, the challenge here became how to hold all the information from the external world without letting it contaminate my therapeutic understanding of Pam's material. Finally, I must emphasize the important role that supervision played in this case. As Pam's therapist, I too needed a safe space to reflect and take care of myself while being there for my adolescent patient, helping her to revisit, restore and repair her past history of unresolved mourning.

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Chapter Eight

All You Need Is Love

Primary Paternal Preoccupation

Seth Aronson

Important lessons about how children can be helped to handle the loss of a parent can be learned from multiple vectors—among them, examining psychotherapeutic work with adults who lost parents as children and who come to treatment for help to heal still-open wounds. Seth Aronson's sensitive, thoughtful, reflective, and elegant chapter about his on-going work with John—an adult who lost both his father and his mother during his developmental years—contributes to the goals of this book in several ways:

First, Aronson elaborates ways in which John is a product of the historical times in which he was raised—the generation of the 1960s and 1970s. Aronson helps us think with him about the intersection of the historical and the intrapsychic contexts of John's life course and psychological difficulties.

Second, Aronson delineates pathways through which John's unmourned loss of his parents in childhood has affected other lines of John's development. We get a view of how these factors have shaped John's adult life, and we see what has been blocked and painful. Child clinicians are invited to think about how Aronson has helped John reconstruct what happened and what this might have looked like to John as a child.

In yet another dimension, we get to see how Aronson blends a variety of psychoanalytically informed perspectives and methods in his twice-a-week work with John. He has worked in the transference and in the therapeutic relationship; he has used interpersonal and object-relational methods; he has blended his attention to the past and the here-and-now; and he has creatively employed both enactments and interpretations.

The mix works, both as a clinical approach, and as a way for clinicians to better understand the utility of diverse theories and ideas in contemporary psychodynamic practice.

Readers of this chapter will find themselves understanding John the child as well as John the adult, and how a remarkable clinician comes to help them both. —Eds.

It was the “summer of love” in 1967. Angela was eighteen, black, and beautiful, proud to carry the namesake of one of her role models (the African-American radical Angela Davis). Angela was caught up in the spirit of the times. The music captured her emotional life; she felt free, unfettered, thrilled to join protests at the university where she would begin her studies that fall.

Morry (also known as Seymour in the home he shared with his Jewish parents in Brooklyn) was also caught up in the changes sweeping the country. With his tie-dyed T-shirt, jeans, and hair drawn back in a ponytail, he wanted “power to and for the people.”

At an impromptu concert in a park, the two locked eyes. Morry was immediately drawn to this beautiful girl; Angela was taken with Morry’s humor, quick wit, keen intelligence, and capacity to debate any issue. After the concert, they went to a coffeehouse in Greenwich Village, and then walked and talked for hours. By the week’s end, they were a couple.

Angela began her courses, but soon thereafter realized she was pregnant. She and Morry discussed the situation and, over both families’ strenuous objections, chose to marry. Their son John, named for their favorite Beatle, was born the following spring.

It was difficult for the young couple. Aside from the issue of being a biracial couple, there were financial worries. Angela dropped out of school. Morry took various jobs and felt the constraint of providing for a young family. He and Angela fought often and, to their neighbors’ consternation, loudly.

Despite the tensions (and Morry’s occasional flings), they remained together. The following summer, they traveled with John (now a toddler) to Woodstock to join in the excitement of the event. The two of them, relying on the kindness of strangers, left John with a woman who agreed to watch other couples’ children so the parents could truly enjoy the event (and partake of the substances and sexual freedom to be found everywhere).

Shortly after returning to New York, and after several violent altercations, Angela and Morry split up. John lived with Angela, who relied on public assistance. Morry saw the child on weekends, when he was not with his latest girlfriend.

By the time the 1970s rolled around, Angela realized she was a young woman with no present life or future. She went back to school and earned a nursing degree. With the burgeoning New York club scene beckoning, she went out on Friday nights to dance at Studio 54, leaving John with a kindly older woman, a neighbor.

John was a quiet, timid child. He excelled at school and was accepted to one of the city's gifted and talented school programs. He had several close friends whose families took pity on this sober boy whose parents were barely out of their own adolescence.

When John was twelve, his father was diagnosed with colon cancer. A couple years later, John earned a spot in one of the city's elite public high schools. Then, in John's sophomore year of high school, Morry died. John's excellent grades won him acceptance to one of the country's top liberal arts colleges. Soon after beginning his junior year, he received a sobering phone call from Angela; she had been diagnosed with early signs of ALS, or Lou Gehrig's disease—a progressive neurological illness. Because her condition was not yet serious and she was living with a boyfriend, Angela encouraged John to stay in school. John graduated with honors with a degree in computer science. The following summer, her condition seriously deteriorated. Angela died at forty-two.

JOHN, AT THE BEGINNING OF THERAPY

The sober, bespectacled, rather detached forty-year-old man sat in my office. He was the father of a precocious three-and-a-half-year-old boy, and he and his wife were discussing having a second child. John spoke in a quiet, deliberate voice that betrayed little emotion. He seemed cloaked in a sense of sadness. He was experiencing anxiety at the thought of a second child entering the family. How could he support the four of them? (John worked in information technology; his wife was an interior designer.) He did not feel he had been much of a father to his son—how could he possibly cope with a second child? His wife encouraged him to consult a therapist, but John was reluctant. Given his history of loss, he told me, he was hesitant.

Having just met John, I inquired, "What history of loss?" In a flat monotone, John recounted the story of his parents' deaths. An only child, he had little extended family. His reluctance to enter treatment was further compounded by the death of a previous therapist in a car accident. I was immediately moved by this history of childhood and adult loss and the sadness that enveloped John. I wondered how his losses figured into his anxiety, his parenting, his relationships, his life. Although there was a passive resignation around him, I also sensed a strong will, a will that resisted exploration, curiosity and emotional expressivity, yet he also had a desire for connection. Toward the end of the session, in discussing his wife's possible future pregnancy, John reported that, once his wife became pregnant, she would undoubtedly have an amniocentesis done. John made a "joke": with his luck, something would go awry with the test, and his wife might die.

John's verbal and intellectual capacities, and the hunger for connection I sensed in him, led me to suggest our meeting for twice weekly psychoanalytic psychotherapy. I detected a desire for this kind of therapy in an anecdote John recounted early on. He was in college, lonely, and he answered an advertisement in the local newspaper for a threesome. When he arrived at the house, he discovered that the couple were, in fact, around his parents' age. Excited that they were interested in him, he went ahead with the encounter, although he had no sexual preference for or interest in the activity. This, to me, suggested the deep hunger for parents who would show a vital interest and regard for him. I felt that, despite John's detachment and seeming reluctance, he could use our work together to begin to address his unresolved mourning, the tragic losses in his life, and how they affected his current relationships. John readily agreed, and we began work together, a treatment that has lasted five years and continues through the present.

In the second session, I inquired about the "joke" that John had dropped at the end of his first session, John explained that his remark reflected his philosophy—"waiting for the other shoe to drop." Given how many losses he had endured, he had no reason not to expect that the next one was just around the corner. He was aware that he held himself back, unwilling to risk engagement in life and the loss he believed would inevitably accompany such involvement.

I noted to myself John's adamant stance against curiosity, engagement, and knowing. It seemed that contemplating the content of an Other's mind was "too frightening and evocative" (Slade, 2006) for him. To explore his mind, with all the affects long repressed, and my mind and how I might think of him, was a frightening and daunting task for John. Over the next few sessions, I learned more of John's history. In many ways, he raised himself—with his father largely absent (except for teaching him how to smoke marijuana), and his mother clubbing on weekends, bringing home a series of men, most of whom looked at John with mild indifference at best.

One significant life experience John reported was a summer camp he attended when he was a young boy. One of John's close friends attended Fresh Air Fund camp and encouraged John to attend with him. Angela readily agreed, and, for four summers, John left the public housing project where he lived with Angela to go off to camp.

John thrived in camp. He said it "saved him." He made friends, developed athletic skills, and experienced his first crushes on girls (although he was terrified to act on them). John's camp experiences brought to my mind both my own summer camp experiences and the writings of Sullivan (1953) and Erikson (1956) on the pivotal role peer relations play in helping children develop proto-intimate relationships—relationships that serve individuals well as they go forward into the world of adult intimacy. Both Sullivan and Erikson underscore the importance of interpersonal relationships outside the family and how they form templates for later relationships. For John, camp was a “lifesaver.” It gave him an opportunity to make friends and to test out new self-in-relation-to-other configurations (e.g., John as basketball player, John as member of the camp community).

John told me that recently, thanks to Facebook, he found some of his camp friends on-line and briefly began corresponding with them. He was surprised to discover how fondly they thought of him. But, as was his style, as soon as these friends wanted more contact, John withdrew. I wondered aloud about what that meant for us, and what that meant for him as a parent and as a husband.

John described himself as “numb with grief” following his father’s death, and subsequently “shell shocked” by his mother’s diagnosis. After Angela died, John held a series of jobs generally well below his capabilities. Despite his clear intelligence and talents, he seemed to sabotage himself at every turn, and was either passed over for promotions or let go.

John’s numbness was evident in his presentation. His affect was markedly dissociated from his accounts of his childhood and of subsequent tragic losses. He noticed details about me and my office. Once, he picked out and inquired about a book, *Making Connections* (Gilligan, Lyons, & Hammer, 1990) from among the hundreds of titles in my office—and then denied the title had any implications for our relationship! He steadfastly kept stronger feelings and longings out of our interactions. Despite John’s “refusal to go there” to discuss our relationship, I never felt cut off from him or alone in the work—signaling to me the deep hunger for connection that lay just beneath the surface of John’s dissociated, flat affect. His “father hunger” (Herzog, 2001) was palpable, and, as it would turn out, so was his own son’s.

At a party one summer when he was 30, John reported, he met Judi, who was to become his wife. Judi came from a large, warm, enmeshed Jewish family—the appeal of which was evident. John was drawn to Judi’s vivacity and attractiveness. He felt energized while with her. His previous girlfriends had been depressed, withdrawn women who required his care, allowing John to hide himself in his caretaking of these needful women and perhaps permit himself some covert reparative experience—saving them as he had been powerless to do for his parents.

It became clear to me that John needed to look to external objects for enlivenment. As a result of his traumatic experience of loss, John’s internal object world was spare, deadened, and devoid of vitality. Whenever a spark or glimmer of life made itself known—for example, when John, after much debating, finally allowed himself to pursue the lifelong desire to learn to play the guitar—the spark would be quickly extinguished. John loved the first few guitar lessons, indulging himself in the fantasy of one day jamming with his children. But, following his established pattern, soon enough John began “forgetting” to practice, and cancelling lessons.

Judi, on the other hand, was bursting with ideas and energy. She coaxed John into taking cooking lessons and bike excursions and attending various social events. I began to wonder how much of an enlivening object I would have to be to John as well if I were to coax him out of his shell.

After a couple years together, John and Judi married. Several years later, their son, Dylan, was born. The family tradition of naming children after beloved singer-songwriters was continued.

Dylan was a precociously verbal child. John recounted a recent exchange Dylan had with Judi, in which the boy inquired about his father's quietness. Dylan wondered if "Daddy was always so quiet because he was thinking about his mommy and daddy who aren't here anymore?" I noted that John's son seemed to be making a connection between John's depression and his losses. John readily concurred. It was clear that Dylan could "mentalize" about his father—that is, engage in a "form of imaginative mental activity, namely perceiving and interpreting human behavior in terms of internal mental states (e.g., needs, desires, feelings, beliefs, goals, purposes and reasons)" (Fonagy et al., 2002).

Dylan could also engage in what Elizabeth Meins and her colleagues have termed 'mind-mindedness' (Meins et al., 2002). This capacity is developed when parents treat their children as having minds and feelings, focusing on the children's subjective states, such as what the child is feeling, thinking, and experiencing. Repeated experience of having a child's mental states be reflected upon by others helps the child become aware of his/her own mental states, as well as those of others. Dylan was hungry for a bond with his father. I believed John was hungry for such a connection as well, but held his capabilities and desire for such contact in check. When it came to developing more flexible and adaptive ways of reflecting on his own thoughts, desires and beliefs (and those of others), John stopped himself short. This, in turn, affected his ability to modulate and regulate affect. Consequently, expressing a full range of feeling was terrifying for John, further contributing to his muted presentation.

Although he agreed with my interpretation of Dylan's comment, that his son was connecting John's presentation with his losses because he missed his parents, John was not consistently able to fully reflect on the impact of his own internal experience on his son. I believed that John needed to more fully recognize and reflect on his own mental states so that he could be more present and available to his son and wife. Through our work and my holding and reflecting on John's emotional states, John could begin to make sense of his and others' inner lives, and widen his emotional expressivity (Fonagy and Allison, 2012). In discovering mentalized emotional connections with his son, I hoped and believed John might be able to discover and connect with heretofore buried and disavowed self- and affective states and develop a stronger sense of safety and security.

I wondered aloud what it would mean to John to relinquish this pervasive sense of sadness and expectation of loss, which represented his attachment to the past. Mourning did not necessarily need to be solely about detachment (Wolfenstein, 1966; 1969). Perhaps John needed to forge some other link to his past, one that was nourishing and vital and that would allow for continuity (Gaines, 1997), rather than his anticipation of dread that had come to color any potential interaction. Such a link would also create a "living legacy," infusing his connections to Judi, Dylan, and any future children with love (Silverman, 1996). Characteristically, John responded to my musings with a deep sigh. These sighs, frequent early on in our work, seemed to indicate John's sense of hopelessness, resignation and helplessness—all of which I interpreted to him.

We both acknowledged that John was panicked at the thought of hope. He could not let himself believe that creating and sustaining new, loving objects would lead to an internal Other who would consistently and reliably think about him and care for him. He was convinced that, if he allowed himself to trust, he would only be bitterly disappointed and find his hopes dashed yet again.

REFLECTING ON OUR RELATIONSHIP

From the start, John adamantly denied any connection to or curiosity about me, our relationship, or his inner life. Sessions often consisted of John reporting on the events that took place between his sessions (we had been meeting twice weekly). When I would ask him to elaborate on his *feelings* about the events, John suggested that he simply did not have any. I felt that I needed to "try to give voice to his internal experience" (Slade, 2006), to begin to symbolize and model reflectiveness. I then would comment on the strength of will (and, I believed, underlying aggression) he must have to block out any emotional response to the many events of the week, events that involved parenting, his marriage, his sex life, his work life, and various family issues (such as the recent death of Judi's beloved grandparent). I believed John's efforts to block my attempts to connect his feelings to the events he reported represented an attack on links (Bion, 1962). I was also thinking about links between his feelings and actions, links I was making in my mind about him (and then sharing with him), and, of course, the growing connection between him and me.

One topic John spoke of with (relative) passion was music. Music was his one connection to and identification with his parents and his early life. He downloaded music often—the music of his childhood. John often attended concerts of the great bands of the 1970s and 1980s. Initially he went alone; eventually, over time, he would go with a friend. He described the music as "melancholy, beautiful, and delicate." It reminded him of "an era of his life" when he still had both parents living.

In our first year of treatment, John marked his birthday, describing birthdays as "sad." When I inquired, he said he avoided celebrating—what was there to celebrate? Besides, he had few friends, and it made him profoundly uncomfortable to be the focus of attention. His discomfort seemed so powerful that I wondered if the opposite were perhaps true as well—that is, that John also yearned to be the center of attention.

Upon inquiry, it turned out that, in fact, John also harbored a wish to have a big party, surrounded by friends. He recalled a childhood wish to invite the Beatles to his birthday party. I remarked that this seemed to reflect his desire to be that important, to matter to adults, to the extent that celebrities like the Beatles would come and celebrate with him. I noted how that wish to matter to a parent, to have Others make him the focus of their thoughts, probably extended to me. "I do want to be recognized," John said, "and I suppose that's what Dylan wants from me." He then recalled a childhood wish for a bigger family.

John wondered if perhaps there was some connection between his wish for siblings and his present growing family. At that time we also talked about him extending his circle of friends by responding to those who had reached out to him (such as his camp friends on Facebook). But John often quickly rationalized away such realizations, or forgot them (despite what I considered to be my best efforts) by the next session.

John's insistent refusal to acknowledge our relationship made it frustrating and difficult for me at times to hold him in mind. It was as if he had to obstruct my thinking and caring about him, to attack the developing links between him and me in my mind, because, if I were to be successful at creating such links, our relationship would develop and then, he believed, disaster would strike.

My first vacation break, a year into our work together, stirred feelings in John of wanting to terminate. In what I had come to recognize as his typical wry, self-deprecating humor, John remarked that perhaps he "needed to stop so he could get back to living his unexamined life and see if in fact it's worth living." I responded that I thought discussing termination was a smokescreen that allowed him to pointedly ignore his feelings about my vacation and fears of losing me. I felt that John was steadfastly examining his life from one perspective only—the perspective of loss—and he needed to balance other perspectives as well (Alvarez, 1997).

John became quiet. I found myself thinking about what Dylan had said about his quietness and shared this association with John. I hoped to demonstrate to John how, even when he was in his states of withdrawal. I actively thought about him and reflected on his experience.

> "Oh. You mean, you were thinking just now about my being quiet?" he asked.
>
> "Yes. Why do you suppose that was?" I asked.
>
> "Dylan thinks I'm sad . . . I forgot about that."
>
> "I didn't forget," I said. "Perhaps you owe it to yourself, and to Judi, Dylan, and future children to be less quiet?"
>
> "I can't help it," John said. "A certain sadness goes along with who I am, and that's inevitable."
>
> Once again, John was quiet. But this time, his quiet led to an association—and a link.
>
> "I'm thinking of my mother," John shared, "how she even continued working for as long as she could. Her sadness, her suffering—she didn't let it define her."
>
> "Perhaps that would be a good lesson for her son to learn as well." I responded.

As time went on, it became evident that John's yearning to be nurtured—to experience the parenting that he was never truly afforded—was interfering with his immersion in his roles as father and husband. Now, to be clear, and fair, John was present at home—playing with his son, taking him to preschool, play dates, and the park. He was a committed partner and spouse, even if he was not always emotionally present. But I could not help wonder if his dissociation, his characteristic way of palpably splitting off affect that I experienced in session, was suffusing his interactions with Dylan and Judi.

John needed to be emotionally held, to allow himself full immersion in involvement with another so that he might experience the "total environmental provision" that Winnicott (1960) described as critical for future object relationships and attachments. Winnicott (1956) described the mother's "primary maternal preoccupation" as an identification the mother has with the baby that is critical to the infant's development. It is a projective identification of sorts. In projective identification, "part of the ego—a mental state, for instance, [of having] feelings—is seen in another person and quite disowned (denied) in oneself" (Spillius et al., 2011, p. 455). The individual then relates to that other person as if he/she embodied the very attributes that were projected by the self. In Winnicott's primary maternal preoccupation, the mother enters an "an organized state in which she is preoccupied with the infant to the exclusion of other interests" (Winnicott, 1956, p. 302), that is, she imbues the infant with all her good wishes and fantasies, which helps the child to grow. She projects into the child all her love and care, and then ministers to the child into whom she has projected such caring feelings with great love.

I wondered whether Angela's preoccupation as a mother had been so total as to constitute the "normal illness" Winnicott (1956) felt to be crucial to the baby's development. If not, what had been projected into John? I wondered if John, as a baby, had been such a disruption and intrusion into the lives of Angela and Morry (who had been barely out of their teens when John was born). As well-meaning as his parents might have been, they often forgot about his needs as their developing child, or worse, perhaps they were forced to dissociate their own needs. Thus, they could not recognize they were not giving John the (projected) love necessary for emotional growth and development, so that he instead had experienced dismissal, indifference, or even, perhaps, neglect.

John's own projections seemed to be based on early experiences of neglect and dismissal. I recalled his parents leaving him as a young child in the hands of virtual strangers; what they did when they took him to Woodstock certainly fell into this category. He could not conceive of connection without disruption and loss—or, perhaps worse, non-acknowledgment. As Winnicott (1963, p. 186) wrote, "It is joy to be hidden but disaster not to be found."

John, as an adult, father and spouse, needed to be found, and to be consistently held in mind. He needed to discover himself, and to become truly accessible to his family. John began to invite me in, only to disappear quickly again. He made brief comments about me, then withdrew them or denied their importance. I found these forays and glimpses of John were frustrating and felt sadistic, perhaps re-enacting some identification with his parents as exciting and subsequently neglecting aggressors.

Following another vacation break, in the second year of treatment, John mentioned how he had read an article that "might be of interest to" me. It reported on research in clinics in the public sector that connected early childhood trauma with poor physical health, with implications for treatment. John was aware that I worked with children and parents—this was one of the reasons he had been referred to me. When I noted that perhaps he was making a reference to his own history, and the (traumatic) loss of me via the break of the vacation, he minimized his observation. He said he did not understand "why I had to always bring it back to him and me."

Rather than engage in a pleasant but intellectualized discussion about the article, I responded that I thought John was telling me something about him and me, as our relationship dealt with his early childhood trauma and loss. In this way, I understood this communication (and many others) as a statement about our transference relationship.

During our vacation break, John, who was a serious runner and physically quite fit, aggravated an old injury. He became preoccupied with his body and "its breaking down due to age." I wondered with him if this was perhaps an avenue for identification with his parents and their bodies, which had broken down. Was this the only way he could identify with parental inner representations and conceive of himself and other—as broken, frail, and damaged?

John associated to his mother's near total incapacitation in the last year of her life. He was terrified of being incapacitated and dependent on others. He worried his body was betraying him. I wondered if his experience of his injury was an unconscious way of incapacitating himself, inflicting guilty Oedipal suffering on himself for having outlived his parents, gone on with his life, and fathered a child.

John's reporting on what went on between sessions now focused on his physical state. I, necessarily and unwittingly participating in a parental transference role, inquired about his health and asked if he had consulted an orthopedist. Grimacing in pain, John often minimized his discomfort—"I can't really complain," he said. I wondered if not wanting to complain was his method of protecting himself from the potential for extreme disappointment were he to voice complaint and then find no one there preoccupied with him, no one to respond or minister to him, much like Winnicott's (1963) infant who experiences the "disaster" of "not being found."

John and I discussed that although his physical pain was quite real and evident, it was noteworthy that, it was after a break from therapy that he could not verbally express his pain. For John, words and language had never conveyed his emotional pain, while physical symptoms often did. In fact, John himself had speculated about the source of a back ache being repressed anger (something he had researched on line). Because I believed John was not able to verbally express his feelings around our separation during this holiday break, I wondered if perhaps his body had become the vehicle of expression of such feelings (Anderson, 2010).

At this point in the therapy John began tentatively to engage with the idea of fathering a second child. He had always wanted a second child, he now said—it seemed only fair to Dylan, who now regularly and persistently inquired when John and Judi were "going to get him a baby brother or sister." As John was beginning to feel parented himself through his relationship with me, and in turn see himself through my eyes as a loving and capable parent, it seemed that he could contemplate being a father himself to this new (as of yet unborn) child.

Around this time John met a camp friend for drinks, and contacted two college friends, briefly exchanging e-mails. But then, as would be expected, when John's friends, excited about reuniting, wanted more contact, he balked. John's withdrawal helped me to realize how intensely John clung to his isolation and depression and how frightening sustained contact was for him, despite the pleasure these connections brought to him.

Ultimately, John invited one of his friends to attend a concert with him. It represented a small but significant step. I believe inviting one friend to accompany him was more manageable than the idea of participating in a larger group activity that intimidated John and revived old feelings that he was boring, dull and could add nothing to a group discussion.

John continued to attend the concerts of 1970s bands. They made him feel alive, connected to parts of himself and his experience from which he had become estranged. He wondered what it would be like to bring Dylan to one of these concerts someday. Hoping to create links and stimulate positive, enriching fantasies, I asked what John imagined it would be like. He became quiet and then said, “I hope I could share with Dylan what I love about the music. It was fun sharing with my friend,” he continued, “and that led me to think—I’m almost embarrassed to say this, but I also wonder what it would be like to go with you.”

I was stunned and touched. Together, we discussed what it might be like, what parts of John I would see, and what parts of me he would observe. John imagined it would provide me a window into parts of him and me that had been hidden. I wondered what kept these parts of him out of the consulting room. John was silent for a few moments. Then he laughed quietly.

“What’s so funny?” I asked.

“I’m just thinking—I’m a tough nut to crack,” he said.

“No kidding,” I replied.

We both laughed.

“But,” John continued, “don’t get your hopes up. I’m not sure this exchange is going to elicit a breakthrough of feelings.”

“I don’t think it works that way, but I agree you’re tough, and that you don’t want me to crack you points to strong will—and perhaps anger—on your part,” I said.

“Anger?” John asked.

Thinking of Bowlby’s (1980) stages following loss, which include despair and angry protest, I replied, “About the years of neglect, lack of acknowledgment and loss.”

> "It's true," John acknowledged, "I don't want to think about those feelings."

> Keeping in mind John's overdeveloped capacity for intellectualization and guarding his feelings, I responded, "It's not the thinking that's difficult. You don't allow yourself to *feel* those feelings."

> "It's true, I modulate them," John responded.

This discussion led to an ongoing discussion of John's anger and its mode of expression (or seeming lack thereof). John revealed that occasionally, when Dylan misbehaved, a rage—strongly dissociated—would suddenly appear. Several times, John had slammed a door in anger, frightening his son and wife. Or, his anger would manifest in cold withdrawal, frustrating and enraging Judi. John acknowledged he had many sources of suppressed rage—his parents' early neglect, and his father's illness and death followed by his mother's illness and death. All of these experiences left him having to parent himself.

John recounted experiencing somatic symptoms at the time of his mother's diagnosis, headaches and gastric problems. In his effort to deny and thwart any expression of strong feeling, John told me he felt he had no right to be angry or even sad. His mother had just been given a terminal diagnosis; who was he to be upset? I suggested that perhaps the somatic symptoms were his body's way of expressing distress and suppressed anger. He recalled what he termed "pre-adolescent anger"—intense competitive feelings and throwing tantrums if his favorite sports team lost.

> My awareness of the importance of the father in helping a boy accept and channel those aggressive feelings led me to say, "And no father to help calm you down and modulate those feelings."

> "It wasn't fair. Why did things take such a cruel turn?" John responded.

> I acknowledged that it was not fair.

> "My parents could never keep their drama from impinging on my life, even before they became sick," John said. "With their preoccupations with their boyfriends, girlfriends, the drugs, the partying—I was never protected, shielded."

> I responded, "We're talking about the kind of protection parents hope to provide to their children. No wonder you're scared now, being a father, contemplating having a second child." I pointed out that, by shutting down all his feelings, John was trying to protect Dylan (and himself) from

> "drama," but he was also shutting others out. Walling off important parts of his very essence was depriving his son—and he himself—from the full range of emotional life.
>
> "I don't want to turn my son into a confidante or peer, like my parents did," John told me.
>
> John is unconsciously driven to protect himself from what would be evoked if he were to express and share his feelings more fully. This was a defensive maneuver. I said gently, "That's not what Dylan's looking for. He's asking for more emotional availability from you. He's asking for a father."
>
> John was quiet. "I need to be more supportive with him, encouraging—you know, like, 'Atta boy'—the things we know are good for children. Judi's great about it, but a boy needs a father."
>
> "Yes, and so does the boy sitting in this office," I replied.
>
> John began crying softly. "It's true," he acknowledged. For the first time, I felt John was allowing himself access to be the needy baby in search of a parental mind—my mind—who would care for and think of him with concern, interest and love.

Shortly thereafter, Japan experienced the disasters of an earthquake, tsunami, and nuclear disaster. John knew I had been to Japan several times to teach (most recently, six months prior). Several sessions later, he arrived looking anxious. "We didn't even talk about Japan. How recently were you there?" I believed John's delay in inquiring about my trip was due to his anxiety about possibly losing me, perhaps leading him to "forget" when I had been there, since I had informed him. He asked, "Were you near the nuclear plant?"

I said I thought the events in Japan once again raised his fear of losing yet another person important to him. John replied, "Yes, damn it. I know it's not realistic, but it's scary. Judi and I stayed up watching the news. It will take an ongoing recovery plan on an epic level, but it's a strong country."

I agreed with John. For the time being I thought it was superfluous to articulate to John that he, too, would require "ongoing recovery," perhaps on an "epic" level. He had begun to demonstrate considerable strength toward creating a life for himself, at great odds, and I was satisfied with the therapeutic action and effectiveness of the metaphor. At least for the time being.

LOOKING TOWARD THE FUTURE

Recently, John reported a dream:

> *Hard to say where I was. I was a camp counselor for a big black kid, bigger than me, but younger. He was some sort of guitar prodigy, and I was supposed to help him, facilitate his playing. He was huge. (I asked, "Huge?") Like the size of a football player. Massive yet young—a teenager, but nice and gentle.*

John associated to taking Dylan to a soccer camp, where the instructor was an African-American man—"not huge, like in the dream, but athletic." We talked about John having wanted his father to teach him how to play ball, and how the dream might reflect his wish for such a father figure, as well as his yearning to be such a guide and force in his son's life. John reminded me of the film *The Blind Side*, in which a large African-American teenager is adopted by a white family. We explored his thoughts about the dream, and I suggested that it might be about his feelings of wanting to be adopted, taken in, cared for, have his playing facilitated, and be thought about—perhaps by me.

John and I talked about how these feelings seemed to be inextricably linked to his feelings about being a father himself. If John could allow himself to have me as "coach," to "adopt" him" in the transference, he, in turn, could learn to be a better "camp counselor" and "coach"—that is, an available, caring, involved father—to his son. John acknowledged how his relationship with me seemed to have opened up a wealth of feelings that had been "asleep for so long." Other feelings that had been "asleep," I thought to myself, included John's wish for parents with whom he could identify. This took many forms for John—for example, his connection to the African-American culture of his mother. With him and me, however, it was his wish to connect with his father's Jewish roots. I am Jewish and I wear a yarmulke (Aronson, 2007).

John briefly explored adopting more Jewish rituals in his home—an idea that had not gone over well with Judi, who was trying to distance herself from what she had experienced as the oppression of her enmeshed, engulfing, large, extended Jewish family. I respected John's spiritual strivings and his wish to commemorate his father, but also wanted him to understand the part I was playing. After much discussion between us about what incorporating Jewish practices might mean not only vis-à-vis John's relationship to the memory of his father, but also vis-à-vis John's connection to me, John and Judi compromised on a select number of Jewish rituals. John felt that, through these rituals, he could carry on the legacy of his father, an important task of mourning (Silverman, 1996), and perhaps also carry parts of me with him as well.

CONCLUSION

In every psychoanalysis, the parent-child relationship is an active therapeutic element (Winnicott, 1960; Loewald, 1960). The therapist is experienced as embodying parental attributes, ministering to the child, providing growth-enhancing acts and emotional provision that the child (in this model, the patient) has never experienced before. While John's psychoanalytic psychotherapy was not an analysis, I believe these elements are powerful models of therapeutic action in all treatments.

John's experience of his relationship with me as an analogue parent-child relationship took on additional significance for him because he was learning to be both parent and child after experiencing tremendous loss. The deep hunger John felt for connection and bonding, and his wish to be known intimately, were initially and for some time, unbearable for him. John had to be acknowledged—mentalized—and held in my mind so that he could begin to expand and amplify his own repertoire of feelings and emotional expressivity. Only then could he begin to tolerate his own disavowed needs and wishes to be known. In this way, John could then better hold in mind his young son, and ultimately develop his parenting capacities.

At present, after four years of therapy, John and Judi are actively trying to have another child. One day, John brought in a photograph—one he had mentioned in previous sessions—of his parents. There are Angela and Morry, smiling during a visit Morry made to Angela and John, long after John's parents had split up. "It's one of my favorite photographs," John said. "I always wanted them to get back together. I never stopped wishing it."

I was moved that John was sharing with me both the photograph and his poignant wish to have his parents reunite as a couple, and I told him so. Sharing my feelings with John mirrored his sharing of the photograph. I recognized what an important step it was for him to let me into his world to see the people we had spent so many hours speaking about. John's gesture in bringing in the photograph, among other similar gestures he had been making, gave me hope that John was now having an experience of being attended to through our work. He was beginning to be able to attend to the tasks of mourning: to relinquish the ardent fantasy wish that his parents reunite and accept their devastating loss; to feel nurtured himself and, by means of doing so, to become able to give to his wife and son; and to more fully realize a richer, expansive emotional life for himself.

Recently, Dylan, now nearly six, was looking at family photos and noticed the picture John had brought in to show me. He asked again about John's parents. When John gently explained that both were now dead, Dylan burst into tears. John hugged him and told him how sad he was about it as well, but that he and Judi were very much alive. To John's surprise, he found tears running down his face. As he sat there holding his son tightly, he gave credence to Freud's notion that, after great loss, the child can indeed be father to the man (Wordsworth, 2000).

Love is all you need.

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Part IV

Therapy in the Office with Emerging and Older Adults after Earlier Loss of a Parent

Chapter Nine

Death, Mourning, and a Daughter's Diary

A Psychoanalytic Perspective

Billie A. Pivnick

Billie Pivnick has contributed a highly cultivated case study that identifies key dimensions in working with late adolescents and emerging adults who have suffered loss. The case focuses the reader's attention on vital nuances of a two to three times/week psychoanalytic therapeutic process. The chapter reflects a scholarly integration of specific psychoanalytic literature as well as the application of derived concepts in enlivened clinical work.

Pivnick invites us to track the unfolding narrative of a young woman, Teresa, while she anticipates the loss of her father and how she continues after his death. Negative childhood and adolescent experiences with the father greatly complicated the task of mourning. Pivnick underscores the duality of Teresa's experiences that were private and singular on the one hand, yet shared and interdependent on the other. This duality was also apparent in the mother-daughter relationship, the patient's romantic relationships, and the therapeutic relationship. Another duality bears upon the dialectic in the patient's own self-development, discovered through the course of therapy, between her sense of what was inside and what was outside herself. At the same time we also track the parallel curiosity of an attuned, emotionally processing therapist.

The role of the journal as an integrative and organizing tool for the patient is described. Pivnick maps the patient's own developmental stages, and shows how writing was facilitative in the making of meaning, and in the patient developing a capacity for reflection and therapeutic progress. Although Pivnick calls upon theoretical perspectives regarding gender-role identification that may not be universally shared, her viewpoints are anchored as she authentically engages the patient. While weaving among memories, associations, metaphors, dreams, transferences, current enactments, and linking past and

> *present whenever possible, the patient and Pivnick work in a co-constructed fashion as they create an intricate tapestry of the patient's life in which the stitches of grief and mourning were central. Teresa's self-development was potentiated in the process.* —Eds.

Picture the prototypic teenage girl: peach petals peeking at the sun. Both tender and tenacious, she enjoys being gazed at, but just as easily retreats from flirtatious encounters, preferring rather to cover up with large shirts and scruffy jeans. Poised at the verge of adulthood, she preens, pouts, protests, and poses, but feels she is still "daddy's little girl" or a "tomboy." If she were a work of art, she'd be labeled "in progress," because everything about her is in transition. Focused on her bodily changes and new hormonally-driven emotional states, uncertain who she is or wants to become, she also yearns for the revelations of conversational intimacy, hoping they will help acquaint her with her own inner space—a world she can sense but not see, an enclosure she contains but can neither reveal nor conceal with confidence.

Her ties with her parents are beginning to fray as her customary cooperativeness turns to surly discomfort with the status quo they represent. She knows she must leave them behind, but doesn't know how she will manage on her own. She must turn away from her mother to establish her own way of being in the world and to create room for a tie to a significant other. She needs her mother to feel fulfilled—enough to manage her daughter's increasing distance, despite the maternal midlife differentiation this provokes. A girl must relinquish the ways she has imitated her father's overt use of power, so she can become acquainted with her own inner strength. She must also give up her unconscious romantic wishes for dad and rivalry with mom while keeping their affectionate connection. She may even puzzle over choosing a loving partner. She needs her dad as someone from whom she can safely depart and to help her assess various risks, including those posed by potential lovers. She also needs to see her dad loving her mother, so she can move on without guilt.

Parents help their adolescent daughters navigate transition by maintaining a firm but flexible hold—containing (Winnicott, 1971), remaining emotionally available in the face of ambivalence (Mahler, Pine, & Bergmann, 1975), scaffolding (Modell, 1996), encouraging the negotiation of a balance between autonomy and exploration (Bowlby, 1973), and augmenting perspective-taking in psychosocial problem-solving (Allen & Land, 1999; Fonagy, Gergely, Jurist, & Target, 2002). Adolescent women may also keep their own counsel through journaling. A journal can serve as a transitional object (Winnicott, 1958; Evert, 1991), being both outside her yet also containing her budding self-reflective awareness. But unlike the transitional object of infancy, the journal can also function as a transformational object (Bollas, 1989) insofar as it helps create conditions for the intersubjective requirements of adult intimate relationships. Writing in her journal can be a way to practice managing self-continuity at the same time she seeks to open herself to sharing of physical and emotional intimacies.

While normal separation requires mourning, bereavement places an even greater demand for internal reorganization. If a girl loses her father in the midst of this tumultuous time, familial, romantic, and career ambitions can suffer setbacks. As a result, she may come to regard herself as incomplete, disunited, or undone, and worse, beyond hope or help. A girl whose newly advancing cognitive and emotional resources are under siege may be unable to mourn, for to do so requires the ability to synthesize opposite feeling states into symbolic form (Segal, 2012); she must transform an external absence into a lively internal presence. To hold these incompatible emotions and associated ideas requires building the capacity to transition from holding psychological phenomena in an embodied way to containing them in bodily states that are given meaning. She must then consider them more abstractly as categories of emotions and ideas that can be shared and compared. Recording unfamiliar and ephemeral experiences in drawing and writing can help make them seem real enough to be exchanged conversationally. A journal used to that end can function as a portable archive of self-states during a girl's journey from familial embeddedness to subjective singularity within a reciprocal relationship.

Reshaping one's sense of self in time through linking disparate recollections, while employing both meaningfully repetitive gesture and inscription, is the essence of memorialization (Pivnick, 2011; Bion, 1959; Volkan, 1982). Keeping a journal, then, can be considered a ritual act that leaves behind a representational keepsake—a memorial space in which the past is both remembered and actively mourned while the future is imagined in the present moment (Bernstein, 2000, p. 347). Because the journal is often addressed to someone it can provide a sense of solace, connection, and unification during times of loss.

Internalization, from a psychoanalytic point of view, is a positive outcome of mourning. Freud (1914; 1917) believed that the mourner has to give up the lost person gradually, through repeatedly remembering the person but realizing that in each of those situations, the lost person no longer exists except as an internal representation. In melancholia (or complicated bereavement), by contrast, memory cannot serve to create distance because the loss cannot be tolerated. Instead, the person suffering from unresolved bereavement often becomes depressed, and his or her identity gets subsumed in the identity of the lost loved one. When the bereaved is a child whose parent has suffered a long illness, the child's defenses may be overwhelmed, resulting in early trauma. Since trauma interferes with the regulation of the self in time, a child can appear to be "stuck" at an earlier stage of development, complicating the use of symbolization as a means of separating from and internalizing the lost parent. In that case, before she can begin the process of mourning, a child must overcome over-reliance on defenses against powerlessness that follow traumatic early abandonment or the frightening intrusion of frequent medical crises.

Some (cf., Wolfenstein, 1969) believe that children cannot mourn because they haven't yet been through the "trial mourning" of separating from their parents. Instead of mourning loss, Wolfenstein contends, children dissociate and tend to enact in compulsively repetitive, rageful ways what they cannot yet symbolize. When a child has suffered a profound loss, such as the death of a parent, other family members' presence during the initial shock may enable enough scaffolding to take place for the creative work of reparative mourning to begin (Ornstein, 2010). But the surviving parent's preoccupation with his or her own grief often precludes that option. In those instances, a therapist can create a relationship with a teen that enhances the capacity for symbolization through mutual reflection (Freedman & Russell, 2003; Garber, 2008; Levy-Warren, 1996). Looking together at a girl's journal can facilitate mourning. For a young woman who has been increasingly aware of her inner space, a journal not only provides a potential focus of joint attention, but also begins to build a Third. This perspective is co-created with another person, and resolves the tendency toward oppositionalism that can result from binary thinking. It is also a means to reflect on her relationship with her therapist.

In this chapter I will describe a psychoanalytically framed treatment of a late-adolescent woman whose father died after a long illness while she was in college and in a six-year treatment, first two, then three times a week with me. I will illustrate how her relationship with her journal helped her both mourn and update her not-yet-fully differentiated representations of herself and her father as she began to discover she was a lovely young woman who could have intimate relationships with others without losing herself.

CASE ILLUSTRATION—TERESA

Beginning Phase of Treatment

Teresa reeled into my office. A bright-eyed, petite brunette, she could easily have been mistaken for a high school cheerleader. She smiled through her tears as she related her tragic story in a detached, clinical manner that failed to match the rest of her demeanor. She noted how little attention she'd paid to herself for the past two years and how tired she felt. Her chronic fatigue went beyond exhaustion, though; it had just been diagnosed as Epstein-Barr, a widespread herpes virus communicated by oral transfer of saliva. Telling her family about her infection had produced an uproar. Although she'd hoped to keep her condition a secret from her father, her mother and aunt had not protected her wish for privacy, and she felt betrayed. She had been referred to me by a friend's therapist after confiding that she didn't want to burden her family but needed to talk to someone.

Teresa described her father's illness at much greater length than her own. For the past two years, he'd been repeatedly hospitalized with metastasized intestinal cancer. Despite her commitments as a college student, she'd gone home every weekend and tended to him while he underwent multiple surgeries and chemotherapy and suffered several heart attacks. A self-described extrovert, she rarely stayed in or cared for her own needs, a pattern that began early in her childhood. Her earliest memory was of herself as a five year old, floating in an inner tube, alone in the family pool—left to care for herself while her mother managed her seven year old brother's impulsive behavior and cared for Teresa's father, who had just had a heart attack. Teresa now felt at a dead end, having neglected many of her own needs and preferences for many years. Acknowledging her long list of concerns, I wondered aloud: "Who is taking care of Teresa?" My query seemed to spark her interest and cemented our alliance rather quickly.

At the top of her agenda, though, was not her exhaustion or the impending loss of her father, but whether she should break up with her boyfriend. After catching him kissing another woman, she had endeavored to end the relationship, but failed. Instead she continued to see him, explaining, "I don't know if it's him or the comfort I get out of being in a relationship." Teresa claimed to have received a great deal of tenderness from her parents while growing up, but she felt she lacked that in her limited number of current friendships. She considered her four-person nuclear family to be her entire world, with her dad "constituting 35 percent." Apparently, she was the person who got shortest shrift in this arrangement. After his recent surgery, which had multiple complications, she'd felt that if he died, she might not go on with her own life: "Even if I'd gone home to stay, which I dreamed of doing, I'd have just stayed alone and gone more and more inward. They would have had to feed me Pablum. . . ." Suddenly catching herself, she disavowed her prior statement: "Wait, that's ridiculous. I'm not in touch with this now. . . . I must be making this up. . . . I'm embarrassed. I should be competent and wanting to take care of myself, not feeling so helpless." She couldn't imagine her helpless despair and hopeful independence as anything other than completely incompatible states.

Her mother, who worked in health care, had taken the family to therapy to talk about the father's impending death. "No one was talking about the fact he was going to die but me. I said to my mother, "Why is this 'The D word'? What if he dies? Don't we have to know what he wants in the way of arrangements?" "My mother said she knew, but I didn't know and I wanted to." When I asked if Teresa herself had felt left out, she said, "Yes, but . . . in the hospital one nurse asked him if he had two wives because I always acted like his wife, taking care of him and asking questions of the doctors." In the aftermath of her dad's surgery, she broke up with her boyfriend. "When I thought my dad was dying I couldn't see being able to derive any comfort from my boyfriend. Plus even if I could let him take care of me, I'd be such a burden."

Teresa's embarrassment over being too close to her family was the theme of many sessions. "Can I take care of myself? Who will look out for me?" she worried. She also feared that she'd never know what she wanted as a career. She couldn't imagine going to graduate school because even though she wanted to be a "woman of action," she worried about her indecisiveness and inadequate ability to protect herself, and she didn't trust doctors. She wondered if she were like her mother, whose sense of resignation had made it hard for her to "take action" against her husband's alcoholism. She hoped I would give her a "plan of action." It became clearer to both of us that she became preoccupied with wishes for independent action whenever she began to feel a longing for something more. She complained of being unable to think or to remember and reported feeling disconnected. As a result, she had trouble keeping herself or our work in mind during the interims between sessions. Her moods swung frequently between very low and very high. Although I had hoped that the twice a week sessions would help diminish her anxiety, I was sensitive to the possibility that it also magnified her concerns about being open with, or dependent on, me.

Teresa also felt conflicted about how open to be with her boyfriend. Although she wished to relax and enjoy their intimacy, she managed to keep out of awareness any feelings, making the experience of pleasure a challenge. "Maybe I'm like my mother. . . . She avoided my father's outrageousness—I hated that. Then when he was sick, she shut down so far that she wouldn't even open up to me. I felt so disowned and angry." During this period, Teresa seemed to enact being disowned: She was caught by someone from her church when she went to a stripper bar with some friends and, as a result, was asked to leave the religious group she'd belonged to. This event made her worry about her rebelliousness and resemblance to her father as a problem drinker. I noted to myself that she seemed to be identified with him in many ways. Was behaving like him a way of seeking more attention from her mother, reflective of relational immaturity, or identification with him as an abandoning "aggressor"?

Soon after the church group rejection, Teresa's father was readmitted to the hospital. Although she still reserved the bulk of her anger for her mother, this time Teresa allowed herself to express some anger at him. She described her envy of her brother and guilt for having surpassed him, but also longed for the admiration she felt her father gave to her brother and not to her. "Do I have to be f—up to be liked by him?" She wondered whether she wanted to find a boyfriend like her brother and father, as a way of drawing closer to them—after all, "real men drink and crash cars." With her boyfriend she stayed on the surface. She imagined if she felt more deeply, she'd "never come back up." Similarly, Teresa feared she wouldn't be able to experience her father's death without either drowning or staying superficial. She felt unprotected by her mother, vulnerable to attack. When a friend's brother died unexpectedly, Teresa made all the funeral arrangements, hoping to prepare herself for her father's impending death. Her friends criticized her for doing too much; her mother, Teresa complained, was too self-absorbed to notice.

The Middle Phase—Coping with Dad's Death

Following her dad's death, Teresa's mourning brought her closer to her mother, away from the city, and home again. Tear-filled sessions were replete with descriptions of how she helped her mother manage the funeral service, cleaned her father's closets, and accompanied her on cemetery visits. While in the city, though, Teresa threw herself into school work and prepared applications to graduate school. Although her mother supported her attempts to carve out a life for herself in New York City, Teresa's wish to keep things the same led her to decide to go with her mother—in her father's place—on a long-planned vacation to an exotic destination. Teresa reported knowing he was gone but also wishing to communicate with him. In a particularly poignant dream, she and her mother floated through space, waiting to contact him. Because his work had taken him away for long periods, they both had become used to waiting for him. Teresa felt it was no coincidence that, while on this vacation, she met a young man named Brad who reminded her of her father. Her father, she said, had lived in a magic bubble of celebration; everything was an excuse to rejoice. Brad, too, liked to "celebrate," and because he lived far away, he too would be away from her for long periods. It was as if, on the one hand, she knew that her father had died; but on the other, she expected him, or someone very much like him, to materialize.

Despite the increased frequency of our meetings, I found it difficult to follow the thread of Teresa's stories from session to session, and she continued to complain about difficulties with memory and concentration. Aware of her struggle to maintain self-cohesion, I asked Teresa what would keep her from recording her impressions in a journal; she quickly embraced this activity as a way to give more continuity to her fragmented experience. At first, she used her journal in sessions to record comments of mine she feared she'd forget. She also used it to help her remember events that occurred between sessions and to keep track of her moods and feelings, especially about her new love interest, who she imagined she might marry despite fear of her mother's disapproval. Until now she had generally ignored conflicts with her mother; being able to acknowledge them privately felt affirming. Composing journal entries helped her tolerate her inability to see Brad, the faraway man she'd met on vacation, as often as she'd wished. It also helped her feelings of inadequacy over being unable to change the fact of her father's death.

Initially she experienced her anxieties bodily. She complained of not quite knowing one part of her experience from another, particularly regarding her body. Confusing the loss of control in orgasm with the loss of control in urination, she noticed that reflecting upon her writing enabled her to differentiate between the two experiences so she could feel more relaxed about "letting go." Because her inner thoughts also felt clearer to her, she noticed differences between herself and her mother. She observed that she appeared effervescent while her mother seemed frigid. Writing in her journal thus helped her to master the difficulties created by being unable to perceive the workings of her inner organs *and* helped her define a boundary between herself and her mother.[1]

Because Teresa's journal helped her create a more private inner space, it became an alternate confidante to her mother. She could now begin to bear witness to her own inner world and feel more comfortable excluding her mother despite her mother's increased need for emotional support. She also now had a place where she could nourish her more autonomous strivings and ambitions. She wrote of the self-assurance she had to muffle during the earlier period of her adolescence when she was expected to become more restrained in her overt sexual expression, a time when she had instead turned to her church group to provide a non-sexualized form of admiration.

Through her writing Teresa also noticed that she had two "modes." In one she was anxious and overwhelmed, like her dad who always feared having another heart attack at any second. In another she was more concerned with the bottom line, like her mom. She felt wise and practical when in this mode. Over time, she developed a third mode, in which she became aware of how angry and critical she felt much of the time, sometimes even toward me. In sessions, she oscillated between shutting me out ("You're NOT coming to my wedding! You're NOT going to be at the birth of my child!"), and wanting my help with being more organized and efficient like her mother. The fluctuations in her identifications gave way to a more authentic internally derived perspective.

Indeed, Teresa had changed quite a bit during our work: She'd gone from an adolescent who couldn't commit herself to attending graduate school or thinking about her future, to a graduate student working toward a future career in health care. In sessions she began to bring up material about doctors and professors. She experienced enormous anxiety about one professor who she felt always cut her down. She worried that I might be secretly critical too. She said, "I want to have it all together. I want to be seamless." When I empathized with her wish to be perfect, she associated to being panicked by an open seam in her coat lining. Perfection, I reflected, seemed to Teresa to mean having no openings.

Although I imagined Teresa's fear represented, in part, a wish to prevent more losses, I have found that these sorts of statements often convey a common genital anxiety in young women who fear being unable to gain access to their own interiors or to control access to their openings (Bernstein, 1990).[2] They often turn to their mothers for help with regulating these anxieties. But Teresa complained that she no longer looked up to her mother because she thought her mother needed too much reassurance and had failed to help her be self-protective. Still, Teresa felt men were no better to rely on. Men, in her eyes, were party boys who were not to be trusted, either for support or constancy. Although disillusioned, Teresa still had hope. She brought in a Jules Feiffer cartoon that read, "Men are weak, arrogant, self-centered, and terrified of women who are empowered. Except for this doctor I met in a bar last night—who's perfect." But she no longer just placed the blame on her father or men for her difficulties in counting on herself. She observed that she didn't value her own feelings enough because they were so changeable. Completely deadpan, she stated, "If I make plans with myself, I stand myself up." We laughed over the truth of that statement.

Teresa had learned to orient herself by pleasing men, following her mother's instructions to "get her expectations down to zero." The idea that she might find a man whose life was also in order was one she now began to consider. She also began to feel she had a choice about saying no to "celebrating" with every man who extended her an invitation. In "giving" that way to her dad, she realized, she had really been expressing her need to be needed—just as he had done.

Teresa's new restraint left her the time and psychic space to notice she was missing her father and that she had mixed feelings about her newest boyfriend, Nick. She commented, "I am managing my vulnerability without his help, because he couldn't give it anyway. I'm managing by being open and risking a relationship, but setting a time limit. This won't go on forever. Since I have my own inner world now, I don't even have to share that thought with him." She then read to me a poem she'd written in her journal, excerpted here:[3]

> Come, swim in my ocean/be enveloped in me/experience the depth of my water—my psyche/and the breadth of my seas. . . . Revel in the beauty of my flora. . . . Partake in the playfulness of my fauna. . . . Understand my need to nurture/to breed/to spring forth new life./Respect my dark and stormy self. Accept my strength. . . . My liquid state is not to be imprisoned/possessed or controlled./My seas are not your dumping grounds/or your depository. . . . I am not meant for mere admiration . . . / I am meant to be experienced. . . . Come, swim in my ocean/Savor the fruits of my seas.

Teresa's next dilemma was whether she could keep setting boundaries with Nick while also maintaining her excited longing. Could she continue to tolerate waiting? She felt the only alternative was to conduct the relationship the way she had learned to please her overly exciting father—to join him in his bawdiness. Teresa had competitively taken pleasure in bantering with her father. She explained, “My dad told graphic stories and jokes, and I think I found them over the top, but I tried to go along and laugh. I even learned dirty jokes to tell him.”

However, Teresa now discovered she was able to both give Nick pleasure and to stop long enough to be sure he took care of her needs, too. Instead of shutting down, giving up, or thinking he would leave her as soon as they had sex, she reported the following exchange: “I hope you won’t leave me.” “Don’t worry, I’m not going anywhere, I’ll be here,” he replied. She reflected to me, “That was just what I needed to hear. Then I felt okay about letting go. Maybe that’s the difference between having sex and making love.”

I observed, “When a man is sensitive to your wish to have him stay and not leave you the way your father did, you are comfortable with making yourself vulnerable.” Although she was becoming less worried about whether a man would make a commitment to her, she now asked, “Why can’t I keep a commitment to myself?” and then remarked: “I should be journaling about this!” “How would that help?” I asked. “If I wrote it down, I might follow through on it. It would be more formal, more concrete. It would help me take the thought and keep going with it.”

In the next session, as she read to me from her journal, Teresa noted, “I should have just faxed this to you and you could read it and have your comments ready when I got here.” This slightly dismissive comment reflected her ongoing difficulty with waiting and longing. It was illustrated by her next comment—in relation to her “starvation mentality”—something her mother had told her about eating when her brother was around: “If you want something, you better eat it now, because it won’t be there later.” She expressed anger that my affection for her was not unconditional, that she had to hold onto her feelings between sessions when she would rather have been sharing them with me. I raised the idea that though my openness had limits, my conditional availability was not quite the same as total rejection, and it allowed me to be more fully present when we were together.

Her resentment of my limits, though, reflected her difficulties being more self-protective. She wondered, “If I give up the opportunity to be with someone, do I have to give up partying altogether?” In the face of her wish to be “swept away” by sexual passion, we discussed the idea that “openness with limits” might be a policy she could adopt, too. When later she didn’t hear from Nick after a mix-up about the time of their date, she planned to put personal ads in the paper, to not be at a loss. My suggestion that she wanted the upper hand more than a loving relationship infuriated her. Shaking her journal at me, she fumed that she wanted to “strangle” me. I commented on her wish not to know about the conflict she felt between wanting to be less directive with her boyfriend and wanting unreasonably to have him at her beck and call. She knew that when her boyfriend submitted, she'd lose respect for him. This line of thinking brought up associations to her father. She called her dad "a big prick" who would lose control for days or weeks at a time, meaning the family had to scramble to accommodate in his absence. Teresa noted that such behavior left her mother totally in charge and contemptuous of her dad. As a result, neither the male nor female role in her family appealed to her.

During my vacation, Teresa used her journal to reflect on her expectations of men. She noticed a pattern in her anticipated scenarios: First, she'd think, "He likes me!" Then, "Maybe he's the one!" Next, she'd think, "Well, even if he's not, he's interesting; I could like him." But now she had an additional question. She asked herself, "Wait, what about me?!" She had been able to stop one of her impulsive encounters with a guy at a campground by listening to a new voice in her head that reminded her that she didn't like him that much. I introduced the idea that she might not feel so easily swept away if she imagined herself as a boat that had a rudder as well as a sail, one that she could lower into the water when she needed to steer her own course. The rudder would consist of her emotions.

Feeling she couldn't keep her rudder in the water both because she didn't want to betray her sense that her father would have wanted her to do his bidding, and because she would consider herself unfeminine if she weren't ready to be rescued or blown by any wind, Teresa began to recognize that when she was with men sometimes it was "like going on a drunk." She saw that she had suspended regulating men's access to her body and emotions by not thinking about the consequences. It occurred to her that her dad's failure to regulate his profanity and sexual innuendoes when drunk was a form of neglect.

Soon after, she came in declaring, "This has been such a great journal!" She read me another poem she'd composed about a part of her that was like her dad in not respecting another part of her that, like her mom, wanted respect and reverence. We talked about her experience of feeling caught in the middle of her parents' impasse. While her mother would be upstairs reading, her dad would be in the basement drinking and inviting Teresa to listen to his sentimental or bawdy stories. She'd sit on the steps between them, too frozen with loyalty conflict to move closer to either one.

In considering whether her search for a man was a way to "fix" something she felt was missing, she reminded herself in her journal to remember such things as: "Do you need a man? What do you have? What do you need? What do you want? What can't you live without?" Several sessions later she announced that she had decided she could live without a man just fine and that she didn't feel so close to her mother any more. Having read Carol Gilligan's *In a Different Voice* (1993), she commented on Gilligan's use of the term, “diffuse togetherness,” to describe the extended merger during development of mothers and daughters. She stated, “Diffuse is my middle name! And togetherness is what I’m afraid I don’t have any more with my mother.” She looked at me, and commented on my expression. “Today I see you as proud of me. You look like the Cheshire Cat. You look how I feel.” Needless to say, this feeling of deep attunement was a special moment in our relationship.

Another day, when struggling to remember something I’d said about something she’d said, Teresa commented, “I’ve *got* to get this. Sometimes it’s elusive. It’s like a big dark space and you’re describing it but I can’t see it. It’s frustrating.” I wondered if she thought she herself didn’t bring anything to our work or did not feel at liberty to take from our work and make it her own. She admitted she was afraid that what she said was less valid than what I said. Soon after she came to session, thinking she’d brought a poem she’d written in which she “claimed a future that included joy,” but then realized she’d forgotten her journal. She commented, “I must have emptied it out of my backpack to lighten my load.” Now I was the one in the dark. When she finally brought in her poem, it was accompanied by the announcement that she had remembered what we had talked about the week before, that she had worked something out on her own during her time between sessions. In a surprise to me, she confessed she had also been thinking about dying. Here are the most important verses of the poem:

As She Lay Dying

And in that space
There was utter peace.
A feeling so new and wondrous
Washed over me like a wave.
The air was thick with serenity. . . .

And in that moment,
And for the first time in my life,
I felt love, joy and peace
That transcended anything I had ever known before.

And a vision unfolded
In which the legions of my ancestry
Stretched onward and outward
Before me.

And I was embraced by my father and
His father and his father before him.
And each man cared deeply. . . .
With no thought of distant or estranged relatedness. . . .
. . . .

And next to the man whom,
Long ago I had given my heart,
Stood our children, their children
And their children too. . . .
They called me by name.

Each ancestral line stretched far beyond
That which my own eyes could see.
And as I looked in both directions. . . .

I rejoiced at being able to
envision this unending line
of my past leading ever forward
into my future.

It left me content and at peace
And I knew
Without my mind ever forming the thought—
I knew I was home.

As we reflected together on this poem, Teresa's references to joining her dad in death alerted me to potential suicidal risk. She denied wanting to actually die. Her thoughts and affect seemed most connected to re-finding her father, this time in symbolic form. Was she also expressing anger at me for leaving her to go on vacation? We considered this. To myself I mused that perhaps she needed her father to manage the separation from me. But this elaborately symbolized poem had suggested to me that she was doing more than just separating from me or identifying with him. Connecting past with future in the present is the essence of memorialization. Through her poem Teresa seemed to indicate she could move beyond just raging or identifying with her father in death. She could internalize a more realistic relationship; without her split image of him. She could now be generative.[4]

Another turning point occurred soon after. Teresa dreamed she was married and was a mother to a sickly baby. Though it was going to die, she held it and realized she was a good mother. She could hold and comfort the baby though it was sick. She had married a man who admired her. She told her baby not to worry, that his grandpa in heaven would take care of him. The baby said, "Who's going to be my mother, Mommy?" In the dream she was upset because she realized she wasn't going to be in heaven with him. But then she realized her dream husband's mom could be the baby's mother in heaven. "It's just like that poem I wrote," she exclaimed. "Yes, but with a mother, too, this time," I added.

During this period of deep intrapsychic work, Teresa maintained her commitment to her friendships and education. Upon completion of graduate school, Teresa interviewed for a job. Her first thought was to set limits: "I won't settle for a sexy job if I'm not treated right." She wanted a position more elevated than the one she received. She decided to stick it out until she got promoted, since reliability and long term gratification were now more important to her. She had formed a sustained relationship with a man (Steve) in which she felt more equal. In fact, she confided that she now felt so comfortable with who she was that she didn't need to insist she "pay her fair share" and that she rather liked being taken out. She commented, "I'm a beautiful, diversified woman. I don't feel like a square peg in a round hole." Suddenly, she caught herself and began blushing and fumbling for words—"you know what I mean." I said with a smile, "Do you mean you don't have to pretend to be a square peg when you're really a round hole?" With a matching ironic tone, she retorted, "Seriously, the men in my family had all the power and I wanted it, too. Now I have power, but it comes in this shape and form." She pointed to herself. At this moment we were together celebrating Teresa's feeling of mastery over earlier genital anxieties but in a context in which we were also engaged in a sophisticated intersubjective exchange. We could feel and acknowledge shared feelings of empowerment while remaining our separate selves.

Over the next several months Teresa began to leave her journal home. When she felt the urge, she'd write something on the back of her checkbook. She explained, "I stopped journaling when I started seeing Steve." Her involvement with Steve had started during my vacation, at a time when she was particularly disillusioned with my not being there for her "when she was on the edge." This was the same time she had rhapsodized in her poem as one of blissful altruistic surrender. We knew Teresa's identification with me had helped her regulate her feelings about losing her father. This seemed to confirm for us that her relationship with Steve and her identification with her father had been used to regulate her feelings of missing me.

The relationship with Steve began to founder when Teresa felt that Steve saw her wish to discuss their relationship meant that she, like her mother, needed too much reassurance. She disagreed. In a startling new development, she was able to take her own point of view instead of his. She exclaimed, "I'll be damned if I'll be in a relationship where I can't be reflective!" When she didn't respond with desperation, Steve began calling her and telling her he couldn't live without her. She explained, "I held onto myself, and we talked."

Reflections on Teresa's Use of the Journal in the Middle Phase of Treatment

Teresa's use of her journal went through distinct stages, much as a relationship evolves over time. Although these shifts were taking place in the transferential relationship with me, she experienced them as belonging to her relationship with her journal—much as one would expect of a transitional object. Initially, she used her journal pages like blotting paper, to soak up overflowing emotion and to record things I said that she felt were particularly worth remembering. In the second stage, Teresa read from it in sessions, so that we could talk over her thoughts and feelings. In the third stage, she wanted me to tell her what to do. In the fourth stage, she realized she could use and trust her own judgment and could be more discriminating with men and say no when she wanted to. In the fifth stage, Teresa made a point of excluding me while describing having the courage to exclude her aunt from a private conversation. In response, I felt discounted, and I became distant. Teresa then asked me to help her with something she was working on that she was actually quite capable of doing on her own. In our discussion of this request, she came to the realization that though she wanted my approval of her perspective, there were some choices that were subjective and therefore open to multiple interpretations. She was able to feel like, and describe herself as, someone who could be "an excluder," without enacting exclusion of me at the same time. She would abandon her journal when she found a man, but take it up again when they had broken up. These stages mimicked the stages of a developing relationship and how it spawns a differentiated but cohesive self: first, holding; then imitating and conversing; then wanting and setting personal limits; keeping something secret, forming a boundary between us; learning to regulate her wish to both devalue and idealize my worth (and hers); making moral choices independently; and being able to represent something she was feeling without enacting it.

Some theorists (cf., Silverman, Nickman, and Worden, 1992) disagree with the contention that children cannot mourn. They believe that a bereaved child does carry internal representations of the lost parent, but that those images have to be updated at each developmental stage. That way the lost person can "age" along with the still-developing mourner. Otherwise, the child risks carrying unrealistic expectations and memories, tinged with emotions and conflicts from earlier developmental periods. Perhaps Teresa was using her journal as a way to update her internal image of her father which had gotten "stuck" when she was five during the trauma of her father's first heart attack and her mother's fears and preoccupation with caring for him. Keeping a journal helped her develop a separate perspective from her mother's. When she was younger, the only way Teresa could be recognized by her mother was to be her cheerful helper—a false-self organization that masked Teresa's fear of death and her wish to be comforted and cared for.

In addition to marking these stages in her relationship with me, Teresa's journal launched her as a poet. In her more literary self-state, she had vision, empathy, and connection—to numerous other self-states past, present, and future, and to significant people to whom she'd been, or hoped to become, attached. That each of these self-states had its own story was apparent in her poem about joining her dad in death. But it was in joining him that she could finally join herself—the younger self who did feel held (in a non-sexualized embrace) and capable of holding. She could also join her inner selves—male and female, young and more mature, joyful and sad. Teresa's acceptance that her power came from her own physical and psychic being, in which being a "round hole" was a positive development**,** can be seen as her initial movement toward post-oedipal mixed identifications with both gender roles (Bassin, 1996).

The Final Phase of Treatment

Teresa and Steve's break-up marked the inception of the final phase. She began again to bring her journal to sessions. Now, though, she said she felt she was coming to therapy more because she liked it than because she needed it. She explained, "I like to check in with someone who doesn't have an agenda for me. Oh, and I started journaling again." She seemed to be telling me that writing in her journal was an adequate substitute for talking with me.

Over the next few sessions Teresa discussed being tired of her endless search for a man, but she also expressed disappointment in what she called "right living through therapy." She also pleaded: "Please tell me what to do, build me up." I commented that when she was angry she couldn't remember the positive things I'd said or how she'd felt being with me. In reflecting on her difficulty holding divided feelings in mind simultaneously, she associated to her relationship with her mother—she remembered how her mom had cared for her when she was an asthmatic youngster. "She either detected the first minor notice of a wheeze, telling me to get the inhaler; or she helped me to be more independent, to go on hikes and just take my medicine and a canteen with me." But she did not experience these aspects of her mother as connected to one another because they seemed so tied to her mother's own shifting states of depression or distraction by her troublesome older brother or father and his drinking.

"Who's taking care of Teresa?" I once again commented. "You forget yourself like you experienced your mom forgetting you." She replied: "The other side of my mother was neglect. But I'm doing a better job of taking care of myself now. I'm not so eager to take care of others at my own expense. I'm not going to throw a baby shower for my brother and his wife to be. They didn't appreciate the work I did for their wedding. I'm going to train for a bike race instead." This was no longer the overburdened and chronically fatigued patient I had met at the inception of treatment.

As we anticipated my upcoming vacation, Teresa noticed how much she didn't like being "left behind." She remarked, "Usually, I get rid of anyone who will leave me; but then I'm lonely." She recalled that early image of herself afloat in an inner tube in a pool with no one else around. It reminded her that she had been utterly alone at times when her mother was attending to her wild older brother. I commented, "If you let yourself miss me when I'm gone, maybe you won't feel so alone," hoping to enhance her ability to tolerate longing. Then she remembered her father's heart attack when she was five and the way she and her mother both worried all the time about her dad. It became more apparent to me that she, her dad, and her brother had all vied for mother's attention and that this early triangulation was complicated by her father's heart disease. Perhaps the compulsive nature of Teresa's search for a man and her wish to include me as someone who could witness her caring for him and him for her**,** without destroying their bond**,** was an attempt to master some of the traumatic anxiety of her early childhood.

The Termination Phase of Therapy

As part of our planned termination Teresa and I read her journal together. She said she felt sad and philosophical, and had been reflecting on the cycles of life and wanting to write again in her journal. I confided to her that I thought her journal had been an important part of the therapy. After leaving the "triage team" with her mother during her father's illness, she had created a new "triage team" with her journal and me**.** Teresa was now focusing on her own trajectory, this time memorializing her own life with an eye toward her future, mourning the loss not only of her father but also of her more dependent younger self. She reminisced about the phase of our relationship in which she had to write down every word I said because she was afraid she'd forget. Then she'd had to read every word she'd written or she'd forget what she had to say. Teresa remarked that **w**hen I had called her attention to the way she had used her journal, it was a turning point; she then realized she could remember her own thoughts, and that had quieted her anxiety. "Before I couldn't find my voice," she said, "then it was in you, and then it was in my journal. Now it's right here in me (pointing to her chest) and I'm not going to lose it."

In a surprising but important revelation, Teresa then told me that when she was a girl, she had kept a diary—one of those little store-bought ones that had a lock and key. During junior high school she used it to record her most secret emotions. Her mother saw it, opened it, and read some pages in which she had cursed her father. Her mother had betrayed her secret to her father, who became enraged at Teresa for what she'd written, barged into her room, and cursed her in retaliation. Although her mother had made her dad apologize, she felt her mother hadn't helped her keep her secret; she hadn't valued protecting her daughter's inner world. Being able to enact excluding me from her journal may have helped her master a feeling of powerlessness induced by her mother's betrayal, her father's domineering intrusiveness, and then her mother's passivity. Together we reflected on feelings from that incident.

She shared that my respect for the integrity of her journaling process helped her repair the despair she'd felt about her loss of privacy.

As our work drew to a close, Teresa stated that she now had confidence she had been lacking before she came to therapy. I commented that she had been able to organize for herself what she wanted to keep in and what she wanted to lock out, who she wanted to take into her confidences and who not. I reflected that she had also learned she could confide in herself. In the final meeting I asked her if there was anything else she wanted to tell me. She confessed that she had secretly come to therapy hoping it would enable her to meet a man, and though she was more confident now, she still felt shaky. She then examined her feelings about whether she needed a man in order to terminate therapy. She decided she didn't, and that it actually suited her to have found herself instead. She concluded that the answer to, "Who's taking care of Teresa?" was Teresa. Though this wasn't the outcome she'd expected, it was the one that felt right.

DISCUSSION

Teresa's story illustrates some of the complexities that an adolescent has to confront and engage with while journeying toward resolution of mourning. Although she initially detached from her father by becoming quite busy and by identifying with aspects of him that had been intrusive and impatient, keeping a journal and interacting with me had allowed her to update her images of herself in interaction with her father in ways that allowed for a less angry, more positively tinged representation. Confiding in her journal, and then in me, helped her build the self-confidence she needed to separate from her mother—in what many analysts would consider an expectable late adolescent oedipal resolution. In becoming more patient, Teresa also became a woman more like me. Only then could she let go of compulsively searching for her father, repeating over and over what was not remembered, *the loss of his protective affection*. As she no longer needed the dissociation of the early triangulation among her "good" mother and "bad" father, she could let go of competing for her mother's approval and attention and instead compete at work and be receptive to more satisfying love relationships.

Mourning is a creative act (Klein, 1940; Segal, 1988). As described by Ogden (2000), "successful mourning centrally involves a demand that we make on ourselves to create something—whether it be a memory, a dream, a story, a poem, a response to a poem—that begins to meet, to be equal to, the full complexity of our relationship to what has been lost and to the experience of loss itself" (p. 65). For a teenage girl whose symbolization capacities are not yet fully developed, a journal can function as scaffolding for the uniting of opposites required for true symbol formation (Freedman & Russell, 2003). As Doris Lessing (1962) commented about *The Golden Notebook*, "the essence of the book, the organization of it, everything in it, says implicitly and explicitly, that we must not divide things off, must not compartmentalize."

Mourning is also a special form of remembering. Since a journal scaffolds remembering, using a journal augments working memory essential to the "standing in the spaces" (Bromberg, 1998) between teen and others, as well as aspects of herself that make her, in the words of Harry Stack Sullivan (1973, p. 26), "more simply human than otherwise." To quote Doris Lessing again: "Growing up is after all only the understanding that one's unique and incredible experience is what everyone shares" (p. xiii).

Teresa's journal helped her bridge the many contradictions and ambivalences in her struggle to break free of lock-step identification with her father. It enabled her to symbolize rather than enact her sense of being at a loss, and to weave together seemingly incompatible representations of herself as both like her father and unlike him. Her dad was emotionally expressive in sentimental ways; Teresa was expressive in poetry. He was courageous in his long battle with his illnesses; she was courageous in striking out on her own. He was self-destructive; she learned to be more self-protective. He was ill and spent much time in hospital care; she had become a worker in the health care system to prevent illnesses. He was always looking for excuses to celebrate; she stopped creating so many parties to celebrate, instead, she celebrated her inner world. Teresa took very seriously the events leading up to and including the death of her father. Like her mom, she could embrace her assertiveness and capacity for self-care; unlike her mom she could relinquish the role of family caretaker. In the end, Teresa managed the loss of both parents as ever-present external objects by emulating her mother, a feminist, in valuing self-reliance, and by trying to live up to her father's spiritual values while tempering his conviviality.

I met again with Teresa during the writing of this chapter to obtain her permission for publishing her case. She had become a successful businesswoman and had been living for a number of years with a man who worked as a writer. She was also a surrogate aunt to the children of a close friend. After our reunion, she sent me an email in which she said, "I had a very funny thought . . . that I wanted to share with you. It is about my long search for a husband in my twenties and thirties (and even before and after that). I realized this: While I never found a husband, I became my own husband! I've had a successful career, I'm financially stable, and I bought my own house. Maybe I found the way to integrate my masculine and my feminine (e.g., husband and wife functions) into my own self! Very cool! Thanks for helping me to set that foundation." She was no longer sitting fragmented and frozen on the steps between her warring parents.

Teresa's father became critically ill when she was in mid-adolescence. Was her entrancement with men also a compulsive repetition of that traumatic period? If so, perhaps it was the sentimental poet-dad in Teresa that had become father to her finally found writer-partner? As a successful businesswoman like her mother, as someone who could reliably hold onto herself like me, perhaps she could finally and safely embrace the freedom entailed in giving her hand to a man.

This chapter is my own reflection on our long-ago relationship. I was struck, after reading my account, at how strongly I now felt the urge to edit Teresa—in a way I didn't then. I wondered why I had never shared my occasional embarrassment on her behalf. Then I remembered a passage from Doris Lessing: "Remembering, half amused, half embarrassed, an emotional condition which was so strong it had the power to absorb into it pavements, houses, shop windows . . . all the women in the place were aware of [the sexual languor of the young girl]. . . . Although to us every appearance of this girl was so powerfully embarrassing, the men did not see it, and we took care not to betray her. There is a female chivalry, woman for woman, as strong as any other kind of loyalty. . . ." Certainly, my non-intrusive stance enabled Teresa to privilege her budding sexual expression and private creativity. But it also placed me in a lineage of analysts much like her imagined familial lineage—mentors who taught me how to contain even deeply disturbing emotions in service of helping patients mourn loss or heal from trauma. Seeing Teresa unfurl from a tendril of a girl to a proud and self-possessed young woman reminded me that she had given me the present of memory. Through her I was able to recall with some exhilaration my own blossoming.

NOTES

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1. Kestenberg (1956; 1968), tracing developmental changes in girls' representations of inner space, concluded that a girl of two or three associated her internal sensations with a fantasy of an inner baby, and then displaced internal tensions onto her doll, which she cared for both by protecting it from injury and subjecting it to rough treatment when her tensions were high. Kestenberg saw the upsurge in the early adolescent girl's activity as a way of mastering confusing genital excitement. With the onset of menarche, making sense of her excitation became easier for the girl. With increased awareness of inner wavelike rhythmic sensations, she would develop positive feelings about her ability to be actively creative in bearing children. Evert (1991) analyzed Anne Frank's diary to illustrate her progression from enacting spreading excitement and outward directedness, through her development of a female crush, to her growing sense that she contained a fertile inner space. A more extensive discussion of the inner space concept can be found in Bassin (1982).

2. Doris Bernstein (1991) felt that as long as a young woman struggled with integrating inner genital sensibilities, her ego functions would become sexualized and gender concerns

would permeate their view of reality. Typical of the genital anxieties she observed in her young patients were difficulty in managing the diffusivity of inner sensations, easily spreading from one anatomical area to another when stimulated; the anxiety they felt over both opening and denying access to her inner space, and their fear of unwanted penetration.

3. I am quoting Teresa's journal with her knowledge and consent.

4. Despite the most thorough assessment of risk, when working with patients expressing suicidal ideation, the clinician is always faced with a modicum of uncertainty that must simply be tolerated. Frequently, the use of the words themselves is a form of action. In this instance, I considered it possible that she wanted me to feel what it was like for her to tolerate the dread that her father could die at any moment while she was helpless to stop him. At times, this type of projected emotional bind can be put into words by the therapist, but often, if the alliance is strong, it must just be contained for a time until the patient is more able to fully manage what feels to her to be unbearable anxiety (Bromberg, 2011).

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Chapter Ten

Mourning a Ghost

A Challenge for Holocaust Child Survivors

Eva Fogelman

As both a scholar and a clinical expert regarding survivors of the Holocaust, in this chapter Fogelman introduces the reader to an adult psychoanalytic psychotherapy approach applied to a case in which the patient and therapist grappled with unresolved loss from the patient's childhood which continued throughout her adult life. Parent loss during childhood, suffered in the massive trauma and genocide of the Holocaust, may lead to mourning that is never complete. Though much was witnessed by Holocaust survivors, often the death of a parent was not directly witnessed or known of at the time it occurred, fueling a child's fantasies of the parent's return. Mourning a lost parent may emerge later in an otherwise-defined treatment, reminding us that, when parent loss is in one's history, it may resurface at any age.

In this case study, we see adult work made relevant and clear to the child clinician. Fogelman's treatment of Paulette is described from both clinical and theoretical perspectives. The reader can see the generalizability of this treatment approach to all adults who may have suffered non-Holocaust experiences of parent loss in childhood. Fogelman brings us close to her patient's subjectivity, underscoring the importance of helping to construct a coherent narrative. Greater memory makes for more coherence, and more coherence elicits fuller memory. A key therapeutic task in Paulette's treatment involved mobilizing and supporting active fact-gathering and reconstruction of memory outside of the therapeutic space. Bedrocks of Fogelman's therapeutic approach—to elicit and frame memory, to know and acknowledge the fantasied parent who died, and to bear witness to the victimhood of the survivor—are chiseled in sharp relief by Fogelman via this exemplary case study. —Eds.

"I would like to mourn on the right day." Seventy years later,
Paulette is still struggling to mourn her father who died
in Auschwitz when she was eight years old.[1]

The challenges to mourn among Holocaust child survivors is well documented (Klein, 1973; Forman, 1974; Kestenberg, 1989; Krystal, 1984; Moskovitz, 1983; Krell, 1985). During World War II, those who watched their loved ones killed, gassed, beaten or starved to death had no time to mourn. Each person was consumed with his or her own survival. Children were either instinctively protected from the harsh truth by an adult, or they learned coping skills, such as acquiescing to adults who could potentially care for them. In most situations children were warned not to cry or scream or even speak, and thus, one way or another, their mourning was artificially stopped before it could begin.

In cases where children did not see their parent die, the mourning process was more complicated because the sustaining fantasy that a parent is alive was hard to give up after liberation. The sustaining fantasy is one of the coping mechanisms that enabled children not to give up fighting for their lives. Often coping mechanisms that were employed during the Holocaust continued into adulthood.

For young children who barely knew a parent or had only other people’s narratives about the deceased, the feeling of mourning had more to do with the loss of having had a parent in the first place. And seventy years later, Paulette says in her weekly therapy session, “I feel like crying. I don’t think it’s related to the fact that yesterday was Father’s Day. I feel like crying for someone I hardly knew.”

Paulette, like many other Holocaust child survivors, did not know when or how her father died or was killed. She was never even sure that he died even though her mother told her he had. No death notice was ever sent. Thus, there was always a glimmer of hope that he’d survived. Now she lights a candle on the day of his birthday because she is sure of that date. She lights on *Yom Kippur*, the Day of Atonement when it is a tradition to light a candle for the deceased. The date she thinks he died keeps changing.

When Paulette was eight years old she was still living in a foster Christian home in Switzerland, one of the many she’d been placed in before and during the war because children received better care there than remaining in refugee camps in Switzerland. When she went to visit her mother, who was living in a refugee camp in Switzerland, she was told: “Your father is dead.” When she returned to her foster home, Paulette knelt by her bed to say her nightly prayers as the devoutly Protestant woman she lived with had taught her to do. She recalled, “I used to say, God bless my mother, sister and father, and that is when it hit me that my father was dead.” And Paulette was changed forever. “As much as I knew about God, that was it. I did not believe it anymore.”

Ten years ago, Paulette started individual psychotherapy twice a week, in part because her relationship with one of her adult sons was tumultuous, while her other son vacillated between embracing or rejecting her. In addition, Paulette was long divorced from her husband of thirty years, and struggled with mourning that relationship as well. However, it was her mother's severe dementia that was the immediate catalyst that prompted her to seek help. Her mother had abandoned her many times throughout her lifetime. It started when she was a year-and-a-half old before the German occupation of France, and continued throughout World War II, immediately after liberation, and a few years later in her teens. As a result of this abandonment, Paulette was full of anger, and wanted to gain some control over her feelings.

In this chapter, I will describe Paulette's ten year psychoanalytic psychotherapy twice a week for eight years and weekly the last two years only as it pertains to her mourning her father. . . . Much time was spent in the therapy to work on mourning her mother, her husband, an abusive previous therapy, which is not the subject of this chapter. Nor will I focus on the relationship with her children, except as it pertains to mourning her father. . . . Following the case I will provide a theoretical understanding of mourning in the lives of Holocaust child survivors. For more than three decades I have been working with generations of the Holocaust and related historical traumas individually, as well as in groups, and research opic through the International Study of Organized Persecution of Children, a Project of Child Development Research founded by psychoanalyst Judith Kestenberg. I have also been involved in training other mental-health professionals to work with these populations at Psychotherapy with Generation of the Holocaust and Related Traumas, Training Institute for Mental Health, which I co-founded with Albert Brok. I have organized and led groups as well as international conferences for this population. My bibliography and related works can be found on www.drevafogelman.com, Wikepedia, and www.holocaustchildren.com.

In the initial intake interview we reviewed a sequential narrative of Paulette's ordeals and transitions. This process facilitated an integration of her pre-war years, the years under the German occupation and in Switzerland, her post-Holocaust life in Switzerland, the United States, abroad and back to the United States. Most of the initial therapeutic work did not focus on her life during the war except in relation to her ambivalence toward her mother. On the one hand she saved her. She was constantly with her until they reached neutral Switzerland. It was her mother's courage that saved Paulette, the courageous act of getting a guide to help them escape to Switzerland. On the other hand, even though that voyage saved Paulette's life, it was a constant source of her nightmares. After they reached Switzerland, Paulette was abandoned by her mother during the duration of their stay in Switzerland and throughout her growing up years after liberation.

In the first two years of twice-a-week psychotherapy, Paulette did not raise any emotions, thoughts or fantasies about her father. Her mother died a few months after we started working together and all her energy was consumed with conflicts over the cremation that her mother had requested . . .

the ashes, a memorial ceremony and tensions that arose with her children. Paulette took a long time to decide where, how and when to spread her mother's ashes. She found a garden near a Holocaust museum and went with a fellow survivor to spread the ashes on a sunny day. Where appropriate I would insert a question about her father and she always said, "I don't remember much about my father so how can I mourn him?"

The facts that Paulette was certain of were that she was born in France, 1935, to Jewish parents who fled Germany shortly after Hitler became Chancellor, January 30, 1933. When Paulette was a year-and-a-half, she was sent to a relative for nineteen months. The reason behind it was not totally clear to Paulette. It may have been that her parents had financial hardship.

When she returned to her parents in Paris, and her father walked into the room, she was frightened. She'd forgotten him. When the Germans invaded Paris, May 17, 1940 Paulette was not yet four years old. She remembers waking up in a very dark shelter sitting on the potty. Her father held her hand, carrying the potty in the other hand, which he dumped near a tree.

She and her mother fled to Southern France along with thousands of Jews and they lived across the way from a 1,200-year-old castle. Her father joined them and the three of them rented a room in one of the farm houses. She remembered a well outside for water which froze during the winter months, and her father had to break the ice to get water. They cooked and kept warm with a stove pipe. That was the extent of her memories of her father early on in psychotherapy. Then, two years into treatment Paulette got a phone call from a friend of her deceased sister who said: "'Someone is looking for you from France. Can I give him your phone number?' I said, 'Yes.'"

The message on her answering machine was: "Your father's suitcase that was left behind has been found." She hesitated for ten days and then called back. This serendipitous call from a stranger named Renee started an interminable mourning process for her father, even as it helped her put together pieces of the narrative that she had never understood. Renee was visiting a relative and in the process met Jacqueline who was the daughter of the farmer where Paulette's family had rented the room in southern France during World War II. Jacqueline asked Renee to look at a suitcase. Renee knew German, and she took some documents and photocopied them and started the research of the Hirsch family. Renee found Paulette via the internet.

This little suitcase offered Paulette hope of learning about her father, rather than living with the incongruities that her mother had created. "I was always confused about him. My mom told me stories that were not true. My mother said he didn't try to save himself. I grew up thinking he deserted me by not trying to save his life which is bullshit. It was common knowledge in those days that Switzerland was safe for women and children and not men." Paulette always questioned, "Did he really go to his parents' house in Paris and leave my mom and me without food?" Paulette's mother always told her, "Don't make him a hero." Paulette said, "I lived with the thought he didn't do enough to save us."

And then there was always this other thought that Paulette held: "I used to think my father was coming back, as in the Orson Wells film *Tomorrow is Forever*. Orson Wells comes back totally wounded and he doesn't present himself to his wife. She says 'You are John.' And he replies, 'No.' She has a child with John and then she has children in a new relationship. John ends up working for her new husband."

For many years, Paulette's confusion about her father, and the date that he actually died, was exacerbated by the fact that her mother gave birth to a daughter in 1943. The story her mother had told her was that her father was working for the underground saving lives. He came to the refugee camp that she and her mother were in, in Switzerland and she went back over the border, met her father and had the baby with him.

Paulette couldn't make sense of it. "My sister was born November 1943. I don't understand any of it. My father died at the end of 1942. Everybody gives me a different story." Many a time Paulette would review when her sister was born, and when her father was deported to Auschwitz, and wonder whether he knew or not that her mother had a daughter that was not his daughter. "All of this got mixed up. It was totally unreal. Bits and pieces that didn't all fit."

Paulette always felt "he didn't think enough of us to save himself. He was more concerned with saving the lives of other people." As for her mother, Paulette felt that her mother risked her life to go over the border without considering her. Paulette remained confused as to how her father was caught in Paris and incarcerated. She thought he might have gone to see his mother in Paris, and he was not careful enough. Both her grandparents died in Paris.

It was not until her sister died, in the late-1990s, that her mother explained to Paulette that she had been raped in the refugee camp. It was her mother's lying about when she'd seen the father that had confused Paulette all those years about when he died. Paulette did not know that she and her sister were not from the same father. The other story that Paulette's mother fabricated was that a man fell in love with her and impregnated her in the refugee camp, but she was waiting for the end of the war to be reunited with Paulette's father. The therapy did not evoke new memories about these stories, rather what surfaced was the anger that Paulette felt toward her mother whom she experienced as self-absorbed and unaware of the effect the lies had on Paulette.

After a few months of preparing Paulette emotionally she went back to Southern France to retrieve the suitcase and reconnect with some of the people who remembered her and her family during the war. It was traumatic to receive the suitcase and to hold the same papers that her father had held. She discovered a man she did not know—a man who had tried everything to get them out of France. In the days pre-copying machines he re-wrote by hand all the letters he had sent. He wrote a letter to a French government official asking for permission to go to Bolivia to start a business that would be profitable for France. He sent an airmail letter which was expensive in those days. He had newspaper clippings and a day book and at the end of it he wrote: *Merde! Merde! Merde!*

What became clear was that the first camp he volunteered to go to was Drancy after which he was deported to Auschwitz. From Jacqueline and a few others who remembered her father she learned that he was a very kind man. He did pro bono work and he was not just a lawyer.

After the suitcase was found, the sequential narrative of her life before and during the Holocaust was reviewed several times extensively, each time adding details to the story. The more Paulette's father became a real person, the more she was able to remember. Using kinesthetic techniques developed by Judith Kestenberg (1994) facilitated recall. Questions such as, what were you wearing to cross the border? Describe the room you lived in and where was your bed? What kind of sounds and smells do you remember in your one room dwelling in Southern France? These very specific questions while the narrative was being told enhanced her memory of her being. It gave bones, flesh, and blood.

When Paulette returned to the States, she realized other reasons why she'd been unable to mourn her father all these years. She had been angry with him for once spanking her. This memory haunted her for years but she did not reveal it in the therapy until she saw the documents and was not angry with him in general. Paulette described the one time her father put her on his lap and smacked her because she was rude to her mother. He lifted the corner of her panties to smack her on her skin. This was done to teach her a lesson. She doesn't remember crying.

Paulette also felt how can you be angry with a man who died in the gas chambers of Auschwitz? At the same time she could not get over the anger that she'd felt toward him all these years, when she'd believed that he had not done enough to save himself and to save her and her mother. The letters provided her with a new understanding of her father that her mother had never shared. As a result, she was now able to remember other times she'd shared with her father, and that he was more affectionate than her mother. The man she thought she hardly remembered came alive so he could be mourned.

Bit by bit, as the narrative became clearer, memories of her father returned: Paulette's father had helped support them by doing notary work for money and by giving German lessons three times a week to the fifteen year old farmer's daughter, Jacqueline, in exchange for food. She remembered her father leaving for various periods of time, then returning, for reasons Paulette didn't understand then. Now, she knows that he was trying to meet with

French officials. When her misconceptions were clarified and her anger toward him dissipated, she was able to conjure up more vivid memories.

She remembered small things, unimportant in themselves, but important because they brought back the man she'd lost: Once, when Paulette joined her father and Jacqueline to play chess, she lost the game and was very embarrassed. She hid under the table as Jacqueline and her father laughed at her. Another time, Paulette joined her father to go to town which was more than a mile and a half walk. Her father walked almost silently as he was deep in thought, and five-year-old Paulette could only keep pace with him if she ran. When they got to town her father brought her to the grocery store and there were big burlap bags of salt and sugar. To keep Paulette busy she recalled that someone said she should separate the sugar granules from the salt. She noticed one was shinier.

After Paulette got the suitcase, I prompted her to conjure up an image of the last time she'd seen her father. I had her close her eyes and try to imagine what she was wearing and where she was standing. Kestenberg (1994) found that girls tend to remember clothes. She could only remember him coming back and forth. She'd always thought he was coming back. "At other times, when he left he always came back. The first time he left and came back he brought pastry. It was very unusual. Jacqueline had gotten hurt cutting material for a dress she was sewing so my father asked that I share the pastry and I did. Another time, I was around six. I had my birthday. I don't remember saying goodbye."

When the Germans came looking for Jews in the town, there was a woman who served as an informant. A different woman overheard the informant talking to the German officer telling him that there was still a Jew in the town. "'He is still here, that one.' Even though everyone knew we were Jewish no one else cared." Paulette's father decided to turn himself in voluntarily to go to a camp for foreigners. He thought it would protect Paulette and her mom better, if he was gone. He was a lawyer and he followed the law.

When Paulette's father did not come back there was no way that they could pay the rent, "So, we had to leave." Paulette's mother, Raquel had some friends in Cannes so they took a train with false identification papers in hand. They stayed in a small hotel and Raquel set up a weaving business. Paulette recalls: "There were two raids while we were there. Both times my mother was warned, once by a policeman on a motor cycle and once by a grocer. We went to sleep that night feeling safe because they did not take French born children."

Arrangements were made for Paulette to go to Cannes. The owner of the hotel took her there. Paulette stayed with several different families. She remembers the Baron de Hirsch family and from there she went to a family that lived by the water in a big house, where she had her own room. Food was served by a white-gloved butler. One of the children taught her to swim and she almost drowned.

At the end of 1942, when Paulette's mother appeared, arrangements were made with a guide to take them across the Alps to Switzerland. Paulette remembers her mother clearly saying: "Children kill their parents by opening their mouth in the wrong place and wrong time." The crossing was the most traumatic experience in all of Paulette's ordeals. For many years she continued to have nightmares.

Paulette spent the rest of the war years in neutral Switzerland. Paulette and her mother started off in the home of people they knew. The house was already filled with other refugees. Also, the woman of the household was concerned with legalities and thought it best that Paulette and her mom register as refugees.

Paulette and her mom were in a refugee camp for a while, and then Paulette was sent to a foster home where she spent part of the years until being sent to several other foster homes. Her mother visited her on several occasions. She got letters from her father who was interned in a camp for foreigners. One postcard had a picture of Snow White and the Seven Dwarfs. One postcard was not given to her until the end of the war. Her mother read it and told her to rip it up. To this day she regrets not having read the content of the letter because she was a "good girl."

After liberation, Paulette continued to stay with one of the foster mothers until her mother got settled in the French part of Switzerland. Paulette marks all her moves by the birthday she celebrated in each house, remembering not only the house she was in but also who she was with for each birthday. It provided order amidst chaos and loss, and a continuity of self which otherwise would have developed very fragmented. The therapist needs a cognitive map of the historical events that happened in order to help a child survivor tell their narrative in a sequential way. Judith Kestenberg (1994) emphasized that children remember in images, and therefore need therapeutic guidance from a knowledgeable listener to fill in the gaps to thread the story into a coherent narrative. Paulette had a running thread which was her birthdays. This may be a way for other child survivors to piece together their stories.

Until she got the suitcase, Paulette did not share specific, individual memories of her father, just the fact that he was there. Her fifth and sixth birthdays were with her parents. At age six-and-a-half was the last time she saw her father. Paulette does not remember yearning for her father. "My father was an elusive figure. For years I would think that he would come back. I once followed a man and accosted him on the train." For Paulette, if you mourn, you are declaring the person dead. She did not want to take that responsibility.

For more than thirty years Paulette kept a diary. Whenever she was upset she put thoughts down on paper to escape and to feel like she existed. Paulette who was not allowed to express feelings for so many years, first with her parents and then with foster parents, and so she felt liberated in writing down her feelings. The process of writing down her feelings was a defense of sublimation. She remained cautious in actually expressing authentic feelings, particularly anger, lest she suffer the consequences. Writing feelings, at least, gave her a sense that she had a right to her own feelings and a sense of integration of her emotional and cognitive self. The historian and Holocaust child survivor Saul Friedlander (1979), who wrote his own memoir, *When Memory Comes*, explained that writing down one's memories, enhances a "sense of coherence." This is reinforced by psychoanalyst and Holocaust survivor Anna Ornstein (2007). There is a desire to "reassemble the fragments of memory in order to establish inner continuity and a 'sense of coherence.'"

When Paulette started collaborating with an archivist who suggested an interactive book of the family history, he encouraged her to write about her past, not only facts but also feelings. Paulette was piecing together the family history for her children and grandchildren. She had a challenging time completing the project because she did not have a true picture of her father. The suitcase and meeting people in France who'd known her family provided an antidote to the many misconceptions that Paulette had embraced as truth.

When Paulette's children were not as interested in her mourning process as she would have liked, she was very disappointed. One of her sons started to take greater interest in the process when Renee came to visit the United States. One cannot mourn alone. You need a community with whom to mourn (Fogelman, 1988; Fogelman & Bass-Wichelhaus, 2002). When Paulette offered to speak at a Holocaust commemoration for hidden children, they already had a speaker. Speaking at a Holocaust commemoration to your peers who are in mourning for a deceased relative can provide a sense of belonging for Holocaust child survivors (Fogelman & Bass-Wichelhaus, 2002). It can make one feel understood, a rare occurrence in the lives of child survivors (Krell, 2007). There is also an element of feeling empowered. You are not only helping yourself but you are facilitating a chance for others to identify with you. Paulette did have an opportunity to speak at her son's synagogue, several times, which gave her some solace.

Paulette's delayed mourning is a common occurrence in the lives of many Holocaust child survivors and adult survivors. In order to mourn survivors are faced with the inherent conflict of fearing to remember traumatic memories because they will evoke "the original terror and they are experienced as unspeakable and unsharable" and simultaneously each memory and even a fragment of a memory is precious because it links the survivor to the past that was destroyed (Ornstein, 2007). The resolution of this conflict for Paulette occurred in the therapy and in the writing of her interactive writing project.

The heuristic model of mourning which I (1988) have formulated for survivors incorporates previous work of George Pollock (1961). Shock, denial, formulation and search for meaning. The first stage, shock, is when the ego equilibrium is jolted into awareness that the person no longer exists in space and time. This was not an adaptive response for survivors (Fogelman, 1988) and propelled the survivor into the second stage, denial, which enabled all libido and aggression to cope with daily life. The emergence of conscious feelings, formulation or "grief reactions" (Pollock, 1961) is the third phase in which there is a gradual recognition of a new reality. The fourth stage is the search for meaning, when survivors attempt to reestablish a semblance of morality, a sense of responsibility to the dead by bearing witness, memorialization, and continuity to the past.

For Paulette, even though her main inability to mourn was related to the loss of her father, dealing with the loss of her father had greater significance because it was related to dealing with the loss of her childhood, and her confused identity, living as a Christian in many foster homes, and saying Christian prayers every night.

All the years that Paulette felt she could not remember enough to mourn her father were years of denial. The shock of hearing from her mother that her father died resulted in her loss of faith in God, yet even still, she continued to embrace the fantasy that he would return. David R. Dietrich (1989) emphasizes that children under seven or so understand death to be reversible, avoidable and changeable. Although Paulette was close to eight when her mother told her that her father was dead, because he had gone, and returned, so many times, Paulette could not conceive that he was not returning.

The first phase of mourning—shock, which is followed by denial—was ever-present for Paulette for many years. It culminated in her accosting the man on the train thinking it was her father. Paulette vacillated from believing that he was alive to believing him dead, to guessing on which date he would have died, to questioning whether or not he knew of her sister's birth, which in reality was probably not possible.

Paulette, whose mother kept rejecting her after the war, had to maintain a sustaining fantasy that her father was alive in order to cope with the ongoing dismissal she suffered with her mother. The fantasy that her father was not dead, unconsciously gave Paulette hope that she would not be all alone in the world.

From more than thirty years of doing psychotherapy with Holocaust survivors, it is clear that psychotherapy cannot speed up the stage of denial. A therapist may not want to take away the defense that has sustained a child survivor for the sake of mourning. If a particular defense has worked successfully for a child survivor, interpretations that stress the denial may prove to be detrimental. In the *Denial of Death*, Becker (1973) explained that denial is a defense against anxiety, obsessions and compulsions. By doing away with a potentially debilitating hazard of loss from consciousness, the use of denial provides an ability to maintain self-confidence in everyday life. Denial, thus, functions as an adaptive mechanism in the immediate aftermath or loss and trauma. When excessive denial stretches from childhood to old age, it impedes the mourning process and unconscious conflicts and symptoms can surface from either pathological or distorted mourning.

Many child survivors feel an abiding and subjective anger that they were abandoned, which complicates the mourning process for a parent who was killed in the Holocaust. This is the case with Paulette who felt she could not mourn a father for whom she felt guilty being angry. When child survivors get past the feeling that they were abandoned, they can begin mourning, for "Mourning is an entirely appropriate response to the loss of a loved person through death or separation, but in melancholia a loss . . . has occurred, but one cannot see clearly what it is that has been lost, and it is all the more reasonable to suppose that the patient cannot consciously perceive what he has lost either" (Freud, 1917).

Paulette did not seem to fantasize about reunification with her father. She also did not have an idealized representation of her father, which is necessary for the internalization of the parental image. George Pollock (1989) described that the internalization process of the image of the dead parent enhances the "mourning—liberation process." Accepting the uncertainty of whether a parent will return or not, and recognizing the finality of a parent's loss frees up the mourner to creative expressions that reconstitute a replacement for what was lost.

Some external force or internal insight can start to breakdown denial (Fogelman, 1988). In Paulette's case it was the suitcase with her father's letters and other writings that helped her.

Another stimulus to breaking down denial is a communal experience of mourning (Fogelman, 1988). Getting together with others who are experiencing similar losses can move a person from denial to formulation, the third phase in the mourning process. When Elie Wiesel was in a chateau in Ecouis, France with other children who were orphans from Buchenwald they were given religious objects and pencil and paper. Wiesel recalled, "We held our first *Minha* (afternoon) service, and we all said *Kaddish* together. Though we knew it well enough, that collective *Kaddish* reminded us that we were all orphans" (Wiesel, 1999).

With formulation, the third phase of mourning comes a desire to know more details of the circumstances of the death and more about the deceased. The content in the suitcase and meeting people who knew her father, though briefly, facilitated the formulation phase of mourning. It did not, however, provide Paulette with the date of her father's death.

Several other extraneous data miraculously added information to make her father a more real person rather than just a fantasy. Paulette got a phone call from England saying, "Are you so and so?" It turned out that the Commission for Looted Art in Europe had discovered two legal books with plates that belonged to Paulette's grandfather. This is the only tangible object that she has from her grandfather. Objects from deceased relatives provide a sense of continuity of the self and of belonging to a family (Volkan, 1999). This too aids in mourning the deceased, for they give one a feeling of knowing what was important or valued to the barely remembered deceased, and thus one is able to mourn more than just a fantasy.

Paulette was fortunate to get additional clues about her father when she got another call from the Commission for the Indemnification of Victims of Spoilation of Antisemitic Acts During the Occupation. When Paulette applied for loss of property five years into the treatment she was not optimistic that she would get much because she had no documents of the content of her parents' apartment that they'd had to abandon. A few years after she applied to the French authorities, she received a letter that they had a letter from her father dated August 3, 1943, describing the contents of the apartment and stating that his daughter born November 1935 was the sole heir to the possessions in the apartment. Based on this time frame, Paulette came to believe that her father was killed in September of 1943.

When the letter from the French authorities arrived, Paulette felt for the first time that her father was watching over her and had tried his best to protect her. She also realized that her father was organized and detail oriented. The Commission found that Paulette's father had put together cut up paper from memory, and drew the design of their carpets and described his parents' assets. She'd thought all was lost in 1958 when her mother filed to recover her paternal grandparents' important furniture, paintings, and a valuable stamp collection and never heard back. In our tenth year of treatment two women came from France and brought a booklet that her father had put together that detailed the family's valuables The jewels her grandmother possessed were also listed as stolen in the hospital. Although she did not get the possessions back, nevertheless Paulette received more money than just an average payment for stolen property. The fact that her father had written down everything that was confiscated was another affirmation of his meticulous approach to taking care of details and for caring for his family. The antidote of what she had learned about him from her mother. This is another instance in which Paulette developed loving rather than angry feelings toward her father. It was the Father's Day after this incident that she felt like crying.

Toward the end of our tenth year of working together, while the process of verifying that the books belonged to Paulette's grandfather, the researcher at the Commission on Looted Art mentioned to Paulette that she read in the Looted Art Newsletter that a researcher was looking for the Hirsch sisters who went to a school in Wurms. She was tracking down boys who attended the school. Paulette gave permission to be contacted about her father's brothers, and in return she discovered a connection to her family history dating back to the 1700s. Bernard, who was a teacher in the school that Paulette's father attended in Wurms, had been helping former students research all the students and particularly the Hirsch family. They are preparing a commemoration of Wurms Holocaust victims. For Holocaust survivors, history gathering, like journaling, is part of integration of the self.

Paulette's main question, of course, remains when in fact did her father die? Reinhard has been able to get documents of the day her father was deported to a labor camp west of Auschwitz. The documents in Bad Arlson offer further clues as to when Paulette's father was in Auschwitz. It seems he was in the infirmary in the labor camp December 15 until 21, 1943 and January 21/23 he was transferred to Auschwiz/Birkenau, and was there for ten days. That has yet to be fully determined. Paulette explained: "There is no death certificate, of course. I am still not sure of the day of his death."

All of this ongoing fact finding is part of the formulation phase of mourning. Psychoanalyst Judith Kestenberg has written that the loss of a parent intensifies the search for the past (Kestenberg and Brenner, 1996). The memories created out of the narrative of others can either help or hinder mourning. In the case of Paulette her mother's narrative that her father should not be seen as a hero, that he did not do enough to save himself or them, had dissuaded Paulette from confronting the reality of who her father was as a person.

When the researcher contacted her from Wurms, Paulette learned for the first time that indeed she came from a prominent legal family that was very much respected and a part of the Wurms community. This again changed her image of her father who could not make a living as a lawyer when they escaped to France. This knowledge about where she came from added to her positive feelings toward her father which enabled her to want to know more about him. Having ancestry that one can be proud of, rather than be ashamed of, also improves self-esteem.

Also, not working on mourning by herself, knowing that other people care just as much to know about her father and when he died and piecing together his life history, reduces Paulette's isolation and lifts a burden off her. She was so helpless in getting details about his life before the war and his death and now others were helping her move from mourning a ghost to mourning her father. Having details of her father and his family and the community he was a part of, not only transformed Paulette from mourning a ghost to mourning a person, but it facilitated integration of the fragmented self she lived with her entire life. Volkan (1999) emphasizes that one's "core identity" that evolves in childhood by being connected to a "large-group identity" if threatened causes an "intolerable . . . terrifying psychological death." These connections to the Jewish community of Wurms, a life-affirming "large-group identity" facilitates in the transformation of identity for Paulette.

Knowing the importance of a "large-group identity" in the mourning process, particularly for Holocaust child survivors, I probably encouraged Paulette more than she was willing to cooperate with my suggestions. The pain she was suffering in her personal life prevented her from reaching out on a regular basis to a community. Paulette also feared being part of a Jewish group because such gatherings could be targets for annihilation again. The fears she would have to cope with prevented her from benefitting from being part of a community.

She is rather fortunate to have miraculously had all these facts about her father come her way. This is the rarity rather than the norm for most Holocaust child survivors who lost a parent. For many, the information is so scant and the mourning so impossible and it continues to be mourning of a ghost. Mourning is often in isolation. Finding some positive aspects of the deceased and getting rid of the notion that one was abandoned and rejected also helps get over the hurdle of not being able to mourn a phantom. Even if a child survivor does not have others who are interested in his or her particular parent, having communal mourning opportunities alleviates the isolation of mourning a phantom.

The formulation phase includes feelings of survivor guilt, anger, sadness, depression, helplessness, and a need to undo are many of the feelings that emerge in this stage. In Paulette's case, the information she has discovered about her father has reduced her feelings of anger toward him. She is feeling more comfort with his memory, less abandoned and feels that he did his utmost to care for her.

According to George Pollock (1989), "the successful completion of the mourning process results in creative outcome. . . . The creative product may reflect the mourning process in theme, style, form, content and it may stand as a memorial." For Paulette, the writing project she has undertaken is a memorial that she feels she owes to the dead and to her grandchildren.

Paulette's mourning process like other Holocaust survivors is interminable. Her writing project is her search for meaning, the fourth stage of mourning. What is it that she wants to convey to future generations in her family? What does she want them to know about her past and her lineage? Paulette has not yet gotten to the larger philosophical questions of the meaning of her survival, the survival of the Jewish people, the condition of humanity and other worldly concerns. When she finishes sorting out her own personal history she may then be grappling with the more abstract meaning of survival of the human species.

Paulette's journey could not have happened without a trained listener or psychotherapist who cared to listen and help her work through her mourning. The victim needs a witness and the psychotherapist or psychoanalyst can serve as that witness. For survivors who have a family member or other interested person to play the role of witness it can also be effective in moving the survivor through the stages of mourning.

As psychoanalyst Samuel Gerson (2009) has written "when people with histories of this sort seek our help, we inevitably come to represent a potential lifeline through fields of desolation and unimaginable ruin." And he adds, "psychoanalysts struggle to contain patients' rage and despair at a life spent hosting the phantoms of family history, so also must we strive to allow patients to live out their absences in the treatment." Through our questioning rather than indifference to the phantoms, the phantoms take on a real existence in the life of the patient.

Samuel Gerson (2009) emphasized that "there is no end to our return to the atrocities of the past." In the case of Paulette the narrative has been gone over and over again. Each time more nuances are introduced.

As Paulette ages she is unconsciously facing her own immortality, though she feels young at heart, is an avid reader, even took some college classes, and is doing more creative artistic works now. "All artists aim at immortality; their objects must not only be brought back to life, but also the life has to be eternal. And of all human activities art comes nearest to achieving immortality; a great work of art is likely to escape destruction and oblivion" (Segal, 1952, p. 207).

On several occasions Paulette has spoken in public forums about her experiences in the Holocaust. She is working on an interactive book for the next generations of her family and on other writing projects, motivated not only by wanting to remember her father, but also to immortalize herself.

Paulette is also assisting researchers who are doing research on the victims of the third Reich in Wurms and eagerly cooperated in my writing of this chapter. All of this is giving Paulette a sense of purpose beyond her own emotional needs. As was explained earlier, mourning a historical trauma, as in Paulette's case, genocide of the Jewish people, requires a communal mourning experience. In therapy I am encouraging Paulette to get the mayor of Wurms to invite the surviving relatives of Jewish residents of Wurms before the third Reich to come back and visit. Although Paulette has participated in conferences, groups and meetings for hidden children over the years, she had resisted mourning her father. Her strong superego, which believes it is not right to be angry with a man who died in the gas chambers of Auschwitz, had superseded the group forces that enable mourning.

Paulette is now immersed with the researchers in Wurms who are piecing together the history of the Hirsch family. She has expressed that "Memory grounds me. It integrates me. It gives me a sense of self. With memories I build a shell around myself, and am then experiencing a circle of life."

Paulette has been challenged her whole life with facing the void. As Robert Prince (1998, 2013) expressed, commemoration and memory enable the bereaved to develop an identity and a self. The mourner and the deceased have been linked with Paulette's father's suitcase and its content, what Vamik Volkan calls a "linking object." Volkan explains, "a linking object is something—usually inanimate—actually present in the environment that is psychologically contaminated with various aspects of both the dead and the self of the mourner . . . and functions as an external meeting ground for those representations that offer the illusion of reunion between the mourner and the deceased" (Volkan, 1984, p. 334). The mourner takes out the linking object from its designated place and in ritual fashion handles it and gazes at it until he experiences an eerie feeling of reunion. This symbolic or realistic representation of Paulette's father enabled her to have an "external bridge" between herself as mourner and her representation of her deceased father. Paulette remains in control of symbolically bringing her father back to life as someone who did everything he could to save herself and her mother from their imminent death.

NOTE

1. Permission has been granted to use material from this clinical case. The names of people and places are disguised as well as other family members, to protect the privacy of the main character.

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Part V

Innovative Applications in Groups, Consultations, and Court Assessments

Chapter Eleven

When the Context Shifts

A Child Therapist Helping Children Who Have Lost a Parent in Forensic Systems

Richard Ruth

For the child therapist contemplating expanding into a forensic or court setting, one must be prepared to work with children experiencing emotional pain, loss and trauma, and for this, reading Richard Ruth's chapter is an enlightening experience. Ruth expounds the benefits of using a psychoanalytic lens to approach the field of forensic mental health, to facilitate a child's opening up and to assess and communicate the child's inner world to those who administer and work in child protective services, court systems, and foster care.

In Ruth's three case vignettes we see an exquisitely grounded clinician, offering himself as a containing object. In all three cases he is logical and professional, exhibiting gentle empathic attunement as he enters into brief but meaningful relationships with these children ranging from five to seventeen years of age, all the while delineating clear limits and expectations. With remarkable sensitivity he uncovers the emotional pain and demons of these children, paying careful attention to their subjective experiences of fear, confusion, sadness and the incapacity to process or metabolize their lives in the absence of a scaffolding, competent-, caring-, and/or good-enough parent.

Ruth describes his personal reactions and thoughts as they are inevitably induced when working with children whose experiences are intolerable and unthinkable. His approach represents his openness and willingness to do whatever each case may dictate, an approach to working in forensic settings that expands the limits of both traditional child therapy and forensic mental health work. Ruth enters into the emotional worlds of those children fortunate enough to enter into his domain. His caveats are essential—those seeking to work with severely traumatized children must be open to a systems view, be willing to collaborate as part of a team, work to maintain a sense of their own experience, and be willing to consult with peers and seek supervision. —Eds.

Psychoanalytically informed mental health clinicians can help children who have lost a parent in a variety of ways. Among these, we can play important roles in forensic contexts—helping courts and other branches of the legal system understand the functioning of children who have lost parents by providing evaluations, consultation, and expert testimony.

SAMUEL

Samuel,[1] African-American, was five when I saw him. His child protective services social worker, a long-time colleague I respect deeply, brought him to me on an emergency basis. I'm generally not able to see children the same day; but sometimes, openings and needs match up. Samuel's parents had been raising him in an abusive cult, and had vanished abruptly when the cult's communal residence was raided by the police.

The little boy brought to my office, literally kicking and screaming, was terrified and terrifying. He seemed chronically underfed, his head disproportionate to his thin body. In a loud torrent—I could not reconcile how such volume could emerge from such a body—he recited Bible verses, at astonishing length, and told me that I was an agent of Satan and that being in my presence would condemn him to eternal hell. But his wide, frightened eyes couldn't stop looking at me. That was our narrow bridge.

I looked back at Samuel, speaking in my most gentle tone, and asked him where he wanted me to sit. I pointed out two possibilities, one a bit further away from him than the other. Samuel nodded, amidst screams, toward the more distant seat.

I sat and listened for a while to the verses about hell and damnation. Over tense minutes, Samuel lost a bit of steam, his eyes wandering occasionally to the toys in my office. I told him he could play with anything he wanted, and that he could speak with me or not, as he preferred. I said with quiet assurance that, despite what he might have been told, I would not hurt him, and would not let anyone else hurt him while he was with me.

Samuel took some wild animals, action figures, and small toy soldiers. A gorilla began to declaim the Scriptural verses, as it attacked some soldiers. Potential defender figures looked on without taking action, as if they could not decide whether to join the attack or help the besieged troops. The soldiers looked like children in comparison to the gorilla. While the gorilla's words were Biblical, his actions were deadly aggressive. Slowly, Samuel's terror was being displaced into play. I took silent notice. Samuel watched me out of the corner of his left eye.

After twenty minutes, I told Samuel that sometimes children need grown-ups to help them when bad things have happened to them. He looked at me in a sustained way for the first time. I said that, if he could take the chance to tell me what his experience had been like, and what he was thinking and feeling, I would do my best to help him, even if other people had told him it was not safe to talk about what happened to him.

I spoke with an assurance I did not fully feel in the moment. I was scared my words would hurt Samuel—the last thing I wanted to do. I was also exhausted, after short minutes, with this tiny, intense boy. In the same moment I realized what I was feeling, I wondered whether Samuel, too, might be feeling frightened and depleted—whether I was feeling some of what he was feeling.

Samuel played some more, and then started to alternate between telling me parts of his history and telling me about his play. He had been beaten, many times, for “sins”—such as taking food when one of his parents, both members of the cult, had told him he should fast and repent. He had never owned any toys, or gone to school, or watched cartoons except once at a cousin’s house. He had memorized many Bible verses. I told him I thought he was very smart, to be able to memorize so much, and brave to talk to me. He told me that maybe the soldiers should march away from the mean gorilla. I told him I thought he was right.

By the time my hour with Samuel was over, he had calmed and told me a good bit about his life. I don’t know whether his recounting and his chronology were fully accurate. But he was willing to share his feelings and experiences with me. He enjoyed playing. He came, over the hour, to tolerate my presence; and, near the end of the hour, he snuggled up to the stranger psychologist he had originally feared, making fuller use of me as a quasi-therapeutic figure. These all seemed signs of his inner resources and resilience.

My job was not to be Samuel’s therapist. My assignment was to be a mental health consultant to his social worker, as she worked to sort out how to begin helping Samuel, and the judge who would be seeing him the next day and making some temporary decisions about him. I recommended that Samuel needed a strong foster placement where his emotions and behavior would be understood. I explained that his emotions would likely fluctuate. At times, Samuel might withdraw, or become upset, and emotionally unavailable, for reasons not immediately apparent. At other times he would likely be emotionally needy, and, at still other times emotionally available, responsive, and appreciative of the foster parents’ care. I said I believed that, in a sturdy and attuned foster placement, Samuel would likely do well.

I told the social worker, and later the judge, that I would not be quick to put Samuel into therapy. There was a risk he might find the tendency of therapy to open up space for looking into what lies beneath the surface too likely to re-stimulate old trauma, and that therapy could be an impediment to settling into his new life. On the other hand, I felt strongly that those involved with Samuel should have access to clinical consultation 24/7, and that, if Samuel's problems became too much for his foster parents or school to handle, we could re-visit his possible need and/or readiness for therapy. I added that Samuel would almost certainly need therapy later on, once he had developed enough ego capacity to begin the arduous tasks of making sense of his early experience and sorting out what he wanted his future to bring. Children have to be ready for therapy; when they are not, there are other ways to help them (Heineman, 1998; Redl, 1966).

In my role as a forensic mental health consultant, I ended up speaking to others about Samuel for much more time than I ever spent with him. As far as I know, his parents never re-surfaced.

THE VALUE (AND VALUES) OF A PSYCHOANALYTICALLY INFORMED APPROACH

Child forensic mental health work has a complex history. Its current state is equally complex, and at times counterintuitive. On the one hand, the Anna Freudian tradition oriented child and family law toward deciding important questions on the standard of the child's best interests (J. Goldstein, Solnit, S. Goldstein, & Freud, 1996). On the other, contemporary guidelines for forensic mental health work emphasize objective and verifiable data and discourage, or at least de-emphasize, bringing issues of children's subjective experience and inner lives into forensic reports and discussions (American Academy of Child and Adolescent Psychiatry, 1997a, 1997b; American Psychological Association, 2010; Committee on Ethical Guidelines for Forensic Psychologists, 1991).

A forensic role puts the psychoanalytically oriented child clinician in a position very different from that of a child therapist. Elements of our usual therapeutic stance are markedly different from some elements forensic tasks legitimately demand. Some clinical methods child psychoanalytic clinicians hold to be of value—following rather than leading the child; allowing the child to structure the interaction; making space for open-ended, on-going work; and avoiding goal-directed inquiry—can get in the way of some of the goals of forensic interviews. On the other hand, other psychoanalytically informed child therapy techniques—considering what the child says and does in play, from a position equidistant among inner experience, behavior, and emotions; minimizing "shoulds"; being equally attuned to what the child says, how the child says it, and how what the child says makes the clinician feel (i.e., countertransference)—can serve child forensic clinical work usefully.

The stance that seemed to facilitate Samuel's willingness to speak, play, and interact with me was informed by values of abstinence, neutrality, evenly hovering attention, and attunement. The approach to the role of play in my interview with Samuel was shaped by Melanie Klein's thinking about the value of reducing a child's anxiety in initial encounters and the presence of meaningful elements of transference from the beginning moments in work with a child (Klein, 1955; Frank, 2009). Much of what Samuel and I had to work with, and much of what helped me form contextually useful impressions and recommendations, stemmed from what I observed about his experience of me (transference) and from what I could intuit from the reactions he evoked in me (countertransference). A more behaviorally framed approach to the task would have obscured this useful information.

I was also influenced by the work of Leary (1997) and of Layton and others (2006) on contemporary psychodynamic technique, which suggests that, in judicious ways, it can be valuable to allow discourse about sociocultural and sociopolitical elements to enter directly into clinical conversations. Thus, I referenced Samuel's experience living in the cult, making links between his play and his history.

Shedler's (2010) findings, that psychodynamic conceptual and technical elements are at the core of successful clinical interventions of many kinds, can be usefully extended into work with children and into forensic mental health work. Psychoanalytic child clinicians in forensic work are uniquely able to help others involved in large, child-serving systems understand children's subjective perspectives. This is especially true with children who have lost a parent. Before Samuel could be helped to make sense of his combustible mixture of abuse and loss, a child protective services agency, a juvenile court, and a foster family needed a clear and empathic grasp of his psychological needs. That was the immediate clinical objective I had to address.

ARLENE

I first met seventeen-year-old Arlene when her three-month-old son was placed in foster care. Arlene was of mixed ethnic and racial backgrounds. A judge referred her to me for a fifth psychological evaluation. Understandably, she arrived with a defiant attitude—what would I do that the other four evaluators had not done? Why did she have to go through this all over again?

I told Arlene that her questions were fair. I said that pretty much all I knew was that a judge had ordered her to see me and that, if she disagreed, she would have to take that up with the judge, through her attorney. I promised her that I would listen to her carefully, and help the court understand her history, her perspectives, and her wishes. At the end of the evaluation, I said, I would tell her what I thought and what I would recommend.

What I explained made sense to Arlene. It was different from how the other evaluators had launched the previous evaluations. She wasn't happy to be with me, but she agreed to consider answering my questions.

Over five interviews, Arlene told me about her background, in considerable depth, nuance, and detail. Her African-American mother was a drug addict who worked as a prostitute and was in and out of jail. Arlene had met her only a few times. She had met her Southeast Asian immigrant father only twice and knew almost nothing about him. Although Arlene was born in the Washington, DC, area, she had been raised in a small, Deep Southern city by her grandmother—a polysubstance abuser who, nonetheless, was steadily employed.

As a child and a young adolescent, Arlene had largely raised herself. Her grandmother worked long hours, and was tired or intoxicated or both when she was home. Arlene said she had been a "neighborhood child" who wandered her working-class, African-American area, known to all and liked by most, or at least tolerated. She never did well in school, but never got into much trouble.

Arlene became sexually active at fourteen. By the end of her fifteenth year, she had had three abortions. When she was sixteen, she got pregnant again and decided that, this time, she would keep her child. The child's father wanted nothing to do with her (or their future child), nor she with him. The conception had occurred outside an on-going relationship, after a sexual encounter that had been at best semi-consensual, on both parts.

The grandmother would not allow Arlene to remain in the only home she had ever known after she became pregnant. Arlene came to the area where I practice—the area where she was born—to live with her mother. Her mother took off after three days, leaving the home and leaving Arlene's life, seemingly forever.

When Arlene could not cover the rent, through her part-time job at a fast-food restaurant, she and the baby moved to a homeless shelter for families. Arlene was younger than the usual parent they admitted, but they bent their rules, aware mother and child had nowhere else to go but the streets. After a few weeks, the shelter reported Arlene to child protective services because she had left her toddler son for a few hours in soiled diapers. She had run out of Pampers money.

Soon into our interviews, Arlene's initial defiance vanished. She found our sessions cathartic, and in a way therapeutic. She spoke with me openly, and, in my clinical impression, truthfully.

Arlene came to most of her interviews with me with her child. No affordable childcare was available, and she had to be out of the shelter during the days. From what she told me, in detailed descriptions, and from what I observed directly, her mothering—at least its physical aspects—was attuned and deft.

Arlene was amazed that I was interested in the details of her life story—things, she told me, other evaluators had not asked about. She was a high school drop-out. When I asked what she liked to do in her free time, she told me, with neither a defensive nor a defiant tone, that she no longer had any. When I asked about her hopes for the future, she looked at me with wonder and said, “No one has ever asked me about any of that.”

Testing showed Arlene had uneven cognitive and academic skills, averaging out in the low average range, with marked difficulties with concentration, reading comprehension, and arithmetic. Her poor vision and compromised visual-motor skills had not been detected previously. Projective testing suggested she did not have internalized positive or competent maternal or paternal objects, or templates of secure and non-conflictual attachment. She showed severe and complex post-traumatic symptoms, affecting her sense of who she was and how she interacted with others (i.e., a substrate of characterologic difficulties). While it seemed clear she loved her child, her skills for caring for his emotional and relational needs were unevenly developed—understandably; she had never had any experience or models of competent parenting. She had no marketable job skills, without which her prospects of providing well for herself and her son were problematic. But perhaps of equal importance, she could see and acknowledge much of this; and her positive interactions with me showed she was open to becoming involved productively with therapy and other services.

Arlene’s most recent previous evaluation had diagnosed her with an adjustment disorder, recommended brief therapy, and urged that Arlene’s son be returned to her immediately. I asked to meet with the colleague who had performed it. She worked for a posh practice; she received me graciously. Though her initial tone was assured, under the surface she seemed wary.

I asked the clinician to tell me her impressions of Arlene. She spoke for about twenty minutes. When she paused, I asked how she had ruled out post-traumatic stress disorder and character pathology. She looked me in the eye, sighed, and deflated. She explained that she had worked, since completing her doctorate seven years prior, in a practice oriented toward managed care. She and her colleagues could see their clients ten times—twenty if need be in special circumstances, but they had been advised to request such exceptions sparingly. They risked losing their jobs, and the practice risked losing its managed care contracts, if such requests became too frequent. She had therefore been told never to diagnose character pathology, because there was nothing clinicians in her practice were going to be able to do to treat it.

Then the clinician’s tone of assuredness returned. She felt she had done a good job for the court. Did I have any other questions?

I was subpoenaed to be present on the date of Arlene’s court review. Arlene’s attorney had not given the judge my report beforehand. Looking sternly judicial, the judge took it from him and began reading it, on the bench. My report was thirty-plus pages, single-spaced. The reading took a long time. The courtroom was quiet. No one dared interrupt the judge.

When the judge finally looked up, she said, “Now, someone has explained what I need to know to make decisions about this mother and this child. Let’s proceed.” I then understood why the judge had ordered a fifth evaluation. More importantly, so did Arlene.

POTENTIAL SPACE AND THE UNTHINKABLE

What seemed to help Arlene feel comfortable telling me her story felt linked to what made my report on Arlene and her son meaningful and useful to the judge. Both my interaction with Arlene and the report I drafted were shaped by the value psychoanalytic clinicians place on *potential space*. This involves creating conditions of empathic attunement; being open to the subtle, unexpected, and disquieting; and, dialectically, being both committed to the focus of the discussion and enough decentered from it that a full range of memories, emotions, beliefs, and experiences-in-the-moment can emerge (Green, 1977; Ogden, 1985; Bromberg, 1996; Pizer, 1996). I worked to create a particular quality of space and availability between Arlene and myself so that she could feel free to reveal the range of what she thought and felt, and show me something of the process of how she came to think and feel what she did. Similarly, when I drafted my report of the evaluation for the social worker and the court, I worked to find a way of writing that brought Arlene alive as much as possible. I tried to help the report’s readers have ample mental space for thinking about her, privileging this over a more concise, narrowly focused narrative.

This differs from the recommendations more commonly made in forensic evaluations, to employ standardized interview formats and checklists (Goldstein & Weiner, 2003; Benedek, Ash, & Scott, 2010), and frame forensic reports in a concise, “objective” manner (Sparta & Koocher, 2006; Greenfield & Gottschalk, 2008). Had I done so, I might have inadvertently foreclosed some of the potential space that seemed so valuable to Arlene, and later to the social worker and the court. In staying too closely tied to tightly focused factual and objective data, I might have gotten in the way of them opening to other important domains—emotions, subjectivities, fantasies, relevant contexts, and ways of thinking.

Related to this is a particularity of children, and adolescents, who have lost a parent—their feelings, beliefs, and experiences, as Heineman (1998) has described them, are unthinkable, beyond their capacity to fully understand and therefore describe. Mental health professionals, like the society at large, assume that children have love, adequate physical and emotional provision, developmentally facilitative experiences—and parents who are living and available. On the basis of good-enough experiences with such competent and present parents, children living and developing under ordinary circumstances form good-enough internal objects, competent parents within, foundational for their subsequent emotional and psychosocial development. The children who are the focus of this paper are not so fortunate.

What becomes unthinkable in the inner experience of children like Arlene, whose parents reject or abandon them, has a developmental dimension—children may not understand what a particular street drug is, or what sexual organs or acts are, or what an adult phrase means. But what makes the experience of children who have lost parents as Arlene did unthinkable also has dimensions of trauma. Horrific experiences of absence and loss at a vulnerable stage of development can preclude necessary internal capacities—such as sense of self, basic security, mastery strivings, and language and cognitive competencies—from forming normally, or at all (Silberg, 2013). Even if capacities to perceive, think, feel, and experience develop, lived realities that are too far beyond expectable human experience cannot take ordinary mental/emotional shape.

Many kinds of mental health professionals can be of valuable help to children and adolescents. But psychoanalytically informed clinicians uniquely bring this level of unthinkable psychological reality into focus and articulate it to relevant constituencies. Cognitive-behavioral clinicians tend to reach their limits when their patients cannot cognize. Those who base their approach to practice on neuroscience discoveries and privilege the biological (Nelson & Carver, 1998; Johnson, Munakata, & Gilmore, 2002; Grossman et al., 2003; Cozolino, 2006; Wyatt & Midkiff, 2006; Dulcan, 2010) cannot translate their clinical insights into answers to the kinds of concerns Arlene's judge needed to address. When important understandings have to be reached expeditiously and important decisions have to be made in forensic contexts, psychoanalytically informed child forensic clinicians have the capacity and potential to offer contributions other approaches cannot.

It is unthinkable, unspeakable, and intolerable that Arlene spent her entire childhood and early and middle adolescence either unparented or pathologically parented. She was habituated to going without basic necessities. She looked quizzically at me when I asked when she had last had a check-up with a medical doctor; she could scarcely conceive of such a possibility. She was a "neighborhood child" at the local abortion clinic as well as where she lived. She had come before a juvenile court not for her own vast unmet needs, but because she was accused of child neglect because she did not have money enough for Pampers . . . or for anything else. When she needed a forensic psychological evaluation, she needed a psychoanalytically informed approach to such an assessment that could bring these kinds of realities to the fore.

MORGAN AND HER SISTERS

Thus far, I have focused on some essential components of the process and task of forensic mental health work with children who have lost a parent. I have tried to suggest why and how a psychoanalytically informed approach to this work can make an important contribution. A final vignette will help us think more about the role of a psychoanalytically informed clinician undertaking forensic work with these children—what it feels like, and how it can work.

The local juvenile court asked me to evaluate Morgan when she was twelve. She had four younger sisters; the youngest was six years younger. The family was European-American and working-class.

The girls originally came to the attention of child protective services when their father was killed in prison. He had gone to prison for beating the children's biological mother to within an inch of her life, in the presence of Morgan and some (not all) of her siblings. Morgan's biological mother had a long criminal and substance-abuse history. The protective services social worker described her as having been "in the wind" for years when I first saw Morgan. At the writing, it is has been five years since I saw the last of these children. Their biological mother has never re-appeared.

Morgan and her siblings had been separated in non-relative foster placements, but were living together with their maternal aunt under a relative foster care arrangement when I saw them. Their aunt—unmarried, and with no children of her own—worked as a dental office assistant, and was pursuing a licensed practical nurse credential at a community college. She was doing her best, but overwhelmed with the children's diverse and intense needs. She had some help with the children from her own mother, but told me she felt she was "going under" when I first met her.

The court asked me to see Morgan because she was in crisis. She was very angry, aggressive when not withdrawn, failing in school, isolated, and uncommunicative. Morgan could barely speak with me. She was near breakdown. Previously, she had been an honor student, popular and out-going.

Morgan managed to tell me, through gritted teeth and barely able to tolerate the associated emotion, about watching her father, years before, beat her mother. At the time of the evaluation, she said, she was "hurt beyond hurt, angry beyond angry." Because her emotional state made open-ended conversation about emotionally charged topics almost impossible for her, she tolerated the more structured interactions of psychological testing better than our two interviews. I also spoke with her aunt/foster mother, three times, about Morgan and about the family.

Morgan took most to the Personality Inventory for Youth (Lachar & Gruber, 1995), a self-report measure. She could not read the items, though she had previously been a good reader. As I read them out to her, she often said, with a tone of awe, “Yes, that’s how it is for me” (rather than the requested, and more plebian, “true” or “false”).

Morgan’s profile showed that she was having psychotic symptoms. These seemed to have arisen in the context of the trauma of what she had witnessed, the disruption of coming to live with the aunt just a few months before, and recent puberty, with its transient undermining of defenses. I felt that the possibility Morgan might have an emerging underlying major mental illness, with prominent neurobiological determinants, could only be ruled out once she had had intensive treatment for her clearly evident complex and very acute post-traumatic stress disorder. I recommended a long-stay hospital program. Fortunately, one such program, a good one, remains in our jurisdiction.

I can capture only reflections and approximations of Morgan’s experience and of the experience of working with Morgan. Important aspects of her experience were unthinkable and unspeakable, so she could not convey them to me, especially at a time of crisis. Because of my psychoanalytic training, for the most part I could tolerate—at some personal, emotional cost—hearing about the beaten mother, the murdered father, the overwhelmed aunt, and the child breaking down as she entered puberty. I could usually stay in the clinical moment with what was present. I was able to be an available professional and a containing object for Morgan and her aunt, and for the external consumers of my work—social workers, attorneys, and a judge. I managed to write essential and relevant elements of Morgan’s history and functioning, and of her needs. I offered appraisals, opinions, and recommendations, including linkages to well configured services.

But the work was hard—objectively hard, and hard on me. I felt that Morgan was falling apart before my eyes, and there was something about my role—to describe Morgan, rather than intervening directly to try to heal her agony—I found hateful. I needed to be in touch with my feelings, because they grounded the work of conveying Morgan’s intense and urgent needs. But some of my feelings came from Morgan needing me to feel what she was feeling. Morgan’s emotional experience was unbearable for her, and close to that for me.

I was working both within and at the edges of my zone of professional and personal comfort. The pace, rhythm, and relational qualities of my work were quite different from those I encounter with accustomed familiarity when doing psychoanalysis or psychoanalytic psychotherapy. I met with Morgan very few times. In those meetings, we got deeper and further more quickly than typically happens in a therapeutic relationship. With informed consent from all relevant parties, including Morgan, and with considerable careful discretion, I spoke with more outsiders than I typically would about work with a child and a family.

What I actually did, beyond the interviews with Morgan and her aunt and the testing, involved: writing a forensic psychological report; speaking a few times over the phone with Morgan’s social worker; speaking with the attorney representing child protective services and the court-appointed attorney representing Morgan’s interests; speaking informally with Morgan’s aunt and grandmother; and speaking with the hospital staff to whom I referred Morgan. I was never asked to appear in court to testify about my findings and recommendations. While I was open to doing so, the parties involved reached consensus on what needed to happen, in large part informed by my report. They all agreed that a court appearance was not necessary.

Morgan did well in her eight-month hospital stay. However, while she was safely out of the household, her siblings began showing heightened behavioral, emotional, and school problems. Each of the children was in psychotherapy in the public mental health system. The therapists were caring and competent, but they were pragmatically, and behaviorally, rather than psychoanalytically oriented. They did not have post-graduate training, and did not have access to clinical supervision. The aunt was also in therapy, but attended her sessions only sporadically. Between work, school, and her parenting responsibilities, she had little time or space for engaging in substantive depth in personal therapy. Given the complexity of the case, and the limitations in the therapists’ training, open diagnostic and treatment planning questions were left unanswered. When the protective services social worker asked if I could evaluate Morgan’s sisters, from my psychoanalytic training and experience I felt I might be able to develop helpful answers to these questions. I agreed to do the assessments.

In conceptualizing this expanded role, I was guided by the notion that the clinician contains what the patient—in this case, patients and clients (i.e., the agency personnel, the attorneys, and the court)—cannot hold in mind, and helps metabolize the material until the patient/client becomes able to take it back in and work with it (Spillius et al., 2011). Morgan’s family, and most of those charged with helping them and making decisions about them, did not have some necessary elements of the training needed to deal with the unthinkable and unspeakable. They turned to me as someone who did. While this pushed a bit against the convenient boundaries of my task, it did so legitimately.

One of Morgan’s sisters seemed to be doing well. She needed therapy mostly for support and developmental accompaniment. Another seemed resilient enough emotionally, but had vision, language, and learning problems in need of substantial help. A third was having substantial internal conflict, evidenced in mounting externalizing symptoms, and needed more intensive, exploratory psychotherapy. Her therapist did not feel trained or prepared to offer such treatment. Understanding this, with the help of the evaluation findings, the therapist helped work out an appropriate referral. The fourth, the youngest, was a highly internalizing child who preferred not to communicate much directly. In her case, the aunt and grandmother needed more regular help understanding what she was showing through her behavior and her play. They got this through more frequent consultations with the child's therapist. The family also needed a much more robust network of informal supports, which their protective services worker helped them develop, through their church and community agencies.

Over the eighteen months of my involvement with Morgan and her family, there were periodic phone calls between me and the protective services social worker. Unusually in our local circumstances, she remained assigned to the case, in large part because she was committed to the family. I also spoke with the various attorneys and service providers involved, and her aunt and grandmother. After our initial meetings to discuss the findings and recommendations in my reports, we discussed the service linkages and therapeutic progress or stalemates. I hoped I could help the parties involved to sort out the issues. At times, the calls were just to touch base with me and let me know that things were going well, or at least going along without crisis.

I get cards from Morgan's family every Christmas—photographic cards, with a smiling family of children, aunt, and grandmother. Everyone signs the cards.

CONCLUDING THOUGHTS AND RECOMMENDED GUIDELINES

I am writing here about an approach to forensic mental health work with children and adolescents who have lost a parent that is different from what most psychoanalytically informed clinicians typically count among their professional activities, and different from what most forensic clinicians believe in doing. Inevitably in a book chapter of this kind, I cannot lay out all the complex workings of such clinical work. I hope I have been able to convey a sense of its possibility, feel, and potential.

For those who can imagine engaging in this kind of work, a few guidelines may be helpful:

1. *Psychoanalytically informed forensic mental health work with children who have lost a parent makes especially powerful demands on the clinician. Seeking necessary training and supports is essential.* The forensic child clinician needs to develop interviewing and assessment skills beyond what most clinicians gain in graduate or analytic institute training. This is often acquired through well focused workshops and conferences, bolstered by supervision/consultation. Even with this training background, I could not imagine sustaining engagement with forensic work with these children without the help of an ongoing peer consultation group.

2. *Ground work in the value of an open systems perspective* (Miller, 1999; Coburn, 2002; Rustin, 2002; Seligman, 2005). It was essential to my work with these children to remain grounded in a psychoanalytic sensibility and to utilize psychoanalytically informed conceptualizations and techniques. But it was also important to collaborate with other professionals and incorporate other relevant sources of knowledge—legal and social-work input; findings from a variety of kinds of psychological tests; the social context of the children's living situations; and narratives of the children as they themselves frame and formulate their experience. Had I used a more traditional, self-contained psychoanalytic frame, I likely would have missed out on much of relevance to the task at hand. Such a frame would not have enabled me to be as helpful to those I was serving.
3. *Consider what is entailed in working psychoanalytically as part of a team effort.* Most psychoanalytic work is done in conditions of privacy. The privacy of the encounter space is felt to be an essential "active ingredient" of the work. But forensic work, by its nature, involves creating respectful, facilitative frameworks of collaboration. In such team efforts, dialectically, the private and subjective can become available to an involved professional audience, and individuals involved with forensic systems can be helped to understand what the large systems affecting their lives are doing, and why. Again, if this is outside a clinician's zone of comfort and expertise, training, supervision, and consultation become essential.
4. *Use all available tools.* Psychoanalytic child therapists understand this more than many adult psychoanalytic psychotherapists do—we tend to be more comfortable admixing play, with or without toys, and art materials, talk, analysis of behavior, fantasy, and guidance; and we are more experienced in using active techniques (Frank, 1992). Yet we may not routinely use the skills of our base professions—in my case, psychological testing—or feel comfortable and adequately skilled in writing and testifying about what we do. Potentially, these skills, essential to forensic work, are learnable.

We live and work in complicated times. The conditions in which clinicians work, and the kinds of problems that come to us, take shapes and trajectories far different from what most of us imagined not so long ago. We can become wary—or, at times, realize we are not wary enough—of familiar ideas and methods. Yet psychoanalytically oriented child clinicians continue to offer, and to contribute to broader social discourse, the capacity to be open to what children, including children in almost unimaginable circumstances, want to tell us in their own unique ways.

I have learned a lot from what children who have lost a parent have told me when I have seen them in the unusual circumstance of a forensic evaluation. Sometimes, they have told me they are grateful for what I have been able to offer them. I hope I have been able to convey to them, and to you, that I am grateful for what they have felt courageous enough to share. And I hope others reading this chapter might be encouraged to consider becoming involved in such work and, if they do, will find what I have conveyed here to be helpful.

NOTE

1. In this chapter, names and other identifying details have been changed to protect confidentiality. Similarly, my emphasis in the clinical vignettes I use here is to illustrate points relevant to the purpose of this chapter, not to tell the full stories of the children I am discussing and my work with them.

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Chapter Twelve

Maintaining Hope in the Face of Despair

The Transference-Countertransference Matrix in Treating Adolescents Coping with Traumatic Parental Losses

Etty Cohen

In her distinctively relational clinical approach to her work with a group of traumatized adolescents, Etty Cohen builds upon her previous publications and here considers the particular impingement of parent loss. She describes the experiences of two female adolescents, who each experienced a parent dying of AIDS, in a remarkable psychoanalytically informed weekly bereavement group treatment marked by intense affect and considerable resistances. Through these girls' experiences, Cohen underscores the correspondence between their losses, their anger, their provocation of the therapist, and the challenging therapeutic process that unfolds. In this chapter Cohen candidly reflects upon what worked and what did not work in this treatment.

Cohen describes an interesting parallel process that emerged, in which the despair the therapist endured, while working with these high-risk adolescents, established the basis upon which the adolescents' own experiences of despair eventually could become acknowledged and processed. Not only did the resistance belong to the adolescents, but to the therapist as well. Deep-seated personal self-exploration is central to Cohen's view of what can impede a therapist's full absorption of (or surrender to) despair, an experience she sees as the stepping stone to hope.

This chapter offers an exceptionally compelling look at countertransference when working in the realms of trauma, loss, and uncertainty. The reader gains an understanding of the importance of despair in both the bereaved and the therapist, as well as the ongoing psychological development of the therapist doing such work. —Eds.

Six girls, residing in New York City, ages fourteen to seventeen, each with one parent dying from the complications of AIDS, gathered once a week for one hour in a psychoanalytic institute. These girls had all grown up in poverty, drug-using families, and had suffered not only abuse and neglect but also previous dislocations and losses. In addition, they had been plagued by the violence of inner-city life, and the effects of unemployment, and overcrowded housing. While they had resources for survival, they were dealing with a multitude of social problems, of which AIDS was but one.

The girls joined the bereavement group and left at different times during the two years of group and individual therapeutic work. When parents are dying, there is no time to follow more traditional procedures. Membership gradually increased from two to three to five, and eventually to six girls (Cohen, 1996, 2003).

This chapter revisits and focuses on the cases of two adolescent girls, Nataline (fourteen years old) and Michelle (sixteen years old) almost ten years after the time period described in my 2003 book, *Playing Hard at Life: A Relational Approach to Treating Multiple Traumatized Adolescents.* The conceptual framework of my book is the psychoanalytic approach represented by Sándor Ferenczi an Hungarian Analyst (1873–1933). His theoretical foundation reflects the relational orientation. Ferenczi conceived of the analyst's role as characterized by an ever-changing envelope of mutual influences. He used the word "elacticity" (1928) to describe the fluid interchange between analysts and their patients. Therefore, transference-countertransference matrix is viewed from contemporary psychoanalysis as a co-created process between the patient's and analyst's intersubjectivities. In addition, I found that many of Ferenczi's theoretical ideas help to clarify the child's experience of trauma (Ferenczi, 1928, 1929, 1931, 1933). I believe his ideas extremely useful for my work with traumatized children and adolescents. Aron and Harris (1993) wrote about the usefulness of Ferenczi's relational concepts in understanding children. It is important to emphasize that although this chapter discusses two girls in group therapy, the theory and techniques can be applied to an individual treatment context as well.

In what follows, I illustrate the application of the dialectical-relational reformulation of the psychoanalytic process in treating Nataline and Michelle. This dialectical process in Hoffman's view (1998) is facilitated by maintaining an experiential openness to the tension between seemingly unrelated, opposing polarities, such as between discipline and personal responsiveness, and between repetition and new experience. I will particularly focus on the analyst's hope versus despair.

While writing my book, I struggled to explore my feelings as sudden terminations frequently occurred in my work with deprived, high risk adolescent patients. Unrealistic and exaggerated expectations and anticipations in working with inner-city adolescents generally led to false hopes that paved the way for bitter disappointment, frustration, and despair. You can see despair as the anticipation of almost certain loss, defeat, and failure.

I met Dr. Neil Altman for consultation while writing my book chapter on termination. In this chapter, I described my own experience of defeat, and helplessness with severely traumatized adolescents. At that time, I was not entirely aware of the depth of my despair, for I resisted the idea that I could be affected by these youngsters. Altman, who writes on analytic work in public clinics (1995), discussed the delicate balance between maintaining hope in the face of despair when working with traumatized inner-city adolescents. He shared with me his belief that analysts surrendering to their despair have the potential to create a new beginning for the analytic dyad, and a therapeutic transformation. This prompted a journey of self-reflection that I now share in the current chapter.

While working with the girls, I experienced an intensity, drama, and urgency, in addition to the general emotional activation, and a sense of chaos and despair. Time, in a deeper rather than literal sense, was a very significant issue in our relationship. The girls did not attend sessions regularly. They cancelled sessions without notice. If I had been more authoritative, would they have been more likely to come on time? Or would I have lost them? At one time, Michelle expressed her wish to experience me as her best friend; at other times, Nataline asked me to function as an authoritative parental figure who could magically resolve her struggles with boys.

Nataline and Michelle were the last girls who terminated treatment. Nataline and Michelle each lost a parent to AIDS during the period of treatment. The aim of this chapter is threefold. First, I seek an understanding of the effect of parental traumatic loss on impoverished minority adolescents, and of how these adolescents cope with this loss intrapsychically and interpersonally. Second, I use the material of these cases as a backdrop for discussing a relational reformulation of the girls and I, who together, were resistant to surrender to our despair. The girls and I could not bear the intensity of despair that we experienced and by defending against this feeling, we did not allow the *true self* (Winnicott, 1960) to emerge in the transference-countertransference matrix. This process then led to an impasse in dealing with losses. Third, moving through a transitional period in which personal traumatizing circumstances exerted considerable pressure on my life, led to a long road of awakening through containing my own despair and that led to therapeutic transformation with my patients today. I will illustrate how co-constructing inner and relational processes offers a significant anchor. When patients and their analysts are regressing together and surrendering to each other, they seek to sustain genuine hope in the face of parental traumatic losses.

NATALINE: "NO ONE I KNOW SEEMS TO LOVE ME"

Nataline, a Caucasian girl, was fourteen years old at the time she joined the group. Prior to joining my group her mother was ill with liver cancer and AIDS. Feeling that she did not have much time left, the mother told me that she strongly desired to repair her relationship with her daughter (as well with her own mother) before she died.

At the time of intake, Nataline's mother, Ms. B, was extremely depressed and angry. She felt that her own mother had not been supportive of her. She lived with her ex-husband who was an alcoholic.

A year after Nataline's mother began dating her father, she became pregnant with Nataline. The pregnancy was unplanned. The grandmother during sessions with me described herself as Nataline's primary caretaker from birth. The mother moved in and out twice before Nataline was five. Nataline lived with her maternal grandmother, uncle, and aunt. She had conflictual relationships with all of them.

Nataline had an inconsistent relationship with her mother who had used drugs on and off and had AIDS (it is not clear to me when exactly her mother developed AIDS). Nataline was resistant to share information about when she had lived with her mother. In addition, her mother, who was very sick, could not keep our scheduled parent guidance sessions. Nataline's father had been in and out of jail, and she had been unable to have a relationship with him. Her maternal grandfather, with whom she had a close relationship, had died of a brain tumor two years before she joined the bereavement group. I did not have any contact with her father or his parents. The caseworker's impression was that Nataline's relationship with her primary guardian, her grandmother, was conflictual. Nataline's losses and the repeated separations from her parents, and the continued disruptions in maternal love she had experienced all created major traumas in her life.

Nataline's mother felt that her daughter had "grown up too fast." In a phone contact, she explained that Nataline did not like to play the way other children did, and that she preferred the company of adults. Nataline did well academically and described a teacher as her confidant, the one with whom she had the closest relationship.

During the course of treatment, my interactions with Nataline were often limited to her requests for me to fix someone or something. For example, she wanted me to invite her mother to a session to make her mother a more responsive person. On the other hand, Nataline limited our involvement. She wanted to know nothing about me, never commented on my presence, and wanted me to be in the dark about her childhood. One sense I had was that I was seduced by her suffering, and worried by her threats of leaving treatment. But, if I were too close, she pushed me away, telling me she would keep her secret to herself, showing photographs of relatives without comment, and recounting dreams without associations.

I struggled to get close to Nataline without "hurting" or "being hurt." Nataline protected her vulnerabilities by moving away. Unconsciously, I believe Nataline wanted me to join her dissociated state so that we would avoid our mutual despair, anxieties and vulnerabilities and remain connected through a state of mutual dissociation. Our access to our true selves was blocked because the girls and I were resistant to surrender to our feelings of despair. This process was mutual, but not symmetrical since I was aware of the existence of my countertransference reactions even though at that time I was not aware of the origin of my reaction.

MICHELLE: "I AM YOUNG, BUT WITH THE STUFF I BEEN THROUGH, I AM OLDER"

Michelle, a Latina girl, was fifteen years old at the time of intake. During intake interviews I learned that Michelle ran away from her mother's home and was referred by a social worker in a homeless shelter where she reported that she had been physically abused by her mother. In addition, she reported that she had been raped twice by her mother's boyfriend a year before. The boyfriend flew out of the country before he was prosecuted. A rumor, that the perpetrator had come back to New York after having fled, aroused fear and anxiety in Michelle. Michelle lived with her aunt and two cousins. Her aunt obtained custody of Michelle after she ran away from her mother's home. Since she had been living there, Michelle reported difficulty sleeping and occasional nightmares, and that she had not been eating well. In addition, she described illusions of seeing her attacker on the street, and panic attacks at the thought of his reappearance. During the intake she also expressed her desperate wish to find her father who she had not seen since childhood. She had been told that he was dying of AIDS and hoped that the therapist would help her to find him. Michelle agreed that she needed to come for therapy because she was "all confused."

Michelle was born prematurely at seven months. She was born addicted to cocaine, and had significantly delayed developmental milestones. Michelle's twin sister died at birth. Due to her poor condition, Michelle stayed in the hospital for three months after birth. For unknown reasons, she was not returned to her mother after hospitalization, but at three months went to her aunt S. instead. Michelle lived with S. from three months to eleven months, and returned to her mother for a trial period. When Michelle was two years old her father started to visit her. Because he was often drunk, Michelle was afraid of him and used to hide in another room when he came to see her.

Michelle lived with another aunt D. from two and a half years old to the age of twelve. Michelle's mother saw her infrequently and made no effort to get her daughter back. When Michelle was twelve, aunt D. got remarried and her husband felt that it was time for Michelle to live with her own mother. Michelle was forced to leave her aunt's home and reunite with a family she had never really known. I could not get more information regarding the quality of attachment that Michelle experienced toward D.

Michelle's mother had six children, but had never married, and it was unclear who the fathers of each of the children were. Only Michelle, who was the oldest, knew who her father was. According to Michelle's aunts, her mother had a new boyfriend "every six months." Apparently, her mother's relationships had involved being with a man who physically and verbally abused her and raped two of her daughters (Michelle and her younger sister who subsequently had an abortion). Michelle's father was the superintendent of the building where the mother lived. He was married with six children and had many affairs with other women, one of whom was Michelle's mother.

Michelle, who was the last to join the group, expressed her willingness to talk about her father who was dying, "I know that my father has AIDS. I don't know where he lives. Can you help me to find him?" In group sessions she read from her journal about her fears and frustration about losing her father.

In one session, Michelle brought pictures of family members. Only later we learned that she had lost some of the pictures of her grandparents and of others whom she had not seen for a long time including her siblings. After Michelle brought in pictures of her family, Nataline then brought pictures of her family including one of her grandfather and she mentioned that she missed him after his death a year earlier. She refused to explore more about what she missed about him.

GRIEF AND PARENTAL LOSS DURING ADOLESCENCE

A brief review of the literature reveals that various authors disagree on the age at which children are capable of mourning. My own view is closer to that of Wolfenstein (1966), who believes that mourning becomes possible only with the resolution of the adolescent phase. This does not imply that some aspects of the mourning process of the adult mourner cannot also be observed in children as a reaction to the loss of important objects, but Nagera (1970) suggests that "there are important differences between the so-called mourning of children and that of adults" (p. 363). Moreover, Nagera noted that, although adolescents establish all the factors which are necessary preconditions for mourning in the adult, their overt behavior and response to loss are significantly different from that of the adult mourner. Nagera noted they were referring to Wolfenstein's case of Ruth and her friend—the two adolescent girls who wished to keep a tough[ness] image of themselves—unable to cry or express their emotions after their parents' death. The significant difference, according to Nagera, is that the adolescent, is still tied to his or her parents, whose presence is required for development to unfold normally until it is finally completed.

It has been suggested by Sugar (1968) that adolescents may go through a period of what he calls *normal adolescent mourning,* i.e. when no death has occurred. He believes that this involves the adolescent recognizing the imperfections of his parents, the loss of idealizations of them, and of the prior view of their omnipotence. This recognition is tied to the loss of childhood, the loss of the dependent intimacies of family life, and the loss of the idealized world of early childhood. These multiple losses may lead to much grief with associated affects of anxiety, helplessness, anger, despair, and yearning for what has been lost, even though there has been no actual loss.

Studies of adolescent bereavement do not clarify whether the adolescent is dealing with the "normal" conflicts inherent in each developmental phase or whether he or she is dealing with the conflicts inherent in the grieving process. In effect, the work of adolescence and the work of grief are similar, for both involve adapting to the loss of objects (either an inner image or a person), both involve coping with changed inner and external realities, and both involve an encounter with the ambivalence and conflicts inherent in the phases of separation and loss: protest/searching, disorganization, and reorganization (Sugar, 1968).

During adolescence, the loss of a profound relationship—whether an internalized object or a person in the external world—may interfere in what seems to be the natural process of maturation:

> Changes that are normally expected may be averted, avoided, or may not even take place. Such an arrest of developmental unfolding may put the adolescent "on hold" in one phase, and thus inhibit the energy and skills necessary to meet subsequent phase appropriate demands. A developmental arrest may also have the opposite effect, that is, of increasing the intensity of a prior phase-specific behavior in a following phase [Fleming and Adolph, 1986].

The sexual development of the adolescent is a very important part of his or her life. It marks the change into an adult, who can never again be as he or she was as a child. Loss may have significance in this sphere; "he may link themes from his sexual fantasy and experience to the loss, or the loss may have effects on his developing sexual life" (Rafael, 1983, p. 166). The death of the same-sex parent may deprive the adolescent of a source of sexual identification that may be important to him or her. Another issue that arises, specifically relating to AIDS, is when the adolescent equates sexuality with vulnerability, and possibly with death.

Laufer (1966) observed the response of an adolescent whose mother died suddenly of a coronary thrombosis. He stated that the "loss of the oedipal object in adolescence may constitute a developmental interference" (p. 291).

Nagera (1970) quoted Wolfenstein as she pointed out in 1965, "the death of a parent would find the young adolescent still far from ready to give him up. At the same time, conflicting feelings toward the parent would further interfere with pure regret and sadness" (p. 383). Wolfenstein has described the reactions of an adolescent girl to the death of her mother. I will select from Wolfenstein's case, some specific aspects of this girl's reaction which lead to the significance of grief work in group settings with adolescents. Typically, Wolfenstein describes how a girl found herself no longer able to cry shortly after the mother's funeral:

> "She felt an inner emptiness, and as if a glass wall separated her from what was going on around her. She was distressed by this affectlessness, and was subsequently relieved when, comparing notes with a friend whose father had died some time earlier, she learned that the other girl had had a similar reaction" (p. 100).

Menninger (1963) stated that adolescents who respond to loss by withdrawing into themselves tend to be in much more serious danger than those who respond aggressively. The withdrawn adolescent is often mistakenly considered to be taking the parental loss so well that there may be no awareness of lasting depression.

The tendency in adolescents to withdraw may be explained as a reaction to having been hurt. In addition to the miseries and identity conflicts common to their age period, bereaved adolescents may experience a fear of closeness, sensing the danger that they will be hurt again. In addition, given the adolescent tendency to fantasize, they may be preoccupied with memories and fantasies of the relationship they have lost, so that they are unable to use present-moment experience.

Anger is an emotion that adolescents in general find easier to express than despair. A feeling of anger at the world, in many instances long before the death occurs, gives extra meaning to anger during the bereavement process. Anger may be motivated by guilt when turned inward, or, when there is angry acting out, the motivation may be either to gain recognition of the adolescent's distress or to punish others for what has happened.

Bowlby (1960, 1961, 1963) considers anger a critical component of grief which relates to yearning for the lost object. Discharge of this anger serves a constructive role in the mourning process (Bowlby, 1980). During bereavement in adolescence, anger is more easily expressed than in earlier stages, and can give the adolescent a sense of power to counteract feelings of helplessness. Wolfenstein (1969) noted that rage is the primary reaction to the loss of a parent, as she has observed in her adolescent patients.

Anger is a dominant form of expression among adolescents facing parental loss through AIDS since this type of parental loss is mostly associated with parental substance abuse and/or unsafe sex. These adolescents experience their parents with AIDS as focusing more on their own addictions and/or pleasure than caring for their children. The anger may manifest in such acting-out behavior as cutting classes, drug use, and failure to practice safe sex themselves. Some factors that contribute to the manifestation of acting-out behavior, and which are evident in the subjects of this chapter, are described by Rexford (1978). She emphasizes that early traumatic experiences, and often repeated object loss, lead the child to identify with some early parental attitudes and behaviors, such as ambivalence, inconsistency, and predisposition to action as a major mode[s] of communication. All these attitudes are general characteristics of impoverished families and, more specifically, are characteristic of the parents of the subjects of this chapter.

Many adolescents in mourning may appear to be seeking adults who will replace the lost parent. Ironically, while they may complain that the caring adults are not offering enough, they attempt to force separation from these adults in order to repeat the experience of loss they have suffered (Freud, 1933). When bereaved adolescents become emotionally involved with a therapist, they may seem to provoke a situation in which they might lose him or her, as if, in order to convince themselves that they have control over the situation of loss. Thus, they may try to provoke the therapist into rejecting them, thereby producing a loss of their own making. This assertion of control is an attempt to separate the sense of being helpless from the experience of being deserted. A therapist who is trying to help an adolescent work through parental loss should have no expectation of gratitude. The young person in mourning is angry; some anger must be directed toward the therapist.

Bereavement factors differ for different populations. Death from AIDS is often accompanied with trauma as these losses cannot be openly acknowledged and socially validated. The dominant feeling of shame attached to these losses complicates the grief process and compounds reactions of guilt and anger in bereaved survivors especially in light of the AIDS. It is roughly estimated that globally there are more than fifteen million children (aged 0–17 years) who have lost one or both parents to AIDS (Demmer, 2009).

The adolescents described in this chapter were traumatized by watching their parents dying, and they experienced many changes in the household and daily life while the parents were hospitalized. The Rotheram et al. (2005) study of 414 adolescents in New York City living with parents with AIDS found that these adolescents experienced the most emotional distress more than one year prior to the death of the parent, the period that the girls in my group were in treatment with me. In working with the girls facing parental loss through AIDS, I have argued:

> Therapists working with adolescents, especially traumatized ones, are faced with intense resistances that have significant and multiple functions, including an attempt to preserve selfhood. Understanding and acknowledging this and other dynamics may prepare us for the adolescents' intense resistance, especially during the beginning phase, when they are questioning our sincerity and commitment to caring for them (Cohen, 2003, p. 91).

AFFECT EXPRESSION IN COPING WITH GRIEF

Many adolescents try to hide inner feelings of hurt and pain in an effort to appear "grown up." Before Michelle and Nataline were referred to therapy, they exhibited signs of depression in anticipation of parental loss. Their despair remained somewhat masked as there were no extreme behaviors that would draw attention to it. Michelle and Nataline seemed to have persistent feelings of anger, resentment, dissatisfaction, and envy rather than despair. To be in touch with their parents' pain was a traumatizing experience. Their resistance to facing fearful reality can be seen as a dissociated aspect of their selves that had to be negotiated with me (Bromberg, 1998).

The capacity to tolerate despair was missing in the girls during the first six months of treatment. They experienced me surviving their destructive behavior so that they could allow themselves, later, to be in touch with their despair. Despair may reflect concern relating to the loss of an object; it implies an ability to grieve, to mourn, and to accept the reality of human limitations. The girls in the group defended against their despair in different ways. Nataline refused to visit her mother in the hospital. Michelle seemed to be able to tolerate some level of despair, and she tried to encourage the other girls to more openly express their grief.

After six months of therapy, as the girls' parents' physical appearance deteriorated, and their mortality became more obvious, the girls began to express their frustration and anger at losing their parents and their fears of being abandoned. As the group became more cohesive, the girls felt safer in expressing their needs and feelings of deprivation. The prevailing "anti-therapeutic" norm in the group was replaced by a "pro-therapeutic" norm. Relating to her father with AIDS, Michelle expressed her frustration at being responsible for losing contact with him and being unable to find him. In addition, she expressed her worries about losing her mother, since her mother planned to move to another state with her new boyfriend. She was fearful about being left alone without anyone to take care of her. Nataline complained that although her mother had told her that she had quit using drugs, she did not believe her. Drug-use became a central issue in the group discussion during this phase. The girls blamed their parents for causing their own condition through drug use. Therefore, the girls felt that their parents with AIDS were responsible for their feelings of having been abandoned. By blaming their parents for their own illnesses, the girls experienced rage in the face of their impending losses that seemed to eclipse their fear and grief. As the anger became more intense, so the ambivalence of the girls toward their parents with AIDS increased to intolerable levels and the girls chose to keep their distance as their only means of psychic survival.

IT IS TOO LATE TO SAY GOOD-BYE

The girls were unable to anticipate their mourning process. After eighteen months in treatment, two parents died and the other parents' health state deteriorated dramatically. Waiting until it is "too late" to say good-bye to the parents with AIDS is explained by Wolfenstein (1966). She points out that the young adolescent who loses his/her parent would not be ready to give up the fantasies of their parents' return. Upon seeing what the other girls were going through, Michelle delayed her efforts to locate her father, finally reaching him a day before his death. She was unable to express her grief and despair feelings spontaneously. However, she was able to express her deep grief in her writings. She became a catalyst of the group helping others to express their struggle with grief. Michelle was the only girl in the group who brought her writing to the group, enabling the other girls to relate to her writings emotionally. Nataline could not watch her mother's deterioration and refused to visit her mother. Nataline, who had been guarded before in treatment, was moved by Michelle's writing, and was able to articulate her pain by saying that she "cannot handle this." When she finally visited her mother, it was precisely thirty minutes too late. Although she refused to express her grief during the session after her mother died, later she was able to bring a dream about her mother to the session. She described how in the dream both of them tried unsuccessfully to reach each other while climbing the stairs. Her dream described the dynamic between them before her mother died, when both of them had tried unsuccessfully to get close to each other. She expressed her pain at not having her mother in her life anymore and her guilt at not having succeeded in achieving an attachment when her mother was alive.

Michelle and Nataline struggled to be in touch with their despair. They lost their chance to say good-bye to their dying parent with AIDS since they were afraid to be vulnerable in seeking attachment at a time when they were going to experience the permanent loss of their attachment figure. They had both feared rejection, and so they dared not make themselves even more vulnerable. In retrospect, the girls' resistance to facing the trauma of losing their parents to AIDS functioned as their protection from a breakdown. In fact, all the girls made dramatic improvements academically and socially while participating in the group.

As an analyst struggling to relieve the girls' sense of despair, I found myself slipping into a mood of helplessness and despair, sometimes accompanied by feelings of self-doubt and guilt. These feelings were only partially understood at the time. I debated internally about how much to reveal. I did not want to upset the girls by revealing too much and thus disturbing their process of healing. There may be an analogy between my resistance to experience their despair and to making a deeper emotional connection with them, and their resistance to making a deeper emotional connection with their dying parents since it may create an overwhelming intolerable emotional experience.

DESPAIR: THEORETICAL AND CLINICAL CONSIDERATIONS

It was Kierkegaard's belief that the worst despair is that in which one does not know he or she is in that state. Farber (2000), discussing the analyst's despair argues that sometimes despair itself provides the very condition of urgency in therapeutic situations. He added that when despair is repudiated, meanings go unexplored.

Instead of surrendering to my despair while watching the girls struggling in their traumatic lives, I tried obsessively to hold onto hope for a better future for them. The girls did not experience much hope in their lives and were repeatedly abandoned by their parents. They were consumed with despair. The girls asked for direct advice regarding how to deal with their parents or boyfriends. Because I was working hard to manage my own emotions, I believe, I failed to lead them to understand their full emotional experience. I was concerned that working through their despair would lead to their breakdown. In retrospect, I then paid more attention to situational factors than to emotional ones. In thinking about this, I have concluded that in order to maintain hope we first need to surrender to despair, i.e., meeting patients where they are before you take them to where you want them to be.

Six years after I published my first paper on the girls group, I experienced an existential crisis and personally traumatizing circumstances, exerting considerable pressure on my life, and leading inevitably to my being in touch with my own despair. It was on a Tuesday morning in July 2000 when my mother died. It was a sudden death that was not anticipated. I made it on time to see her unconscious before her death. It was an extremely traumatizing experience for me. While I was in Israel grieving, during the Shiva, I learned that I had to go through a surgery. After recovery, I returned to the United States.

In addition to not being able to mourn my mother's loss with my sisters, I had to go through my own personal trauma. It was a new experience for me to feel the intensity of my own personal despair that was not familiar territory for me. At that point I began writing my book. It was a therapeutic experience for me since focusing on writing channeled my attention in an emotionally resonant direction. I built upon discussions I had with Neil Altman in 2003, in which he underscored how analysts' surrendering to their despair opens new possibilities for traumatized patients. I learned that surrendering to my own and my patients' strong emotions has the potential to transform us both toward change. For Ghent (1990) this emotional surrender as transformation is "a quality of liberation and expansion of the self as a corollary to the letting down of defensive barriers" (p. 108). Having gained some distance with the passing of time, I now wonder, did the girls need me to join them in their despair? Or, did they need me to inspire them to feel more hope?

Farber (1966) argues that hope and despair are powerful partners, each encouraging and supporting the claims and strategies of the other. While despair means literally the loss of hope, the movements of despair are frantically directed toward hope. Despair—potentially at least—is both destroying and renewing

In reviewing my work with the girls I believe that my countertransference despair was an expectable, and potentially useful, response to the girls' efforts to induce such a reaction. The girls, mired in their despair, sought to draw me into the mud with them. The girls unconsciously needed me to join them in the despair. Not joining them would have meant that I could not tolerate this experience. I believe that the girls needed me to join them before they could welcome me pulling them out of it toward feelings that there would be hope in their future after losing their parents. Viewed in this light, my refusal, at times, and experience of being unable to be in touch with mine and their despair, can be considered a resistance to making deep emotional contact. Sometimes, hope can be reached only through an immersion in prolonged and harrowing despair.

Upon later reflection relating to my own experience of despair, I believe that in working with the girls I realized that probably the only way I could help them was to experience helplessness along with them. I knew that I could not give up on them; I could neither withdraw from them nor abandon them. In other words, instead of pushing them to maintain hope by saying that things would get better, I needed to manage their despair, and my own, which meant surrendering to my despair, accepting, tolerating and containing it. Surrendering to the girls also meant that I had to give up the safety and the distance of the traditional theoretical stance, and be open and willing to adapt to the uniqueness of each individual patient in order to establish a therapeutic alliance. Or, the therapist must be able to tolerate ambiguity by negotiating in a different way with each patient. This surrendering to the patients was conceived by Ferenczi (1928) in his paper, “The Elasticity of Psycho-Analytic Techniques.” By elasticity he meant, “the analyst, like an elastic band, must yield to the patient’s pull, but without ceasing to pull in his own direction, so long as one position or the other has not been conclusively demonstrated to be untenable” (p. 95).

During the time when the group was running, I had struggled in the process of surrendering to my own despair. If I kept enough distance so that I did not completely feel the girls’ despair, I ran the risk of being experienced by them as rejecting and alienating. However, if I were so close to them that I felt their powerful affect of despair, I might have been catapulted into another form of distancing that could have proven to be equally deleterious.

Looking back at my work with the girls, I believe that my disclosing to them of my countertransference feelings would have been the best way of dealing with these kinds of situations. With the girls, expression of my countertransference would have been essential to reassure each of my ability to handle strong emotions, relieving them of unnecessary anxiety and guilt. I believe that disclosing my countertransferencial feelings such as saying: “Listening now to what you are going through upset me. Like you all, there were times that I felt deep sadness when I felt hopeless in losing people close to me” would lead to the girls being silent. Throughout the course of treatment I had learned that the girls’ silence generally meant emotional connection with me. But, at the time I was too busy then focusing on their future, on reorienting toward the meaning of their lives instead of joining their despair. It may be that my collusion with the girls’ defenses was the only way to connect with them. Disclosing my countertransference had been a struggle for me working with the girls. Hoffman (1994) comments on the patient’s need to experience the analyst’s emotional involvement: “When the patient senses that the analyst, in becoming more personally expressive and involved, is departing from an internalized convention of some kind, the patient has reason to *feel recognized* in a special way” (p. 189). Even though *how* we feel is critically important, it has minimal therapeutic impact if it is not communicated to the patient in a form he or she can understand. I believe the more defensive the patient is, the more overt the communication needs to be by the analyst disclosing his/her countertransference feelings.

Upon reflection today, and in my current understanding of the process of grieving, I believe that the girls’ intense anger defended against their despair, even though they manifested short periods of tenderness toward each other and me. Since each of the girls was in a different developmental struggle with different use of defenses, I had to be aware of not retraumatizing them by trying to uncover their feelings that they were defended against. For example, while Michelle shared with us her feelings toward her dying father she had not seen for years, Nataline said to Michelle that she was not as strong as Michelle and would not be able to handle her mother’s dying. I believe that in individual therapy the clinician has more potential to follow the adolescents' capacity to deal with unbearable feelings associated with losing a parent. However, the girls in my group were resistant to have individual treatment so I did my best seeing the girls only in group therapy.

DISCUSSION

With all traumatized patients, transference and countertransference matrices related to reviving the trauma uniquely manifest themselves within the analytic dyad. The beginning phase of my work with the girls group was characterized by their transference as enraged victims with me serving as the helpless parent (Davies and Frawley, 1994). During this period I felt extreme despair. At that point I believed the girls were not ready to react to their impending loss. Also, their defensive behavior of identifying with the aggressor functioned as a defense against feeling despair with and against their fears of being left alone without a parent to care for them.

Mitchell (1993) eloquently described a patient who needed him to join her despair about the treatment in order to emerge eventually into hope. The patient needed to experience her analyst's willingness to stay with her, in her dreadful hopelessness.

Mitchell addresses the analyst's struggle with the transformation of hope.

> . . . The analyst's hopes for her patient are embedded in and deeply entangled with her own sense of herself, her worth, what she can offer, what she has found deeply meaningful in her own life. The more we have explored the complexities of countertransference, the more we have come to realize how personal a stake the analyst inevitably has in the proceedings. It is important to be able to help; it makes us anxious when we are prevented from helping or do not know how to help. Our hopes for the patient are inextricably bound up with our hopes for ourselves (pp. 207–208).

As I apply these ideas of Mitchell, in treating the girls I felt my despair was in the service of my avoiding truly encountering my suffering. In this case, I would say I was hoping for something predictably unrealistic, that is, that I could get through my work without feeling intense emotional pain. At that point in my career I was inexperienced in working with adolescents who were suffering parental loss. After nine months into treatment, as I was better able to tolerate their destructive behavior, and mutual tenderness emerged, the girls began to deal with their losses. This was a short period that lasted five months when movement toward love was evident in the girls' lives. They started to express tenderness toward people in thir lives, including other girls in the group and me. The girls began to feel safe enough with each other to explore their vulnerabilities. The girls brought pictures of their family members, some of whom had died, some who were dying, and some of whom had "disappeared" from their lives. From speaking about people in their lives, the girls moved to talking about their families and about the parents, whom the girls were going to lose to AIDS. In the beginning of treatment they had expressed anger toward their sick parents for becoming infected with the HIV virus. Now they shifted to expressing tenderness toward them and despair of losing them.

The girls terminated therapy at different times during an eleven month period. Michelle and Nataline were the last to terminate treatment. During their last months in treatment, the time that their parents died, my expression of despair when I disclosed that I also lost a parent, angered the girls. Clearly, despair was intolerable for them and for me. I suspected that if they had let me join them in their despair they would also have had to re-experience the grief they felt on all those occasions in the past and present when they had wished for hope for better life and it had not been forthcoming.

Working thirteen years before this group as a mental health officer in the Israeli army was significantly different since the traumatized soldiers I had worked with were generally highly functioning young adults. They went through ego-oriented assessment before they joined the army, in order to evaluate their internal and external resources that would indicate coping skills in stressful situations. In contrast, the despair the girls felt with me was qualitatively different from the despair the soldiers felt. It is important to point out the difference in the kind of traumas that the girls and the soldiers struggled with, as well as the difference in my reaction to them. My own suffering while listening to the girls' exposure to repeated catastrophe, made it impossible for me to adequately contain their projected unbearable experiences of their despair. In comparison to my work with the girls, I became more aware of my vulnerability and despair in working with the soldiers. As Israelis we all grew up in a society in which wars and terror attacks were a familiar part of the landscape. Working as a therapist with multiply traumatized soldiers in my home land, Israel, treating them in my native language, and grieving over the loss of friends, family, and fellow officers was our shared and familiar experience. It was familiar territory for me.

As Aron (1996) stated,

> The patient and the analyst each want to be known and to hide, and each also wants to know the other and to avoid knowledge of the other. Both the patient and the analyst are motivated toward isolation and toward relationship, toward autonomy and toward mutuality, toward agency and toward communication (pp. 234–235).

Following Aron, Maroda (1999) writes about the mutual surrender that constitutes an emotional opening up, a falling away of the analyst's resistance to being known by the patient in the deepest way possible. From Maroda's point of view, the analyst's surrender is both an intrapsychic and an interpersonal event. She argues that this leaves us with questions: what exactly are we trying to accomplish? How do we facilitate this process within a mutual relationship? And, if being more human and emotionally available is really essential to our task, how do we accomplish this without unseemly gratification?

The process of surrender involves letting go of the *false self,* implicitly allowing the *true self* (Winnicott, 1960) to emerge. Similar to Winnicott, Horney's (1945) central issue is the deep struggle between the real self and its quiet despair of not being recognized, seen and acknowledged, and the forces of the false self that loudly demand attention because of its dramatic suffering. This type of suffering generates its own despair (Giselle, 2009, personal communication).

While working with the adolescents in the group I felt pressured into experiencing myself as "hopelessly flawed." The experience was so intense that I would have to arrange for short breaks after being with them so I could regain my equilibrium, usually stepping out of my office for a brief walk. Only later, nine months into treatment, did I become more able to contain and process this unsettling despair.

The sessions with the girls were riveting for all of us. My own suffering while listening to their repeated experiences of catastrophe made it impossible for me to adequately contain their projected unbearable experiences of their despair. It is easy to reject the unpleasantness of a despairing patient's negative ways of relating; it is difficult to acknowledge our own hidden wishes to join the struggle in order to feel connected, and to rationalize how much more mature we are than our patients. I want to close this chapter with Maroda's view that reflects the spirit of my own:

> . . . The point of change occurs at the point of emotional surrender. Although the objective of the analysis is the patient's emotional surrender, some degree of surrender on the part of the analyst is necessary to facilitate this process. Surrender qualifies as one of many relational events that is mutual, but not necessarily symmetrical (Maroda, 1999, p. 63).

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Chapter Thirteen

Take Me to the Moon and Wait

A Model for Accompanying Families with Young Children Through Parental Illness, Death, and Mourning

Ariane Schwab Hug and Daniel S. Schechter

In a university-based hospital in Switzerland, Schwab Hug and Schechter describe how they work collaboratively with children of severely ill or recently deceased parents. In their model, they traverse between crises and day-to-day life, addressing concrete needs along with children's dreams, as they move from fear to hope, and from denial to reality.

Informed by psychoanalytic and developmental theories, Schwab Hug and Schechter consider what is on the minds of the children and other family members while providing a holding environment for those experiencing trauma and loss. When indicated, they bring in social services, contact schools, and make referrals. They work at hospital bedside while the parent is an inpatient, and then provide the children therapy in their outpatient offices using play materials and self-created or existing books. Family members are seen in varying configurations as indicated—as individuals, as dyads of ill parent or healthy caregiver with a child, and in subsystems of siblings and parents.

In this chapter Schwab Hug and Schechter apply their model to the eight-month treatment of a family with two young children, a critically ill mother (who dies in the course of the treatment), and an overwhelmed, grief-stricken father. They strike a balance between allowing the children to take the lead and facilitating the expression of avoided, painful, trauma-related affects. With great sensitivity, they address the illness and impending death of the mother, helping the children construct a mental representation of her as well as a coherent, integrated narrative of their experience. The children come to learn they will not lose their memories of their mother—they can visit her in their hearts, minds, and dreams. Schwab Hug and Schechter promote resilience while avoiding secondary traumatization to the children.

> *In working with overwhelming, unpredictable events, therapists must be flexible and sensitive to the experience of uncertainty, and to the changing needs of children and families. Although the services available in the Swiss system are far beyond what we offer in the United States, the model described can be adapted to community mental health settings with fewer resources.* —Eds.

> *Because I could not stop for Death, he kindly stopped for me;*
> *The carriage held but just ourselves and immortality.*
> —Emily Dickinson (1863)[1]

As consultation-liaison pediatric psychiatrists trained psychoanalytically, we consult in the pediatrics, maternity, and adult-care hospitals of a large university medical center. We are regularly asked to see the children of severely ill, dying or recently deceased parents.

The ensuing journey is a hard one. We accompany the children and surviving parent as they move toward a new family constellation and self-representation. We make an effort to understand and make explicit the children's and surviving parent's distinct developmental needs, desires, and fears. Fostering social-emotional growth supports resilience in the wake of trauma and loss.

This chapter describes a psychoanalytically informed evaluation and treatment model we have used in our hospital setting, directly working with families. Our approach prioritizes thinking about and linking affects, thoughts, and actions, in both relational and developmental contexts, with sensitivity to cultural dimensions. At the heart of this work is support, encouragement, and modeling of "mentalization" within the therapeutic relationship. Bateman and Fonagy (2008) define mentalization as the mental process by which an individual *implicitly* and *explicitly* interprets the actions of *himself* or *herself* and *others* as meaningful, in terms of likely intentions to effect a reaction from the other or to communicate one's own needs, feelings, and beliefs. The capacity for mentalization is often imperiled when the relationship to primary attachment figure(s) is menaced or severed (Schechter et al., 2005).

Our work prioritizes clarifying and confronting defenses that threaten resilience and promote traumatization, such as avoidance of trauma-associated affects. When appropriate, we may interpret intrapsychic conflicts expressed by children and surviving caregivers in symptoms and behaviors. This occurs when families struggle with the reality of severe illness and death of a parent.

In teams of two to three child psychiatrists, we frequently begin our work with the parents without the children present, and then we invite the children to the adult-care hospital. We make every effort to understand the children's take on what they see, hear, smell, taste, and feel when they visit the ailing parent. We facilitate better communication of desires, fears, and reactions between patient and family, among medical and social services staff, and between patient, family, and professionals. For more discussion of our liaison role with other care providers, see Sargent (2010).

As soon as possible, we move our treatment setting to a safe, child-friendly place and involve the children's available caregivers. We have outpatient offices in an apartment building near the three hospitals to which we consult. This permits the child to know that he or she has a refuge where he or she can "play with illness and death" as themes that can be safely confronted and contained, or play without themes of illness and death in the foreground.

Our work becomes as much prevention as intervention. We maintain flexibility to move beyond a brief consultation-liason intervention to medium-term psychotherapy. While we work in the Swiss healthcare system, the model we describe is compatible with other healthcare systems that are attuned to the psychological impact of the experience of adult patient-as-parent, and the impact that the patient's children and partner have on each other. All the professionals must be willing to collaborate. Our role is to reach out to all involved for the benefit of the patient-as-parent and his or her whole family. In the event of the death of the parent prior to our consultation, we address the needs of the surviving caregiver(s), the children and the extended family.

While we wait to see what the patient brings to the session, we are careful not to collude with avoidance of trauma-associated affects by sitting back and waiting (see Coates, First, & Schechter, 2003; Coates & Schechter, 2004). Striking this balance is essential and one of the most difficult aspects to master. Initially, with the entire family present, we establish why the children have been brought to our attention, and why at this time. We listen for each family member's understanding, wishes and fears. By the end of the first session, we gently let the child know it is "okay" to talk or play with age-appropriate play materials they, and we, bring to the sessions. We facilitate children communicating their feelings about their own and their family's perceived experience with illness and death as well as other aspects of their lives.

In the next two sessions, after there is evidence of a more or less trusting alliance, if the child does not address the illness or death, we might turn to more specific "exposure" that supports the child's resilience. One of our child and adolescent psychiatrists or psychologists works with the child and family to make meaning of their experience, careful not to traumatize the child secondarily. The therapist remains attuned to the child's level of arousal, body language, changes of topic, maintenance of organization in the play narrative, and regulation of aggression and of anxiety. To confront trauma-related affects sensitively, for example, we might create a story-stem with a child or animal character, use an existing children's book that contains elements related to the child's experience, or co-construct an original "book" to facilitate the formation of repair in the form of a coherent, integrated narrative of the child's experience with the lost parent before and after death.

Given the fluctuating course that some of the ill parents experience, we remain flexible to move back and forth between hospital and consulting room. We may move between mortal crisis and day-to-day life, concrete needs and abstract dreams and fantasies, hope or denial and grim reality, facing the possibility of ventilators, palliative care, death, funeral arrangements, burial or cremation, and memorials.

For our journey, we keep a "ready-to-go" suitcase of play materials (family dolls, animal figures, medical kits, emergency vehicles, toy food and furniture, drawing materials, Play Doh**,** and other age-appropriate materials), in case we must meet the family at the bedside or in the hospital waiting area. In addition, we make ourselves available by phone if it is not possible to get the children to the hospital. We remain open to whatever the family's needs are, including addressing concrete day-to-day needs and collaborating with other professionals. We strongly believe that this "extra-therapeutic work" (e.g., using social worker services to ensure housing or bill payments, or calling teachers to discuss why a child is not able to concentrate in class) is essential to maintain the alliance with the family. The therapist's modeling of a "holding environment" that extends beyond the consulting room renders the treatment possible and counteracts the sense of helplessness, isolation, and passivity that often comes with these clinical situations. If concrete needs are not met, then the very possibility of the family participating consistently in the therapeutic process will be compromised.

To support a good therapeutic alliance and reduce a family's anxiety, we take very seriously wishes that we be present—or not—at critical care meetings, extended family gatherings, viewings of the body with the child, funerals and burials. We strive to maintain a balance between what is possible and what is not, given the family's constraints and our own. We often co-construct memorials such as drawings, writings, photo assemblies and other mementos—as transitional objects and helpful rituals.

As mentioned, our work takes place in an academic medical center. An advantage is that there can be multiple members of a treatment team. We may see the family together and then divide and hold individual sessions or parent-child sessions with different siblings. Disadvantages of the setting are that team members' availability may be affected by patient load or institutional interruptions due to emergencies or shortened rotations for junior members of the team. When a parent or other caregiver has difficulties that go beyond what is feasible and appropriate to address in the context of caring for the adult-as-parent (e.g., complex individual psychopathology), we refer that individual to a colleague from the Adult Psychiatry Consultation-Liaison Service for additional help.

Our team works with the child, the parent, and the parent-child relationship. We focus on parenting with the ill parent and/or the healthy caregiver. If there is more than one child, we try to offer each child his or her own therapist and then bring the therapists together for joint sessions with the parent(s) or caregiver(s).

In the following case illustration, we describe how we worked through the confrontation and acceptance of loss in a way that permitted both mourning the past and movement forward into the future.

EMBARKING ON A JOURNEY WITH THE FARROUD FAMILY

We followed the Farroud family for more than eight months, through the mother's illness and subsequent sudden and unexpected death, until their journey back home. Both of us were involved in this family's treatment, sometimes together, sometimes in separate settings. We will sometimes speak in first person plural, and sometimes in the singular, to clarify who did what.

Our journey with the Farroud family began with a call from the adult Intensive Care Unit social worker. She was involved in the care of a gravely ill Kuwaiti woman with end-stage pulmonary fibrosis who had been put on the lung-transplant list. This social worker was concerned about the father's anxiety and what she described as disturbing behavior of the couple's two children, Abdul**,** four years old, and his sister, Leyla, age eight.

The social worker told us the Farroud family resided in Kuwait and had come to Switzerland for vacation. During the flight to Geneva, Mrs. Farroud felt short of breath to the point where she required oxygen on board. She became delirious and was rushed to the emergency room of our hospital by an ambulance that awaited her plane upon landing. Her condition was critical. She stayed for one week in intensive care due to significant hypoxia. She narrowly escaped intubation.

After a week, still on oxygen, Mrs. Farroud was transferred to a step-down ward. There, it was decided she needed a lung transplant. Because she was a young mother, even though she had entered as a tourist, Mrs. F. was immediately placed at the top of the Swiss lung transplant list and given full social benefits, including public housing, money for food and necessities, and permission for her children to attend public school. Because she was unable to travel and a transplant was not possible in Kuwait, the father accepted the hospital's proposed plan.

For this Arabic-speaking family with English as a second language, having to remain in Geneva, a French-speaking city, was a rude shock. The hope that it would be only a matter of time before Mrs. Farroud would get her transplant sustained the family. After that, they believed everything would be fine. Despite warnings by the doctors that Mrs. Farroud could contract pneumonia or encounter other complications that could prevent her from surviving until the transplant, Mr. and Mrs. Farroud transmitted a message of hope to their children.

FIRST CONSULTATION ON THE PULMONOLOGY WARD (DR. SCHWAB)

My first encounter with Leyla and Abdul occurred three weeks after their arrival in Switzerland, in their mother's room on the ward. Mrs. Farroud was sitting up in bed wearing her oxygen mask. She appeared bloated from prednisone, wilted and uneasy, saying that she feared becoming short of breath and emotional. I had the impression that, to protect herself, she kept her body and face as still as possible. Her slow, cautious, deliberate movements were in marked contrast to Abdul's psychomotor activity. He sat next to his mother in her bed, speaking to her loudly as if to turn her attention away from me, another annoying doctor. He played with her oxygen mask, moving it from side to side. Then, crawling on her legs until she flinched, he turned her face toward him so she would not forget for a moment that he was there.

Leyla, by contrast, sat silently on a chair far from her mother's bed. She fingered through a book but was clearly not reading it; rather, she paid attention to her mother's interaction with me. Mr. Farroud, just outside in the hall, was having a conversation with the Kuwaiti couple who had invited the Farrouds to Geneva.

I got up to close the door and introduce myself to Mr. Farroud. He immediately excused himself from his friends and came into the room, exclaiming, "Oh, Doctor, we really need you! I don't know how to handle my children. This is too much for me!" He explained the family had escaped poverty and family dysfunction in their native India through education and employment in Kuwait, without any expectation of support from extended family.

LEYLA AT EIGHT AND ABDUL AT FOUR (DR. SCHWAB)

I asked if Leyla could sit with Abdul in the hallway with the door ajar. This was a compromise given Abdul's separation anxiety. He drew pictures while I talked to Mr. and Mrs. Farroud in her room. Abdul tried to cling to his mother's bed; Mr. Farroud insisted he wait with his sister. Whatever Mr. Farroud said sternly in Arabic worked, but only after I had spent a good part of the session with the whole family together.

Mr. and Mrs. Farroud both described Leyla as “a joy,” a good student, very conscientious about everything she did, sometimes expecting too much of herself. They confirmed the social worker’s concerns that Leyla was displaying worsening signs of generalized anxiety, insomnia, and compulsive eating, to the point she had become mildly overweight.

On the other hand, Abdul had always concerned his parents. He was born prematurely and had to remain in the hospital for three months after his birth. After Abdul’s birth, Mrs. Farroud’s pulmonary fibrosis had worsened, and she began to have sustained periods of oxygen dependence. Despite this, until the trip to Geneva, Mrs. Farroud had been able to take care of both children with little help. Mr. Farroud had worked full-time in a food-supply business. Mrs. Farroud was, without question, the primary attachment figure for both children; it was to her they would turn when they were frightened. Abdul had almost never been separated from her before. In Kuwait, he had slept in his parents’ bed. Since the family’s arrival in Geneva, he had become an impossibly picky eater, and had trouble going to sleep. He would toss and turn, often awakening in tears, complaining about monsters, fatiguing Mr. Farroud in the process.

Mr. Farroud dreaded each time hospital visiting hours ended. Abdul had terrible, loud tantrums every time he had to leave his mother behind. Even worse for Mr. Farroud, Abdul had become “willful” and did not listen. He began to hit and even kick his father during his tantrums, something he had never done to his mother.

Despite their devotion to each other, I learned, Mrs. Farroud felt guilty that she had ruined her husband’s life, and Mr. Farroud had ambivalent feelings toward his wife. He was angry toward his family of origin. They had advised him to leave Mrs. Farroud and look for a healthy wife. He was angry at his wife for being ill and burdening him, and also for having changed so much since he had met her. He said with great pathos, “While I care for her so much, sometimes, with all this medical equipment and the changes in her body, I don’t recognize her—she’s no more the woman I fell in love with.” It was obvious that these issues needed to be addressed. Referrals were made for each of the parents.

I left this first meeting anxious about stepping into a situation full of both high expectations and great uncertainty. I felt for this family’s plight as foreigners who had planned a family vacation and now found themselves in a strange country, hard-hit by fate. It was a challenge to contain my impulse to reassure the family too much, to give them the impression that I could save the day. I contained the reality that their plight from here on out would be very tough. They faced the gravity of the mother’s illness, Mr. Farroud’s state of mind, a language barrier, two small children, and the Swiss bureaucracy. I could only reinforce with them the need to go step by step, day by day, and that I would be available to listen during regular appointment times.

At this point, I was the sole therapist for the family. At first I saw Abdul and his parents together and then Leyla individually while the mother was in the hospital. Dr. Schechter, as unit director and supervisor, told Mrs. Farroud that, in the event I became temporarily unavailable, he would see the family, in particular Abdul and his parents; I would see Leyla individually after Mrs. Farroud was discharged. We thus presented ourselves as a team.

FIRST INTERVENTION WITH THE ENTIRE FAMILY (DR. SCHWAB)

I asked that Abdul and Leyla come back into their mother's hospital room. In front of all four family members, I pointed out their strong points of resilience: "It is normal to feel frightened and angry under these circumstances. You are all worried about mom's health and want her home and feeling able to be there for you. And she wants that, too, but is stuck with this illness." I acknowledged the children's fear that they would be alone and helpless with their mother so ill and in the hospital, and how hard it was with Mrs. Farroud not spending nights with her family, so far from home. I said, "It is important that you know that you are not alone here in Geneva. We think that the sleep trouble, the compulsive eating, and the tantrums that Leyla and Abdul are experiencing are all signs of the enormous stress they are undergoing . . . apart from their mother in an unfamiliar foreign country. At the same time, they are worried about her as she is unwell, and so it is also hard to express disappointment and frustration to her. . . . It's hard for you to think about all this. So I am here to think about this with them and you."

Mr. and Mrs. Farroud thought Abdul was the most obviously affected. My concern, intuitively and paradoxically, was more about Leyla, who seemed withdrawn and older than her age. She was too compliant. I could see by her expression and body language, her biting her nails, and her hunger as she compulsively ate chips and candy, that she was suffering more than the parents had let on. Perhaps her parents were relying on her too much to fill her mother's shoes when Leyla herself needed a mother. I asked to see Leyla in individual sessions once a week, and to see Abdul together with both parents, while the mother was in the hospital. Meanwhile, I said to Mr. Farroud, "Abdul needs to be sure that you will keep on taking care of him, even if he acts badly or is mean to you. I think he understands that Mom cannot take care of him like she had before. He wants to know that you will do it and that you will try to understand what he wants and needs, even if he is too agitated to know those things himself."

Mr. Farroud seemed to be disappointed by my intervention. He wanted a child psychiatrist to fix everything quickly, by magic. Yet my intervention seemed to help Mr. Farroud feel more actively involved in the search for solutions and coping strategies. Near the end of the session, he looked at Abdul briefly and sadly, as if to resonate empathically with Abdul's neediness in the face of his mother's ill health, even if only for a moment that day.

LEYLA SEEN INDIVIDUALLY WHILE MOTHER WAS IN THE HOSPITAL (DR. SCHWAB)

We decided that I would see Leyla individually once a week, at first in the hospital outside of her mother's room. Leyla initially insisted that she was "fine." She said firmly several times, "At least, I am sure mom is going to be all right, and we will very soon be able to leave Geneva." I echoed what she said with a slight modification: "We certainly all *hope* mom will get better and that you and your family will be able to go home and get back to your life, not just all this medical stuff." She looked up at me fondly and began to tell me about her best friends, her school where she learned English, and her neighborhood back in Kuwait.

As I began to get a sense of her life back home, Leyla began to complain about Abdul. Annoyed, she said, "He's just so stupid . . . he always follows me . . . he never leaves me alone!" She then angrily confirmed that her father expected "too much" from her. She was expected to take care of Abdul and to keep him busy and well behaved. Precociously, she exclaimed, "I'm eight, not 18!" I said, "It certainly doesn't seem fair to be asked to be your brother's mother when you need a mother yourself!" Leyla then turned to explore my toys, as if the intervention had allowed her, at least in the safety of our session, to return to being a child.

In subsequent sessions, Leyla expressed alarm at the increasing frequency with which her father was losing control. She said, "He shouts at me now for little or no reason, as if he would turn crazy with his eyes all wide." She continued, "He doesn't even know how to cook. If it were only up to him we would only eat biscuits and milk . . . it would be completely different if mom were there."

Gradually, Leyla turned from exploring my toys to exploring my appearance. She became mindful of points of shared feminine identification. She liked my earrings and the color of my nail polish. We compared bracelets. She added that her mother had beautiful bracelets at home and had given her some of them. I said, "Talking about bracelets is fun. We both are girls, a little bit like your mother and you, and maybe talking about all these girl-related things is also something you miss a lot with your mom being sick." Leyla replied, No, I can still do that with her. It's just that she gained a lot of weight, and she's not as good-looking as before."

THE FAMILY MOVES WITH MOTHER TO A NEW HOME (DR. SCHWAB)

After three months, Mrs. Farroud's condition was stable enough to await the transplant outside the hospital. Social Services found the family a suitably large apartment, though in a suburb at great distance from the hospital, with only one bus line connecting the neighborhood to the rest of the city. Mrs. Farroud qualified for ambulette service; we hoped that, by coordinating her medical visits with the family's outpatient mental health visits, we could ensure them coming in.

I started to see Leyla in my office. We were all hopeful we could stick to a regular schedule. Dr. Schechter spoke to Mr. Farroud and proposed that he see Abdul and his mother while I saw Leyla, and Mr. Farroud would see his adult therapist downstairs. Mrs. Farroud declined her own therapy in order to be present for the children: "Therapy for me means restoring order to the home," she said. Focusing on the children's daily routine grounded her as well.

LEYLA′S FIRST OUTPATIENT SESSION (DR. SCHWAB)

Leyla spoke as she created flowers out of Play-Doh and then chose a game she used to play with a friend in Kuwait. After that, she took origami paper and began to create small animal figures. She explained she had learned to do origami from her mother.

With an exciting sweep of hope that took us both like hummingbirds flitting from toy to toy, I shared Leyla's wish that life would again be sweet. Only toward the end of the session did I realize that the activities Leyla had chosen vividly recalled her life back in Kuwait, when her mother was in better health. I said in response to this realization, "Now, as things are seeming to get back to life as usual, it is as if you would like to go back to a time when you didn't have all the worries that you have now, when you still were living in Kuwait." Leyla did not look up or reply. She put away the toys carefully, understanding that the session was ending. She began to worry about writing down our next appointment so that her dad "would not forget."

This period turned out to be more difficult than we expected. The family was no longer contained by the inpatient facility. The tasks of setting up a life outside the hospital as immigrants on a temporary medical visa infringed on our safe therapeutic space. Despite every effort, appointments were missed because Mr. Farroud was busy arranging his telephone, the children's school enrollment, bank accounts, and bill payments.

My next session with Leyla was a month later. In the interim, she had sustained a minor illness. We focused on the stress of adapting to a new school in a foreign language, in a new neighborhood where the family was clearly perceived as "foreigners."

Leyla insisted that all was well at her new school and at home, as if to reassure me as she needed to reassure her fragile parents. In the session, she made small, perfect Play-Doh flowers. I said, "I am wondering whether you are trying to reassure both of us [because] your mother is coughing more, and . . . as much as you might like to be close to your mother, you must keep a distance to protect her since you got sick. Also you must not complain or be angry, and you are worried your father might lose his temper. It seems that you feel you must show me that everything is fine."

Leyla again denied her feelings. She said, "No, I never thought that about my mother. Sick is just sick; it's not dead." I emphasized that, if I were in her place, I would feel scared my mother could die, and I would be very angry that I must act so grown up and not complain. But, I shared that I would find it hard to let anyone know for fear of hurting them.

Leyla pounded one of her Play-Doh flowers. "That feels good," I said. She laughed and flattened all the Play-Doh vigorously. I joined in. I felt we were making progress. My intervention provided a containing model of mentalization. I was taking Leyla's perspective, linking mental states of anger, fear, and frustration. While Leyla could not, at her age, explain why the intervention had offered relief, the angry pounding of the Play-Doh let us know she understood my message, cognitively and emotionally. She was relieved to have her angry feelings validated, in a safe relationship in which she could express herself, without fear of damaging me.

SOME INDIVIDUAL AND FAMILY SESSIONS (DR. SCHECHTER)

I met Mrs. Farroud alone in her hospital room, just after her discharge had been cleared. She told me she was comforted by the fact that Abdul had become calmer and more playful. He was eating better since she had become more available to interact with him. Nevertheless, she worried that she was easily becoming fatigued and dyspneic, and dying, and that "he would want too much" of her. She said, "I won't be able to keep up with him and he will not understand."

I reassured Mrs. Farroud that every moment she was emotionally available to Abdul would be a building block of their relationship together. At four, Abdul would be able to hold this in his mind when Mrs. Farroud could not be there. She found this idea consoling. Mrs. Farroud spoke of plans to cook meals and teach Leyla to cook for the family so that, if she were tired or "otherwise not there," they could eat her food. She showed me that she had written down instructions so that her husband and daughter could manage the home "responsibly," the way she wanted.

Mrs. Farroud impressed me with her thoughtfulness as a mother. Despite her shortness of breath and dependence on oxygen, I could forget that she was gravely ill; she was so able to be present, holding her children and husband in mind.

Two weeks later, Mrs. Farroud had moved to her new home and the entire family came to our outpatient offices. Dr. Schwab and I greeted the family in the waiting room, helping Mr. Farroud get the wheelchair that had been outfitted with a heavy oxygen tank out of the small elevator. We waited while Mr. Farroud hurried the children up the stairs.

We were very hopeful that October day. Mrs. Farroud was dressed in a beautiful emerald green traditional dress from her country, bedecked with gold bangles, necklaces, and earrings. Her hair was coiffed. Despite periodic fits of coughing, she appeared vital, calm, and engaged.

I asked Abdul to sit outside the office and draw while I spoke to Mr. and Mrs. Farroud inside. He protested and darted into my office, looking at a robot, a rubber snake, and a toy pistol on the shelves. Mr. Farroud reprimanded him and told him to put the toys back and wait outside. In a mentalizing mode, I suggested that I understood how it might be too exciting for Abdul, knowing that mom and dad and all the toys were in my office, but that he had to wait outside. Mr. Farroud took him outside with the toys so I could talk briefly to Mrs. Farroud. She said she was relieved to be home and at the same time eager to have her lung transplant; the call could come anytime. The hospital had given her husband a special cell phone for the purpose of receiving the important call. She prayed she would have enough strength to keep up with the children before that. “They don’t leave me alone,” she said. “I am so exhausted—even after going to the toilet. And as soon as I close my eyes, Abdul jumps on the bed and wakes me as if he is afraid that I won’t awaken.”

“How difficult that must be for you!” I said, “And for him.” I suggested that Mrs. Farroud try as much as possible to schedule even fifteen minutes of full attention to Abdul and then to Leyla, and then to structure something for them and their father so that she could rest.

Mrs. Farroud told me that Mr. Farroud was having trouble with the children. His temper could flare too quickly.

Abdul then knocked on the door. Mr. Farroud apologized. Once again I spoke for Abdul: “Abdul does not want to be left out. He wants all the time he can have with mom.” Mrs. Farroud and Abdul smiled, looking at each other. Then Mr. Farroud began to play with the toy cars, as if he needed to divert attention from what he feared would provoke anxiety.

I suggested we sit back and see what Abdul wanted to do. He took the toy pistol and fired it at his father, who looked to me for help. I explained that Abdul was doing what boys often do at his age, and that we men might play along. “But he acts very naughty, Doctor,” Mr. Farroud said. “He does not listen." I said, "I think he and you have had a very trying time since you arrived in Switzerland. Now that mom is home, she's still not well enough. Abdul wants to make up for lost time, playing and having her around."

In the play with Abdul, I put up my hands and said, "Oh, no! Are you the police or a robber?" Mr. Farroud answered for Abdul: "He says he is robbing you, Doctor." I responded, "Oh, you can have everything I have." Abdul then pretended to take as many toys as he could. He put them in his mother's lap and asked his mother, "Can we take them home?" Mr. Farroud said, "No, they are for playing when you are here with the doctor."

Mrs. Farroud reassured her husband, "Relax. We will give the doctor the toys back." Her understanding of Abdul's needs in the face of the father's stress was moving. She was helping regulate both her son's and her husband's anxiety. I wondered what Mr. Farroud would do without her.

In this exchange, Mrs. Farroud showed that she could hold Abdul's pretend play in mind. Unlike her husband, she did not get stuck in the content of Abdul's communication. She understood his wish to hold on to something of his session with me. Her capacity to retain this mentalizing stance was precious to our work. It was a foundation to build upon in the face of her husband's worries and preoccupations. Mr. Farroud understood it was impossible for his wife to be her former consistent and healthy presence in Abdul's life. Because one of the two parents could provide a foundation for the children's development of mentalization, the therapeutic work was less difficult.

I looked forward to the next session but then noticed Mr. Farroud anxiously looking at his cell phone. I remembered we were on borrowed time. I raised the issue, "Do the children understand that mom may at once have to return to the hospital?" "Yes," Mrs. Farroud explained. "They helped me pack my bag. which is all ready. We put toys and pictures in it."

Abdul then became more frenzied in his play. He took down one toy vehicle and animal after the next, and then the medical kit. He began to give us all injections. "You are taking good care of us, especially mom," I said.

I recognized that a transplant was a risky procedure. My mind turned to the transience of our time together. Mrs. Farroud commented on the toys Abdul was shifting back and forth. She paid appropriate maternal attention to support Abdul's exploration, despite the difficult conversation we adults were having. I said, "The children have given you toys and drawings for your journey, and what do they have of yours?" Mrs. Farroud said she had prepared photographs, her scarves, and jewelry for Leyla, and lists of things to do. She had cooked. She planned to give Abdul her pillow to guard. Mr. Farroud anxiously checked his cell phone messages. He looked stressed: "She has prepared everything, Doctor. She spends hours cooking and putting the food into containers. Our freezer is full. She thinks of us always."

Reassured, I encouraged Abdul and his mother to play. From her wheelchair, she held the treasures he was finding in her lap and pretended to take the medicine he offered her.

At one point Mrs. Farroud laughed, triggering a coughing spell that would not stop. Abdul looked frightened. I turned his attention to play with toy ambulances to give space for Mr. Farroud to help Mrs. Farroud. It was to no avail, and Mrs. Farroud asked to be excused from the room. Our time was clearly fragile.

When Mr. Farroud left the room, Abdul followed. I heard Mrs. Farroud coughing and wheezing in the bathroom. She was very much out of breath. It was then time to get to her pulmonologist appointment. Abdul followed his parents out, with my toy car and pistol in hand. I gently said, “We must save those toys here for you for next time.” Mr. Farroud told Abdul he would get him an ice cream if he gave back the toys, and he did. None of us knew that was to be the last session with Mrs. Farroud.

HOPES DASHED AND REDISCOVERED (DR. SCHECHTER)

Shortly after the previous session, Dr. Schwab and I were called upon to address racially motivated bullying at school that had left Leyla in tears. A few days later, a lung donor was found, and Mrs. Farroud was transplanted. However, despite an initially promising recovery, under immune suppression she developed fulminant meningitis. She died two days later.

We all felt the carpet had been pulled out from under us. We maintained cell phone and text-message communication through very dark days. Mr. Farroud initially called to cancel the children’s appointments, but we were able finally to schedule an emergency family session with Mr. Farroud, Abdul, Leyla, and both of us therapists.

Mr. Farroud came in talking very loudly on his cell phone. The enormous stress he was shouldering was palpable. Speaking to us, he talked too quickly, frequently sighed, and then raised his voice abruptly. He told us that members of his extended family were wanting to come for the funeral, demanding more than they were giving. He felt we understood his needs as a now bereft single father with two children, in a foreign country, dependent on social services. He needed to make arrangements with the mosque, hospital morgue, funeral home, and public officials. Because his wife’s transplant and death had occurred outside of Geneva, he had to deal with two different bureaucracies to arrange the funeral.

Mr. Farroud was overwhelmed. He could not even think about his family’s future. He looked tired and sad. He expressed rage toward the medical team that had taken care of his wife, how they had simply announced their condolences and left him on his own.

Leyla sat in silence across the consulting room from her father and Abdul. Mr. Farroud was thinking of asking Mrs. Farroud's younger sister to marry him to replace his deceased wife, as an obligation to her family. This was a past cultural tradition.

Leyla looked ill as he spoke. She avoided eye contact. Her behavior seemed to make Mr. Farroud anxious. He said, "She doesn't say anything since it happened. She's just like her mom . . . she hides her feelings." He turned to her: "Please, Leyla. Talk to your doctors. I can hear anything."

In a frenzy, Abdul took his favorite ambulances and cars, the medical kit, and the toy pistol. His father turned to him and with a sense of frustration, he said, "He acts as if nothing has happened. He doesn't understand! He keeps asking when we are going to see mom at the hospital."

I held off explaining that Abdul's behavior might be expected at an age when children often tend to show exaggerated egocentric concerns following loss. I put myself in Mr. Farroud's place. He had given so much to his wife and was now expected to give much to his children, at a time when he felt cheated and emotionally wrenched.

As we have described in our research, traumatized parents can become unavailable to attend to their children upon reunion (Schechter et al., 2010). What becomes transformative is the therapist jointly attending with the parent to avoided affects and memory traces (Schechter et al., 2006). With tears welling up in his eyes, Mr Farroud asked us how to talk to his children. "What do I answer to my children, Doctors? I don't want to say the wrong thing!"

Dr. Schechter responded, "It is so sad to think about and say that you can no longer visit mommy in the hospital, that you cannot see mommy moving, talking, or breathing anymore. You cannot make new memories with mommy, true. But you can never lose the memories that you already have with her. She is forever in your hearts and minds." Mr. Farroud looked at his children to see if they were all right. He seemed reassured. He repeated in Arabic, "You can visit mommy in her heart and mind." These words seemed to reassure him as much as his children.

NEXT SESSIONS WITH LEYLA (DR. SCHWAB)

Five days later, Leyla arrived with a long face. Mr. Farroud reported she had had a tantrum because he refused to buy her a dog, a longstanding wish that had intensified with the loss of her mother. Leyla explained that the family could not own a dog or cat while her mother was alive because of the risk to her health. Now Leyla wanted a dog. Mr. Farroud, clearly overextended, was enraged with his daughter.

With her father safely outside in the waiting room, Leyla seemed more relaxed, but she avoided saying what she was feeling. The coherent narrative I had heard in the session before her mother's death was replaced by a confused, traumatically charged account of her experience of the transplant, from the time her father's cell phone rang to the long waiting in the "other hospital." What was most difficult for Leyla was her father not telling her directly about the complication after the surgery. She said, "All of a sudden, dad said that we had to do drawings to say goodbye to mom." The nurses invited the family to see their mother before her body was removed. Leyla said, "She wasn't moving at all . . . and her face . . . oh . . . it looked so different. . . . It was not my mother anymore." She became silent, and then said, "I can tell you that I am angry at the doctors at that other hospital—and even at God—even though dad says that this is wrong. I want to go back to Kuwait as soon as possible!"

The following session, two weeks after the funeral and after the departure of extended family, Leyla came in smiling as she had before her mother had died. "Today, I do not want to talk about sad things!" she said.

Leyla went to the treasure chest where we kept her drawings and crafts and took out a drawing she had done the week before her mother died. It depicted a pirate boat, with a muscular captain managing his crew. She attached a second sheet of paper to that drawing with tape and she extended the sea. Then, she drew a big red cross under the water and whispered to me, "It's the treasure, and the pirates are looking for it. There are three pirates . . . but then a fourth one comes, who helps them to find the treasure. . . . He will divide it up evenly for the other three." I asked, "He doesn't keep anything for himself?" Leyla answered, "No, he wants to make the other people happy." I inquired, "Are you like that sometimes?"

Leyla did not respond. She quickly switched to another activity. "Let's cut out paper snowflakes!" she said excitedly. While we both worked at cutting out patterns from folded paper, Leyla spoke about how she saw that snow had fallen on the mountain peaks surrounding Geneva. As we finished our work for the session, Leyla said quietly, "My mother told me that I had once seen snow, on a visit to the mountains in India, when I was very small, like Abdul. I don't remember it, but I remember my mother telling me." I said, "Perhaps together we are making snowflakes that look like the ones you saw with your mother." Leyla insisted that I keep mine in her treasure box in the office and that she take hers home to remember our sessions together.

ABDUL AND MR. FARROUD AFTER MRS. FARROUD'S DEATH (DR. SCHECHTER)

While Leyla was having her session with Dr. Schwab, I saw Mr. Farroud and Abdul in my office. Mr. Farroud repeated that, no matter how many times he told Abdul his mom was dead and that she could not come back, he kept asking where she was. “Abdul asks lots of strange questions and I don’t know how to answer. He asks me out of the blue, ‘Mommy is where?’ I told him that her body was in the hospital but now her body is in the ground. Then he asks, ‘When is she coming home?’ Then he gives me a picture or a flower and he says, ‘This is for mommy. You will give it to her?’ Doctor, I cannot sleep. I think I just need sleeping pills. . . . Sometimes he asks me if mommy is crying because we are not with her.”

“You feel like crying when you hear these questions,” I said, noticing Mr. Farroud’s tears welling up. He answered, “Yes, but I must focus on organizing everything. What do I tell Abdul? I say mommy cannot cry.” I commented that it might help Abdul, and him, to think that Mommy is comfortable, that she no longer coughs, that she is happy he is playing and thinking of her.” Separation reactions and images vividly expressed by young children can pierce adult caregivers’ defenses, their “protective shield” (Freud, 1920; Schechter & Willheim, 2009: Coates, Schechter, & First, 2003).

Mr. Farroud had trouble focusing on what I was saying. He raised his voice, as Abdul played more vigorously with crashing cars and asked his father to take down the toys from the highest shelf. Mr. Farroud said, “These kids want so much. This one does not let me think. He is always talking, always wanting something, more and more.” I responded, “I bet you can feel like that, too. You just lost your wife, your companion, the mother of your children. And when the kids are letting you know they want more from you, you feel everything that you have lost. And rather than all three of you together sharing this tragic sense of what you have lost, you feel burdened.”

Mr. Farroud became tearful for a moment. He turned to the cultural details that he needed to carry out. He would be obliged to go to Mecca with the children to pay homage to his deceased wife within the month. I felt these adult realities, while important, were foreclosing prematurely on the moment of connection we were sharing, and on his sense of loss and Abdul’s. I had shared from the beginning of our work together that we must treasure the moments we have, and take mental pictures to hold them in our minds, as we never know, given the complexity of life, when we will next see each other and under what circumstances. “Yes, Doctor,” he said. “I should slow down and let you help Abdul.” In a mentalizing stance, I replied, “Together we can help Abdul by thinking about what a four-year-old boy might want and need to know.”

I took the book entitled *The Invisible String* (Karst, 2000) from my shelf. I sat close to Mr. Farroud and Abdul, who looked up from his toys at the illustrations as I read the book. In the book, an uncle is said to be in heaven. The child in the story maintains an invisible string to connect with him. An illustration shows a starry night. Slowly and quietly, I made eye contact with Mr. Farroud and Abdul. I said, “Mom is like the uncle in the story. She has gone by now from the hospital to heaven. You will always have a connection to her. You can see her in your heart and your dreams.”

Abdul, with fascination and excitement, repeated in clear English, “Mommy in the sky.” When I closed the book, Abdul got up and asked to play with a wind-up robot on my shelf. “Not moving,” he said. I responded, “We can make it move by winding it up.” I showed him how to turn the key. He did this repeatedly. I explained to Mr. Farroud that children his age do not understand, as Leyla did, that death is final. It is not like cartoons where characters come back again and again, so it might help Abdul to think of his mother in a happy place that he could imagine.

In accordance with their faith, Mr. Farroud organized the family pilgrimage to Mecca. We at that point did not know when or if we would see each other again. Tolerating uncertainty while steadfastly accompanying the family as they allowed us to accompany them was the best we could do.

Some who are analytically trained could view this unpredictability as defensive. In cases such as that of the Farroud family, we find that such an interpretation would not be constructive. A helpful analytic stance in the face of overwhelming and unpredictable events involves bringing to light the reality and implications of traumatic loss, and is as much a preventive intervention as a definitive treatment. We attempted to understand, clarify, and contain trauma-related affects while sensitively confronting the Farrouds with reality. This modeled a therapeutic, reparative relationship and a secure base that could later be fortified and extended in subsequent treatment with another therapist, in a different country, in their native language. We tolerated and maintained reasonable flexibility with the family’s comings and goings, and empathized with the harsh external realities that impinged on the development of a deeper process at the time.

NEXT SESSION WITH LEYLA (DR. SCHWAB)

For the first time in treatment Leyla described a dream: “I went to someone’s house. He was a terrorist but we did not know it.” I remembered that Leyla and Abdul had been bullied and called “little terrorists” as a racial-ethnic slur. She continued, “We were having something to drink with dad, and the terrorist tried to shoot my mom. I screamed, ‘No! Please don’t shoot!’ But he did anyway, and she was dead. I called the police and they caught him.”

I said, “That’s a terrifying dream,” “Yes, it woke me up” she answered. I asked, “What was most scary about it?” Leyla replied, “I couldn’t stop this terrorist. And it was as if dad could not see what I could see, and I had to do something, but it was too late.”

I explained, “That’s too much to put all on your shoulders. But despite that you could not do anything to save your mother, you were able to call the police in the dream. And you stopped that terrorist before he could hurt someone else. So while it is a scary and sad dream, yet you do something good to help other people.”

In speaking about the manifest dream, we focused together on the obvious traumatic elements. My analytic understanding was that Leyla’s felt rage toward her mother for her illness and death, and that her Oedipal strivings might come into play. These thoughts were in my mind but left uninterpreted. Leyla’s anger at her father for parentifying her was also left untouched. Leyla associated to the dream, however, by saying that her father could be very annoying as he “burn[ed] the food and talk[ed] on the cell phone endlessly,” leaving Leyla to attend to her brother.

Leyla had a hard time leaving the session. This was a new occurrence. On her way out, she offered me gifts from her treasure box that she made herself, drawings of Christmas stockings that I could use to decorate my office for the holidays. One gift was a ring made of paper. She said, “You must never take it off,” with a huge smile on her face. I brought up our separation, saying, “This ring looks like a life-long link, doesn’t it?” Leyla said, “Yes, it is.” I responded, “We both don’t know when you will leave for Mecca, which means we never know when we are going to see each other again. These gifts are maybe a way for you to make sure I will not forget you even when you are away.” Leyla replied, “You got it!”

FINAL SESSIONS WITH THE FARROUD FAMILY (DR. SCHECHTER)

The family returned after their visit to Mecca. Leyla began the family session by saying, “Abdul says that he wants to go to the moon.” Mr. Farroud echoed, “Yes, Doctor, he says he wants you to take us all to the moon and back. He told us in Mecca, ‘When we get back to Geneva, Dr. Schechter will take us to visit mommy.’” Leyla said, “I told Dr. Schwab that I think mommy is not on the moon but that she is on a star.” I (Dr. S) said, “You each have your special and very beautiful places for your mom. It feels good that we can imagine her in such beautiful places in our dreams and in pictures we draw.”

I offered the children paper and crayons. Both drew their versions of where their mother was. Abdul drew a frenzied scribble-galaxy of blue and purple with a green circle with rays emerging above the scribble. I asked what he had drawn, and Leyla explained, "He says the blue and purple part is Kuwait and that the green is Mommy on the moon."

In the final sessions, many converging images were brought in, including: the star of Bethlehem (related to the approaching Christmas holiday); the mother's shiny bangles and beads during her last visit with us; the star and crescent moon associated with Islam and the pilgrimage to Mecca; the illustration in the book *The Invisible String*; and the star-like snowflake that paradoxically warmly bound Leyla to her mother's memory. A new intrapsychic constellation had emerged, co-constructed between Mr. Farroud, Leyla, Abdul, and both of us therapists.

Ironically, after the powerful spiritual journey the family had taken to Mecca, the feeling among the children was that they had found something of a temporary home with us.

But a new blow fell. Dr. Schwab and I met with Mr. Farroud while the children drew quietly in the waiting area with the door ajar. He told us that now that his wife had died and had been buried within the time accorded by Islamic law, the family's visas would expire. They would have to return to Kuwait. He had to start anew, finding a new job, a new home, and new schools and caregivers for the children.

LEYLA'S FINAL SESSIONS (DR. SCHWAB)

It was difficult to discuss yet another loss with Leyla. She was mad to have come back to Geneva only to say goodbye. If she could have gone from Mecca to Kuwait, everything would have been fine, she said. Mr. Farroud said that on the plane back to Geneva, Leyla had begun to suffer stomach cramps and headaches, and she had resumed waking up during the night. Mr. Farroud said when he talked to family members and people in Kuwait about moving back (without telling the children), he was sparing the children worry about the possibility of moving to yet another city. But at least it would be in Kuwait.

Neither Leyla nor I really knew if this session was to be our last, just as we had never known if her mother would survive to be transplanted, or get to go home, or live or die after the transplant. What was certain, amidst this uncertainty, was that we had shared the ambiguity, as difficult as it was.

Mr. Farroud told the children they would be leaving Switzerland to go back to Kuwait, but not to the home or the city where they had previously resided. He did not know all the details; he was waiting to hear about a job assignment from his former company.

I had one further session with Leyla, in which she was able to play with this "maybe, maybe not" concerning her future. We decided to say goodbye to each other with the idea that we could always say hello again. We did not know if we would see each other after the Christmas holidays. Leyla took my business card, with my email address. I told her we should always be able to be in touch and find each other.

ABDUL'S LAST SESSION (DR. SCHECHTER)

As Mr. Farroud had to accept a cell phone call related to his job assignment in Kuwait during our session time, I invited Abdul into my office and left the door open slightly so Mr. Farroud could come in. Abdul was at ease, with no apparent separation anxiety. After looking to see that the usual toys were present and setting aside a car, an ambulance, and the pistol, he took out crayons and paper and started to draw. Again, he drew a blue and purple scribble; but this time a rocket came out of it, with a red scribble to the side. I asked what it was. Abdul said, "Visit mommy . . . mommy on moon." We played as Mr. Farroud explained that it was important for him to answer his calls. Abdul did not budge.

After Leyla finished her session with Dr. Schwab, she came into my office and started to draw. Both children drew quietly as I looked on. I told Leyla that I thought her brother wanted to visit their mother on the moon. She spoke to him in Arabic. Then she laughed and reported, "Now he's drawing himself and mommy on a beach on the moon!"

Leyla meanwhile drew an elaborate multicolored picture—the sea, hearts, shells, stars, wind and waves, birds and flowers. A big pink amoeba-like mass was in the sky. Leyla explained that it was Kuwait. A big red star with a pink letter "M" was in the middle. I asked her what it was. She said, "These are all the things that mommy liked and that I like—and there is mommy on the red star!"

After two months of attempted contact, we received a thank-you letter from Mr. Farroud. The family had finally landed in a place where they could stay and recover. Dr. Schwab has since received several emails from Mr. Farroud describing their new life—most recently this past Christmas, maintaining the reparative connection we had created through loss. Through the Internet, *The Invisible String* took on a new meaning.

DISCUSSION

We come to the end of our trip to the moon and back, with its dark and bright aspects. Death stopped for us, but only for a short call; then, the carriage, or rocket, kept on traveling, with us therapists on board.

We observed many discontinuous, random, and unclear points of light and darkness from the different perspectives of the travelers, the Farroud family. Their fragments of experience, in the context of trauma, did not link together to form a coherent narrative. New intrapsychic representations of the lost mother and wife who, despite her illness, provided a solid secure base for the family; it was generous, nurturing, and reflective. The mental representation of a lost parent has been noted to be an important sign of coping with loss, reinforcing children's resilience (Silverman, Nickman, & Worden, 1992).

As therapists, we appreciated how Mrs. Farroud had provided for her family; in the darkness she could see ahead. We had worked to give that gift back to the family. From the vantage points of Mr. and Mrs. Farroud, Leyla, Abdul, and us two therapists, the story of Mrs. Farroud's tragic medical crisis, hope before transplantation, and unexpected death on a planet called Geneva made more sense as we worked together. In the children's symbolic play and drawings, they were able to overcome many traumatogenic elements in their mother's loss while preserving her as a guiding light. Mrs. Farroud was able to maintain what Winnicott (1956) called a primary maternal preoccupation. Even during her dire illness, Mrs. Farroud continued to be sensitive to the needs of her children and husband; she was acutely aware of their impending loss. In turn, the family formed a strong positive maternal transference to us during this dark period, and this ultimately helped brighten the children's outlook after her death. Leyla was able to develop an increasingly coherent narrative, and Abdul was able to hold a positive representation of his mother in his mind's sky.

We do not mean to paint too sunny a picture. But we have provided an example of a family whose risk for further trauma and disorganization increased with time, but they were helped using a model of psychoanalytically informed consultation-liaison. We provided them flexible accompaniment across in-hospital and outpatient settings, using individual, dyadic, triadic, and family frames, in pre-mortem and post-mortem periods. As we accompanied the family, we maintained a sense of constancy, a psychoanalytically minded, developmentally informed, relationship-based, mentalizing stance (Schechter, First, & Coates, 2003).

Our mentalizing stance was evident in how we identified salient affects, and considered links from one affect to another, from verbal content to affect, from possible intents and psychic conflicts. We used verbalized clarification, confrontation, and interpretation. Our mentalizing stance was also embodied in gestures, nonverbal expression, and somatic states and sensations, as described by Shai and Belsky (2011). For example, Leyla's demonstrative pounding of Play-Doh was met by her therapist's smile and accepting regard. We joined the nonverbal with the verbal, allowing the therapists to express a bit of anger or laugh without worrying about hurting anyone.

As time moved forward, Leyla was forced to confront the grim reality of dashed hope, and she felt profound sadness. At the same time, she also expressed more anger, mainly toward her father. Reality was too acute, too traumatic to give her the opportunity of tolerating ambivalence toward the same parental representations. It had to remain split. Gill (1987) has described how premature death of a parent both resonates with and renders too frightening the Oedipal fantasy that seems to become reality.

In our work, we remained aware of these interpretations but never made them explicit to the patients in this time-limited treatment. We worked with Leyla to help her tolerate conflicting feelings and identifications with her mother (e.g., through both cooking and gaining weight), and with Dr. Schwab (e.g., comparing nail polish and jewelry). We held in mind Abdul's age-normative reactions to his mother's illness and death, and played and spoke with him accordingly. In Mr. Farroud's presence, we took Abdul's perspective to address his needs, and in so doing modeled how Mr. Farroud might address Abdul's needs. This is a straightforward application of Fraiberg's model of treatment (Fraiberg, Adelson, & Shapiro, 1975).

In parallel, we worked with Mr. Farroud so he could empathize with his daughter's point of view and better tolerate his children's needs and expressions of anger and neediness in the face of their traumatic separation and loss. Clearly, the threat to their primary attachment imposed by Mrs. Farroud's illness and death became more salient themes; pre-Oedipal themes and annihilation anxiety moved to the foreground. Our role became more of containment, as positive transference objects and as real people, outside the endangered family who could serve to anchor the children in a safe harbor while the storm raged around us.

One of the most potent transformative factors was our ability to assure, as much as possible within an academic medical institution, a predictable, safe, containing frame. We aimed to hold sessions on the same day of the week and in same place. Also, while we allowed the expression of repetitive traumatic play themes, we ensured that people and property remained safe. We actively intervened, to confront avoided affect and ensure that what had no resolution within the child's possible control in reality could reach symbolic resolution in play or drawing. Abdul's doctor play, for example, could be understood as a defense against helplessness and separation anxiety.

Also important in the treatment of this family was the mutual support and reflection between us as therapists. In a way, we searched for the Farroud family together, in parallel to the two children's search for internal representations of their mother after she died.

The co-construction of memories and narrative linked the children in our intervention, first with mother present, and in a new way after she was lost. Our work provided a transitional space, a launching pad for the children to go out into the world with nurturing memories amidst the stark ones, memories shared with us as mentalizing clinicians.

We have highlighted several essential ingredients to our work: maintaining a developmentally sensitive position vis-à-vis our child patients and their families; working with the children both within and from outside their relationships with parents, siblings, and ourselves as therapists; and taking a mentalizing stance. The latter enabled us to model and support existing capacities to consider what was going on in the family members' minds and in the minds of others, even when traumatic stress and grief seemed to make that alomst impossible.

NOTE

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Chapter Fourteen

Father Quest and Linking Objects

A Story of the American World War II Orphans Network (AWON) and Palestinian Orphans

Vamık D. Volkan

Psychotherapeutic efforts are traditionally personal and private, but also occur in broader historical, social, and political contexts. Many people suffer great losses due to wars and other kinds of collective tragedies, including children who lose parents. For these individuals, a traditional treatment may not be available or sufficient.

In this chapter, the renowned psychoanalyst Vamik Volkan tells of his work for many years with a group of people, now adults, whose fathers died in World War II, when they were children. Their experiences of parent loss, as Volkan describes with absorbing nuance, are complexly intertwined with past and current government policies toward these "orphans," shifting gender and political realities over the last decades of the twentieth century, and dynamics in their families and communities. Ultimately, with Volkan's involvement, they find a collective voice and form an organization that has facilitated healing for many of them.

Volkan's connection to his work with the World War II orphans was intimately informed by his psychoanalytic thinking and sensibilities. His recounting of his work with the orphans is interwoven with excursions into theory, his personal experiences as a Turkish Cypriot, and his recent research experiences at an orphanage for children who lost parents in the Palestinian intifada.

In Volkan's theoretical frame, the reader will find here lessons that can inform both psychoeducational and psychotherapeutic efforts with children who lose parents in large-scale disasters, such as war and civil conflict. It is unmistakable that Volkan has facilitated their unearthing and telling of healing stories through his committed involvement with the World War II orphans, *and at its center, his availability as an exquisitely sensitive and attuned listener.* —Eds.

This chapter describes my nineteen-year involvement with and observations of nearly two hundred persons in the United States who lost their fathers during World War II when these persons were children or in some cases before they were born. These individuals, as children, developed only fantasized father representations. As adults, they became involved in "father quests" and were driven to find "linking objects" or "linking phenomena," which enabled them to psychologically connect with their fathers' mental representations. Through such activities they were able to develop more realistic mental representations of their fathers and mourn their losses. I will draw upon my experiences with this group of orphans, as well as written and verbal data I obtained when I asked them to describe their conscious efforts to develop the ability to mourn as adults. I will also describe my work with fifty-two children at a Palestinian orphanage to further illustrate the adaptive utilization of linking objects and linking phenomena.

AWON

It is estimated that when World War II ended there were 180,000 children in the United States who had lost their fathers. The United States government officially called them *World War II Orphans* even though their mothers were still alive, and financial support was provided for them through their teen years. Some states also provided funds for their support. Many of the "orphans" who were accepted to colleges and universities were given stipends for four additional years. In the late 1980s, a group of these orphans began getting together, and in 1990, they founded *The American World War II Orphans Network (AWON)*. At the present time AWON has nearly 900 members.

As children, with the help of persons in their immediate environments, the members of AWON slowly created mostly or totally "fantasized mental representations" of their fathers. These representations responded to the children's needs, wishes, fears, and identity formation processes. Since their fathers had died or disappeared amidst wartime circumstances that had increased nationalistic pride, most of the time such fantasized mental representations were grand, very rigid and mysterious. Correspondingly, as children, most of the AWON members experienced their own self-representations as "special." They felt different from other children whose fathers were still alive.

There was a second loss for these children. Since their mothers (and other important persons providing mothering functions for them) were themselves in mourning, the children lost having mothers who were emotionally well-anchored and ready to enter into responsive engagement. On occasions young widows were shunned by their women friends who thought that the widows might be dangerous objects who would take away their husbands. In other homes, a mother who was remarried would keep the orphan's father's image present in her new home, but in split fashion. She might wear two wedding rings or keep all concrete items associated with her dead husband only in the orphan child's room. If their mothers had remarried and there were stepsiblings, the orphans sensed that they were different from their stepsisters and brothers who had the same last name as the man who was sleeping with their mother. In such homes, their biological fathers' names were often not mentioned at all except when the orphans were alone with their mothers who might whisper their first husbands' names. Some orphan children were totally deprived of items that had belonged to their biological father, such as photographs, medals, or books.

There were further losses. I heard stories about how a father's death changed the family's financial fortunes, sometimes causing the family to move to a new location, depriving the child of familiar home and friends. Government officials would also visit the family of an orphan every year or so and investigate how the mother used the government money allotted for the orphan. I learned that mothers would experience anxiety about such visits. Some orphans who felt humiliated and abused by stepfathers or stepsiblings did not remember such official visits, but as adults they wished they had known about them as children.

Many of the mothers of the World War II orphans who were experiencing complicated mourning could not help their babies or small children in some aspects of their developmental struggles. These mothers often supported their offspring's specialness. Feeling "special" increased AWON orphans' narcissism, however, it was often hidden under a sense of shame. Most of the nearly two hundred orphans that I got to know, besides feeling "special," also spoke of feeling "shame" as children, feelings which lasted for years or continued to exist in adulthood. When these orphans were, for example, asked by a teacher to speak or write about their experiences with their fathers, they would not talk about their fantasized images of their fathers because others could not understand them. Such father images and corresponding self-images had to be hidden. Feeling shame functioned as an envelope in which a narcissistic core would be hidden. Furthermore, some of the orphans had identified with their mothers' feelings of shame, such as when their mothers were shunned by women who had husbands.

I do not wish to imply that the AWON members are people who are overwhelmed with psychological problems. Many of them are well-educated and highly successful: judges, military officers, psychologists, social workers, and other kinds of professionals. However, in their internal worlds, many were stuck in complicated childhood mourning processes that were never-ending. They later would name this "obligatory" psychological preoccupation their "father quest." Throughout their lives, they needed to find "him" in their lives, in their spouses, in their professions (Hadler & Mix, 1998). This in itself sometimes created psychological difficulties.

CONCEPTUALIZING ADULT-TYPE AND CHILDHOOD MOURNING

Freud's (1917) "Mourning and Melancholia" is the first paper that deals with internalized object relations. It refers to the object relations and internal work of an *adult mourner*. This internal work concerns the images of a lost object and the fate of the mental representation of this object. Here I use the term "representation" to refer to a collection of images.

Adult-type mourning can be divided into two phases: (1) the grief reaction, and (2) the work of mourning. The grief reaction includes responses such as shock, denial, bargaining to reverse the outcome, pain, and anger, which eventually lead to the beginning of an emotional "knowledge" that the lost object is gone forever. Before grief is completed, the work of mourning begins. This phase of mourning involves a slow process of revisiting, reviewing, and transforming the mourner's emotional investment in the images of the lost object. The work of mourning refers to an internal encounter between the images of the lost object and the corresponding self-images of the mourner.

Since unassimilated mental images of lost objects remain in our psyche even when they are tamed, shrunk, repressed or denied, adult-type mourning, in a sense, never ends until the mourner dies (Volkan & Zintl, 1993; Kernberg, 2010). What the completion of a "normal" mourning process means, as Veikko Tähkä (1984, 1993) stated, is the mourner's making the mental representation of the lost person or thing "futureless." The object representation of the lost item has no future. A young man stops fantasizing that a wife who had been dead for some time will give him sexual pleasure, for example. Or, a woman stops wishing to boss her underlings at a job from which she had been fired years before (Volkan, 2007a, b). The mental representation of the lost object may be temporarily activated only during some special occasion, such as when a young woman dreams the night before her wedding day about her dead mother, or a person recalls a lost one during a very specific anniversary of a past event. The normality of adult-type mourning also refers to a mourner's ability to identify with some positive aspects of the mental representations of the lost object, to assume the ownership of the assimilated images' ego and superego functions, to "play" with the lost person's unassimilated internal images without being overtly preoccupied with them, and to turn such "plays" into sublimated expressions. A young man who had been a rather irresponsible person before the loss of his father, for example, can become a serious businessman like the deceased. Adult mourning, when not complicated, includes psychological gains after losses.

Very small children do not have a firmly established mental representation of another person. As described long ago by Robert Furman (1973) and Erna Furman (1974), small children cannot mourn as an adult would. A significant loss, to a small child, is experienced as a tearing away. Preoedipal children who lose important figures in their lives sense that something is missing, a sensation not unlike the feeling of being hungry. In order to understand how any given small child is likely to react to a significant loss such as the death of a parent, however, there are a number of considerations: the child's age, the type of loss, the security of the home environment, the ability of the adults to provide substitutes, and innate resiliency. The more experience a growing child had with the lost person or thing, the more he or she is able to maintain the mental representation, and the closer the child's mourning will be to an adult's. Even when children learn what death is on one level, a belief in its reversibility remains, however hidden it may be. As David Dietrich (1989) stated, a lost parent becomes a "lost immortal" figure—a haunting experience. After age nine or ten, children have a more realistic concept of death and its finality.

Martha Wolfenstein (1966, 1969) argued that the "normal" adolescent passage (Blos, 1979) provides a model for an adult type of mourning. Youngsters learn how to modify or even let go some childhood images and change, to one extent or another, mental representations of others who were subjects of their childhood attachments and other types of intense relationships. When the AWON members went through their adolescent passage, their lack of actual experiences with biological fathers, and their "need" to protect their own specialness, at that time interfered with taming or loosening the rigidity and specialness of their fantasized father representations or with letting them go. The AWON members whom I got to know could not fully "learn" adult-type mourning. They could not make their fantasized father representations "futureless."

As I became more closely involved with the AWON group, I noticed how the members began to utilize their existing, and newly found or created linking objects and linking phenomena (Volkan, 1972, 1981) to turn their fathers' mental representations into more realistic ones, and I also noticed how, as adults, they began adult-type mourning. Before telling some of their stories I will describe linking objects and phenomena and what I learned about childhood mourning in an orphanage. My observations in this orphanage were helpful in my understanding AWON member's "father quest."

LINKING OBJECTS AND LINKING PHENOMENA

Decades ago, after studying fifty-five individuals suffering from complicated mourning processes, I coined the terms “linking object” and “linking phenomenon” (Volkan, 1972). These concepts refer to items or things that contain externalized mental representations of dead individuals or lost things and corresponding mental representations of a mourner. For example, a young man “chooses” a broken watch owned by his dead father and, psychologically speaking, makes it magical. In this case, the mental representation of the dead father is externalized and meets the son’s mental representation “out there.” Internal adult-type work of mourning becomes replaced by a continuous preoccupation and relationship with the broken watch. The son thinks of fixing it, but never tries to do so. He feels a sense of relief in exerting control over the broken watch. He locks it in a drawer and thus distances himself from an internal struggle with the mental representation of the dead. Through the utilization of the watch as a linking object, the incomplete mourning process becomes externalized as well.

The concept of a linking phenomenon can refer to a song, a smell, a gesture, an action, or an affect that functions as a linking object. It was raining on the day a young woman attended her father’s funeral. The song “Raindrops Keep Falling on My Head” came to her mind. Later, she utilized this song as a linking phenomenon whenever she felt internal pressure to mourn.

Linking objects and phenomena should not be confused with childhood transitional objects and phenomena that are reactivated in adulthood. A transitional object represents the first not-me, but it is never totally not-me. It links not-me with mother-me, and it is a temporary construction toward a sense of reality and security (Winnicott, 1953; Greenacre, 1969). Linking objects and phenomena must be thought of as tightly packed symbols whose significance is bound up in the conscious and unconscious nuances of the complicated internal relationship that preceded a significant loss. These objects and phenomena are associated with mourning in childhood only after the child has established object constancy and has a mental representation of the other, even though this representation may still not be firmly established or may be primarily fantasized (Volkan, 1981; Volkan & Zintl, 1993).

Linking objects and linking phenomena also should not be confused with keepsakes. Just as a child’s every teddy bear is not a transitional object, a mourner’s every keepsake is not a linking object. Adults who do not have complicated mourning cherish keepsakes to remember a lost person or thing. A keepsake does not function as a repository where a complicated mourning process is externalized. A typical keepsake provides continuity between the time before the loss and the time after the loss, or generational continuity if the lost person or item belonged to a previous generation. On the other hand, a linking object is a psychological “tool” utilized for dealing with complicated mourning or reactivating a “normal” mourning process years after the loss, as I will illustrate below. A dead person’s framed picture on a mantle with which the mourner is not preoccupied is a keepsake. When a mourner, even many years after the loss, is preoccupied with a similar picture by ritualistically touching it daily while developing tears, or locking it in a drawer while experiencing anxiety whenever the drawer is unlocked, or not being able to travel a long distance without first placing the picture in a special location in his or her baggage, we can assume that this picture has now become a “magical” tool utilized to maintain complicated mourning. If, in the future, the perennial mourner is able to make the lost person’s representation “futureless” then the picture loses its “magic,” and becomes a “typical” keepsake. Persons with complicated perennial mourning and children who do not have a well-formed mental representation of the lost person or things and who have a fantasized mental representation of the lost object, develop linking objects or linking phenomena.

Initially in my decades-long clinical study on mourning, I focused on the pathological aspects of linking objects and phenomena. Since I was working with psychiatric patients with perennial mourning, I considered the existence of linking objects or phenomena only as a sign of mourners’ externalizing and “freezing” of their mourning process. Even then my colleagues and I thought about utilizing linking objects and phenomena in the therapeutic setting to bring the externalized and locked-up mourning back into the patients’ internal worlds, to be unlocked and restarted (Volkan, Cilluffo, & Sarvay, 1975; Volkan & Josephthal, 1980; Volkan, 1981).

Later I began noting that some perennial mourners gained useful time through their utilization of linking objects and phenomena. I learned that keeping a sense of belonging to the past as well as a foot in the future (where the lost person or thing will no longer be present) can be a helpful transition for these individuals when circumstances change. In contrast to perennial mourners who remain in a pathological state the rest of their lives, those who are able to use this gained time to re-internalize the meaning of the linking object or phenomenon may eventually function as more healthy mourners. At this time they usually throw away their linking objects. Some of them turn their linking objects into keepsakes.

When I started to work with immigrants, refugees or displaced persons I noticed that they often create linking objects or phenomena (Volkan, 1999, 2006a,b). Some become pathologically preoccupied with them to the degree that they do not have much energy left to spend on finding new ways of living. When an immigrant, refugee or displaced person uses a linking object or phenomenon in a creative way, he or she connects the lost persons, things, locations, or culture with efforts to give them up, “bury” them and move on. The adaptive use of a linking object or phenomenon gives such a person time to work on his or her denial of what is lost, to accept changes, and to realize what may be gained.

LINKING OBJECTS AND PALESTINIAN ORPHANS

Around the time the American World War II Orphans Network (AWON) was established, but before my involvement with its members' complicated mourning processes, in the spring of 1990, I visited an orphanage in Tunisia and examined Palestinian war orphans residing there. During this visit, besides learning about various aspects of these orphans' psychological states—such as their identifications with children in Palestine who, at that time, were involved in the Intifada—I observed the importance linking objects and linking phenomena held for them. My one week of intensive work with these orphans would later be helpful in my understanding AWON members' psychology.

I visited Beit Atfal al-Sumud (Volkan, 1990), a home for orphaned Palestinian children. It housed fifty-seven boys and girls ranging from the age of eight months to eighteen years. As a member and chair of the American Psychiatric Association's (APA) Committee on Psychiatry and Foreign Affairs, I was encouraged by Israeli colleagues, with the permission of the PLO, to observe the Palestinian orphans in Tunis and then present my findings in Jerusalem.

I observed all the orphans for a week, and I conducted two to three hours of interviews with fifteen orphans who spoke English, to acquaint myself with their internal worlds, including affects, fantasies, dreams, repeating dreams, internalized object relationships, identity issues and perceptions of external world events. It soon became clear to me that each child or youngster at the orphanage lived in two worlds—the cheerful surface group life in which Beit Atfal al-Sumud provided such abundance of loving care; and a unique, personal internal world that reflected the traumatic events to which they had been exposed, including losses of parents and siblings. Many of those whom I interviewed had crying spells after going to bed, and almost all of them had nightmares in which aggression usually was symbolized by Israeli soldiers. Some could not differentiate between fantasy and reality.

I observed the five youngest children who were found as babies in a war zone and never knew their dead parents. At the orphanage they were playing together in a group. At first they appeared as "normal" children do in play. I observed that they would try to stay together as a "team," and if one of them were separated from the others, he or she would become agitated. On the fifth day of my visit, I attempted to speak with these children one by one, with the aid of an interpreter. Individually, all of them then became "abnormal"— one hallucinated, and another one literally destroyed the interview room. As soon as they were placed together again, as a "team," they appeared to be "normal" once more. I concluded that they were having difficulties in their sense of personal identity. Their commitment to "we-ness" supported their "normal" behavior. After a while I noticed variations of this phenomenon in the other fifty-two orphans, as when the orphans called one another "brother" or "sister," even when biologically most of them were unrelated.

The orphans who had linking objects, such as photographs, connecting them with dead or disappeared parents appeared more adjusted than those with no linking objects or no memory of their babyhood or childhood caretakers. Those who had linking objects could maintain more individuality than the children and youngsters without such objects. The orphans who possessed linking objects were preoccupied with these magical objects that they protected as if their lives depended on them.

It is beyond the scope of this chapter to describe my full findings from Beit Atfal al-Sumud in detail, but in order to focus on the role of linking objects and linking phenomena in the lives of these orphans, I will describe the case of one handsome seventeen-year-old whom I will call Farouk. When I met Farouk he had lived in this orphanage for eleven years. He was the captain of the soccer team and knew perfect English. When Farouk was five years old, he witnessed the killing of his father, his mother, a sister, and a cousin. Farouk and his uncle were the only survivors, and later he was separated from his uncle. He told me the above story in a matter-of-fact way and informed me that he no longer remembered his parents' faces. He confessed that when alone he often wept. "I know it is a healthy thing to do," he said.

While Farouk was talking, he was involved in an unusual activity. He kept rubbing his right shoe. When I became curious about what he was doing, he told me that as a child, while watching his mother and grandmother cook sweets, he accidently stepped in a hot pan and burned his right foot. His father had put ointment on the burn and tried to soothe his pain. This was Farouk's earliest memory. He still had a scar from this episode, and without my asking him to do so, he removed his right shoe and sock, showed me the scar and demonstrated his tender way of touching it. The scar covered the lower part of his right foot. He confided that when he touched his scar, "I almost recall my parents from within, from inside my body." He had recently received a scar on his left knee while playing soccer, but he said this was nothing; the old scar was everything.

Listening to Farouk I realized that his scar stood for his lost parents, family, and home. By touching his scar he could bring lost relatives and home back to his life; by not touching his scar he could say "good-bye" to them. Farouk had an ability to sublimate. He was a star soccer player, scoring more goals than anyone else, using his foot with the special scar, and perhaps discharging feelings of rage and revenge in this way. The other orphans seemed to be aware of the specialness of Farouk's scarred foot. They would come and touch his right shoe and sometimes his scar, and their self-esteem and sense of well-being would increase.

My experience at Beit Atfal al-Sumud in Tunis informed me that individuals with linking objects or phenomena utilize them in various ways. Five years later I would give my first talk at an AWON bi-annual meeting, informed by my experience.

AWON′S DEVELOPMENT AND AWON ORPHANS′ MOURNING PROCESSES

In the late 1980s, a World War II orphan, Ann Bennett Mix, became keenly aware that she did not know any other person who had lost a father during that war. She turned to government agencies, but they were of no help to her. She located the organization, No Greater Love, a group that was established in 1971 to provide programs for remembrance and care of families who lost a loved one in the service of the United States or in an act of terrorism. But Ann Bennett Mix wanted to find a place where WWII orphans, like herself, could get together. Utilizing No Greater Love's brochures and other media, she invited WWII orphans to meet. These meetings became the first steps to forming the American WWII Orphans Network, AWON. It was then that she learned that these individuals also felt "different" from their friends, often knew very little about the real facts concerning their fathers, including how they died, and had never spoken to other orphans before she had gotten in touch with them.

I was curious about why this group of orphans waited until they reached their forties or fifties to find each other and why they then tried to mourn their childhood losses. Interviewing some of them who had children, I formed an impression that when their children came to the age their fathers were when they lost their lives, these orphans experienced unconscious anxiety about losing a loved one again, this time their child. In a sense, they were reactivating identifications with their childhood mothers in mourning. This stimulated increased psychological motivation to look at their original loss. With the establishment of AWON, they became involved in a meaningful group process.

In 1995, I attended my first AWON bi-annual meeting and gave a talk entitled, "Fifty Years Later: The Psychology of Losing a Father in Childhood," and then sat in on some of their small-group discussions. Nobody had designed this 1995 event to be therapeutic. Later, many AWON members told me that this event had functioned as a significant stimulus for many of them to get involved in activities to end their childhood preoccupations with fantasized father images and to search for ways to mourn as adults.

I began my 1995 speech with descriptions of how children at various ages understand the concept of death, ranging from having a sense that something is missing, to perceiving death as temporary and reversible, to beginning to have a more realistic appreciation of its finality. Using lay terms, I explained what a “mental representation” of the “other” means; I then used the term “*mental double.*” Although not by design, soon my speech became an interactive dialogue between me and the audience. I asked the AWON members to close their eyes and have a silent conversation with a close relative or friend who was not in the conference room, about an important personal issue. I wanted the image of the absent loved one to appear in their minds. After a few minutes, and after they opened their eyes, I told them that the visual images with whom they had a conversation stood for the “mental double” of the absent person. Using such an approach, the audience could more readily appreciate how internal object relations exist, above and beyond actual interpersonal conversations. Next, I asked the audience members to relate to the mental double of their fathers. This allowed them to appreciate something that they already knew, but they had acted as if they did not know. While their fathers’ mental doubles were mostly or totally fantasized, nevertheless, they were very much “alive” in the minds of these orphans, even though they did not have first-hand pictures of their fathers and could not imagine what their fathers had really looked like.

We spoke of how, after death, a lost person’s mental double continues to exist in the mourner’s mind. I explained that adult work of mourning involves a process in which the mourner is engaged in a relationship with the lost person’s mental double until issues between them are settled. We discussed the orphans’ difficulty being involved in an adult-type of mourning, since the mental doubles of their fathers were very rigid, and since throughout their lives they had had difficulty loosening up or modifying these mental doubles. The orphans became aware that they needed to find new links to their fathers and make the fathers’ mental doubles more realistic. Such activities would give them an opportunity to relate to these mental doubles in a more flexible manner.

I explained that adult-type mourning includes feeling anger at the image of the lost person. This feeling is connected with an obligatory narcissistic wound, because we feel rejected or hurt by the death of someone to whom we are emotionally connected. In routine work of adult-type mourning, experiencing such angry feelings helps mourners psychologically acknowledge that a loss has occurred. It is part of reality testing and it is normal. When the death of someone is connected with violence such as murder or suicide, an adult mourner’s normal anger unconsciously becomes connected with exaggerated violence and this creates complications. Since the AWON members’ fathers had died in war, and since the AWON members had rigidified their fathers’ mental representations as special beings, and since social pressure had not allowed them to be upset with heroes, the AWON members, I noted, usually could not openly express their normal anger as part of an adult-type of mourning. Only a few of them were openly angry at their fathers (fathers' mental representations) for having volunteered for dangerous military duties or for being foolish enough to expose themselves to snipers or enemy fire without taking proper security precautions. Most of the AWON members who were aware of a sense of anger had displaced these feelings from their fathers' images onto others: "Why didn't the General move my father's unit from the location where my father was shot, since the General knew that this unit's ammunition would be depleted very soon?" I explained to the AWON members that it would also be normal if they sensed anger about being left behind as they made their fathers' images more realistic.

I wanted to know about special items and things that connected the AWON members with their fathers' images. I introduced the concepts of "linking objects" and "linking phenomena." I explained to them how linking objects and phenomena can be utilized in pathological fashion to externalize and freeze the mourning process. However, after an orphan becomes aware of mixed feelings about the mental double of the lost father, linking objects can be used in creative ways, to help the mourner maintain generational continuity, and to support the mourner's self-esteem. I reminded them of the story of one of the AWON members, to illustrate the adaptive use of a linking object. During the war this man's father used to send home cartoon drawings from the battlefront. The son used these drawings as linking objects in his childhood and teen years. As an adult, he re-internalized the meaning of the linking objects, in other words, he was able to identify with his father's cartoon-drawing mental double. Like his father, he used his pen creatively and became a graphic designer (Hadlerand Mix, 1998). I explained to the AWON members that linking objects may also be used as instruments for restarting a frozen mourning process.

Since 1995, I have attended all AWON bi-annual meetings, except one, and I have presented eight plenary talks to the group. I continued having conversations with AWON members about their fathers, and listening to them as they talked to one another in small groups, at dinners, or in other social settings. The AWON members refer to me as their "perennial speaker." All knew that their "perennial speaker" is a psychoanalyst who had helped many individuals with histories of losses and who had written books and papers on mourning. None of them was on my couch. But, I believe that I evolved as a shared transference figure—a caring, alive, father figure who could help them to leave behind their childhood fixation, and have courage to learn how to deal with the mental doubles of their biological fathers. My being a "steady alive object," I believe, was an important factor among other factors, including their being together and sharing their stories and inner processes openly, and with appropriately deep emotions that put them on the right track toward adult-type mourning.

Starting in 1995 the AWON members began including the term “linking object” in their vocabulary, examining their own linking objects, and making incredible journeys to find new ones. Now they were on a road to make their fathers’ mental doubles more realistic and to start adult-type mourning.

AWON MEMBERS’ INVOLVEMENT IN LINKING OBJECTS AND PHENOMENA

The AWON members were not directly traumatized during a war or war-like situation themselves, as were most orphans at Beit Atfal al-Sumud, yet they shared certain psychological experiences. For example, similar to my observations at Beit Atfal al-Sumud, those AWON members who had objects such as their fathers’ photographs, letters, medals or graves and utilized them as linking objects, fared better in creating more realistic father images and in adjusting to life in general.

After my 1995 talk, the AWON members began seeing their existing linking objects as items connecting them to ambivalently related and confusing father mental representations, and experiencing them as tools to gather more realistic information about their fathers to unfreeze their mourning processes. The members started searching for new linking objects as well as new facts about their fathers. Here are some examples of their discoveries:

A retired colonel in the United States Army and an AWON member, Jack Forgy devoted his life to finding government files, hospital records, and other documents in order to help others in the organization.

Patricia traveled to Papua, New Guinea and found her father’s missing aircraft in an uninhabitable mountain jungle. At the crash site she found her father’s remains, identified through his dental records. She accompanied her father’s remains as they were flown to the United States for burial at Arlington National Cemetery.

Sam grew up not knowing where his father was buried. Through AWON he met a man from Luxembourg and learned the existence of a book about the war in that part of the world that was written by a photographer. In this book there is a picture of Sam’s father’s lifeless body. When Sam met the photographer he learned that the man had been a friend of his father, and from him he also found the location of his father’s final resting place in Queens, New York.

Penny’s tour guide from the Marshal Islands found a wartime video. Watching it, Penny saw her father and his crew lined up in front of their plane—for six seconds. Penny later described this moment: “My soul was filled with joy as this was the first time I had seen my dad move. It made him real and not just a picture on the wall."

Betty went to Livergnano, Italy, near Bologna. There she met a man who had made his garage into a kind of museum of items collected from a nearby World War II American-Nazi battleground. This museum contained a hodgepodge of relics: an American flag, books, papers, communication equipment, helmets, uniforms, and a container of ten metal water canteens. The United States Army did not print soldier's names on the canteens they issued, but Betty's father, apparently using a bullet, had scratched his name into his canteen. The museum keeper gave this canteen to Betty. For several years Betty related to her father's canteen as a magical linking object, ritualistically touching it daily while experiencing deep feelings lasting from some minutes to some hours. It now stands, as a keepsake in a special place in her family living room next to her father's picture. She brings her father's canteen regularly to AWON meetings.

Like many of the orphans at Beit Atfal al-Sumud who shared Farouk's scar as a collective linking object, many AWON members have spoken about Betty's father's canteen being a collective linking object for all AWON members. One of these members is Millie. Millie's mother did not save any physical items from Millie's father, and when Millie wanted to find something concrete that had belonged to her father, the government could produce only a piece of paper with burnt edges. But, within the AWON family, Millie could share in the excitement when other orphans talked about their existing linking objects and items that belonged to their fathers that were later found. As the orphans at Beit Atfal al-Sumud did, the members of AWON call one another "sisters" or "brothers." Other members of AWON, like Betty, also regularly bring the newly discovered linking objects to their bi-annual meetings and to many other smaller regional gatherings to share them with the other orphans. Members work on transferring shared or individualized linking objects into normal keepsakes.

The AWON members communicate often with one another through email, and AWON publishes a quarterly newsletter, *The Star*. Almost each issue has long descriptions of one orphan or a group of AWON members visiting Normandy, Italy, Belgium, Philippines, Northern Africa and elsewhere, places where fathers died or vanished. It describes ceremonies in graveyards where fathers are buried, finding fathers' dog tags or pieces of bone, identifying the wreckage of a father's airplane, or meeting people who actually had known the dead men before they were killed. Books describing AWON members' stories have also been published (Hadler & Mix, 1998; McGuire, 1999; Carter, 2004; Frederick, 2006; Ratliff, 2007; Fowler, 2008; Klein, 2008). Former NBC News anchorperson Tom Brokaw's *The Greatest Generation Speaks: Letters and Reflections* (Brokaw, 1999) also refers to the

AWON members' stories. One orphan likened what he and other members of AWON had done with the research, reading, and travel-worthy of a PhD.

On Memorial Day 2004, a most significant event occurred in the AWON members' lives: the World War II Memorial was officially opened in Washington, DC. Ann Bennett Mix and other AWON members had played a role in the design of this memorial. Through their efforts there are 4,000 gold stars on the Freedom Wall that surrounds the memorial's Rainbow Pool. Each star represents one hundred U.S. soldiers lost during World War II. At the opening ceremony 800 AWON members with their spouses and children gathered, cheering, crying and excited. Senator Robert Dole, a World War II veteran, gave a moving speech to the AWON members. My speech followed Senator Dole's and explained how memorials like the World War II Memorial evolve as "shared linking objects" (Volkan, 2006a, 2007b). Then I joined the AWON members and their families, at the opening of the memorial. Ann Bennett sat with the dignitaries on the ceremonial stage. This event provided an opportunity for immense catharsis and collective mourning. Anna Ornstein (2010), a Holocaust survivor and well-known psychoanalyst, states that such events occurring, "as they do at designated sites and times . . . offer opportunities for re-experiencing a shared past that requires little or no verbal explanation" (p. 645).

In the ten years following my 1995 speech, during their bi-annual meetings, many orphans who had been AWON members from the group's inception, started informing others that their "father quest" now had "closure"—with an understanding that mental representations of their fathers, now much more realistic, will always stay with them.

Responses to my 2010 letters, e-mails and interviews describe how the AWON members who reached closure, or came close to it, no longer feel ashamed or have difficulty speaking the name of the dead father out of fear of censure. They also no longer feel alone and different. They report how discovering who their father was, where he died, and when and how, has helped them develop realistic mental doubles. They also report their changing perspectives of their mothers, how they have developed an understanding about their mothers' complicated mourning process, and the often stressful influence their mother's complicated mourning had on them as orphans.

Otto Kernberg (2010) describes how in normal mourning the mourner's actions after the loss include some that would have been greatly appreciated by the person who is lost. The AWON members did not know their fathers, but I believe that what Kernberg describes to a great extent explains why many AWON members who reached closure or came near to it have developed a deep sense of generosity. They talk about an inner mandate or even an obligation to help new members of AWON to experience "AWON moments." By doing so, they feel that they honor their fathers' and mothers' mental doubles. AWON members have also financially contributed, generously, to the World War II Memorial and museum. During recent years AWON has lost some members' mothers, as well as members themselves and sometimes members' children. As far as I could observe, mourning reactions to these sad events have not been complicated.

DISCUSSION

In this chapter I have described my brief connection to fifty-two Palestinian children at an orphanage in Tunis who lost one or both parents during the Middle East conflict when they were children. In-depth interviews and psychological tests have illustrated that those children who had items such as photographs or songs connecting them to the mental representations of the lost parents. Even in a confusing, ambivalent and/or "magical" way (using linking objects and linking phenomena), they were able to make better psychological adjustments in their lives.

I have also told the stories of some of the approximately two hundred members of the American World War II Orphans Network (AWON), who, in their forties and fifties, reactivated mourning processes over the loss of their fathers who died during World War II when they were children or before they were born. The role of linking objects and phenomena helped many of the members of AWON to make better psychological adjustments to life. This was illustrated through the members' creative utilization of existing linking objects and phenomena, or finding new ones, thus enabling the AWON members to develop more realistic mental representations of their fathers, and establish firmer generational continuity.

The Palestinian orphans' and the AWON members' stories are helpful in designing preventive measures for the wellbeing of children who are losing their fathers and mothers during present wars or war-like situations in various parts of the world. These measures should include warning family members left behind not to get rid of objects capable of connecting the children's self-representations with their mental representations of lost ones. Family members should also be helped to encourage children not to censure speaking of and inquiring about those who have died.

This chapter describes how I, as a psychoanalyst, without initially planning to do so, stimulated the AWON members' reactivation of their mourning processes. I wish to be very careful not to exaggerate my role. What I have done, however, may be helpful for psychoanalytically oriented mental health workers as they design community projects dealing with losses in wars and war-like situations, and in their therapeutic efforts with children who have lost parents in a range of circumstances.

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Chapter Fifteen

Death of a Father on September 11, 2001

Video-informed Consultations with Widowed Mothers

K. Mark Sossin, Phyllis Cohen, and Beatrice Beebe

The changes in the world after the events of September 11, 2001, and the losses in the aftermath, were not political abstractions, but deeply experienced human realities. Those of us working as child and family mental health clinicians after September 11 know this intimately. Many of us searched for conceptual frameworks and intervention models that could help us make sense of what happened and develop ways of helping those who were acutely affected. The Project for Women and Young Children of 9/11 created a space for thinking through what is the same and what is different when children's development and inner processes are disrupted by massive, collective, external trauma, in contrast to the ubiquitous individual conflicts and disturbances many children experience and more familiar to most therapists.

In this chapter, we are introduced to the exemplary work of Beatrice Beebe, Phyllis Cohen, K. Mark Sossin, and their colleagues. They have worked together since September 11, 2001, helping a group of widowed mothers and their children who lost fathers in the tragedy. They bring their thinking and their model of observation and intervention alive, through exquisitely described moments from semi-annual meetings over the span of twelve years with one of the mothers and her son.

Using a method of video-recording mother/child and therapist/child play sessions that occurred only once or twice a year, and then giving feedback to the mothers, Beebe, Cohen, and Sossin demonstrate that helping grieving children and mothers make meaning of what they experienced is not only possible, but therapeutic, and facilitates development. Not all of us will have access to such a committed team of child psychoanalysts, researchers, and other professionals, committed to working together over time; but all of us, unfortunately, will encounter children and families affected by mass violence. The ideas that

> *readers will encounter in this chapter, we believe, can stimulate ideas for ways of intervening, grounded in the description of this challenging and transformative clinical work.* —Eds.

> *". . . I want to be able to be there for my children, to be attentive to their needs, and [you, (Drs. Beebe, Cohen and Sossin),] . . . really help me see my children with a clearer perspective. This . . . is important because although my children are "normal," they have experienced a great loss at a young age, which has changed the course of their lives. They will carry this loss with them always, but they don't need it to define them or hinder their joy in life . . ."* —A Mother of the Project, Anonymous, quoted with permission, JICAP, 2011, p. 203.

As New Yorkers and as therapists, we were enveloped in the searing loss, sorrow and unease that shattered our safety on September 11, 2001. We created the "Mothers, Infants and Young Children of September 11, 2001: Primary Prevention Project" to reach out to the grieving widows who were pregnant when their husbands died in the collapse of the World Trade Center. We had complex motivations for this project. Certainly an effort to deal with our own feelings of helplessness was one of them. We assembled a group of therapists who shared intense concern for the lives of the unborn infants, their siblings, and their widowed mothers, all of whom were considered at risk.

Our approach drew from our training in psychoanalysis, psychodynamic adult, child and family therapy, dance and movement therapy, observation and research in parent-infant and parent-child interactions, non-verbal communication, and attachment theory. We developed a multi-faceted Project.[1]

We organized support groups for mothers and children, led by two to three therapists in the communities where the mothers lived. We offered visits to Beatrice Beebe's mother-infant research lab at the New York State Psychiatric Institute. In these visits we filmed mother-child and therapist-child play. Excerpts of tapes were viewed in videofeedback sessions with the mother, together with several therapists. We made clinical referrals as necessary. We also created a support structure for ourselves by meeting every other week for two hours. We describe the evolution and impact of ten years of our Project, including gleanings from our core group of eight therapists[2] and other collaborating colleagues (Beebe, Cohen, Sossin, & Markese, 2012).

Our Project was motivated by the knowledge that "parents who experience traumatic grief are often preoccupied with their own losses and may have difficulty being fully emotionally available to their infants and young children," no matter how competent they may be (Beebe & Jaffe, 2011, p. 157). We knew that pregnant women's emotional distress following the death of their husbands could negatively influence the development of the yet unborn infant, as well as that of any older children. Research, first with primates (Schneider & Coe, 1993), and then with humans (e.g. Huizink et al., 2004), found that stress during pregnancy predicts compromised developmental outcomes. Thus, we aimed to foster healthy attachment processes and to monitor the overall development of the child.

This chapter describes our work with one particular family over a decade. We report on a woman who was pregnant on September 11, 2001, her then 2¾ year old child (the older sibling of a child born after September 11, 2001), and her contact with many of the therapists in the Project. An individual therapist would not likely replicate what we did, and how we worked was not specifically child therapy. Nevertheless, we think that the work we report has important implications for dynamic, developmental, and relational processes in individual child therapy, and for dyadic parent-child therapy, during times of trauma, loss and mourning.

OUR INTERVENTION

We describe two related facets of our Project. The first is the "lab visit," in which the child played for ten minutes with the mother, and then for ten minutes with a therapist, while being filmed in a split-screen format.[3] When the children were infants, Beatrice Beebe was filmed in the brief infant-therapist play interactions. When the children were one year and older, Drs. Mark Sossin and Phyllis Cohen, and occasionally Dr. Suzi Tortora, alternated in the child-therapist sessions.

The second facet is the video feedback consultation, in which the mother met with three or more therapists from the Project for a two-hour session, incorporating video from the prior week's lab visit. Video feedback can facilitate a parent's understanding of her child and of her own style of interaction with her child. This process can lead to an expansion of the mother's capacity to reflect on her relationship with her child, and ultimately to behavioral changes in the ways she interacts with her child.

In the video feedback sessions, the authors, along with other team members, offered support to the grieving mothers as they struggled with varying degrees of vulnerability. Through their pretend play, the children beseeched the mothers to wonder further about what could have been if their fathers had not died (Sossin & Cohen, 2012). The mothers began to speak about their losses in this therapeutic space. They gradually became able to reflect on their personal life stories, including their fears, doubts, ambivalence, and anger. Mothers gradually became able to link their experiences of their husbands' deaths to early attachment histories, prior trauma and loss, and multigenerational transmission processes. The mothers made heroic efforts to make their beloved children feel secure, and to pay attention to their unfolding maturational needs, while experiencing profound sadness and the loss of their assumptive worlds.

While observing the children and mothers interacting on video, we attended to self- and mutual regulation patterns in verbal and nonverbal behaviors, such as vocal turn-taking, mother and child level of distress as displayed in facial, postural and bodily patterns, the mother's ability to follow her child's pretend play themes, and the dyad's sharing of space. We also attended to the mothers' ways of holding the children's minds in-mind. The actual use of video (as to selection and number of vignettes observed, and overall length of observation), varied across mothers as was clinically useful (following Beebe, 2003).

Styles of interacting and themes in play revealed the children's preoccupations, emerging symbolizations, and coping efforts. In the feedback sessions, we would uncritically bring to the mother's awareness how her own coping strategies vied with those of her child. For example, her wish to avoid painful thoughts might come into conflict with her child's yearning to know more. We focused on process, including affective shifts, interactive "fit," and occasional "mis-matches." We attended to the mother's states of mind, her own levels of sadness, hopelessness, and wish to withdraw from the overwhelming nature of the task of recovery. We attended to her equally salient wish to be there for her children, to find ways to recover their lives. We never lost sight of the theme of helping the mothers support their children in their development of representations of their lost fathers.

Our Project team viewed families longitudinally, comparing children's manners of playing and interacting across contexts (with mother or therapist), vis-à-vis other children in the family, and across our sample of participating families. Without applying the quantification of a research methodology or formal clinical assessment,[4] we developed our own modes of intervention. We drew upon our team's rich knowledge base regarding trauma and grief, attachment processes, nonverbal behavior, developmental phase acquisitions, and psychodynamics in mother, child, and family, to weave together our understandings.

We gauged the power of our interventions in what the mothers wrote about their experiences in the Project (Mothers of the Project, Anonymous, 2011). We also gauged the power of these sessions through our own self-observation and collaborative processing of the work (see The Therapist Group, in Beebe et al., 2011). We were aware that many of the families we saw, though in crisis and in the perpetual shadow of a sudden and horrific loss, would not have sought psychological intervention. For many, what we offered was acceptable because it was not traditional psychotherapy, but rather a preventive intervention; the prerequisite was an event, not a diagnosis. Since our interventions have continued across a decade, we have had the unique opportunity to respond to families' changing needs, while observing continuing struggles as well as developmental progress in the course of mourning, adaptation and resilience.

MINIMIZING THE HARMFUL EFFECTS OF LOSS ON YOUNG CHILDREN

The stress impact on the parent-child relationship in the aftermath of loss can greatly affect a young child even with less direct exposure to traumatic events. Relevant literature has been aptly reviewed by Markese (in Beebe et al., 2011), underscoring ". . . the bi-directional effects that the traumatized child and parent have on one another" (p. 352). Young children's adaptations to highly stressful and traumatic events have been shown to be especially entwined with parental symptoms (Scheeringa & Zeanah, 2001). The nature of children's vulnerabilities has been highlighted in Scheeringa and Zeanah's (2008) study of the effects of Hurricane Katrina on preschool children. Nearly half of the children who had been evacuated prior to the storm, who suffered displacement from homes that were damaged, suffered from PTSD symptoms. The intergenerational transfer of stress and trauma, viewed through the lens of correlational research (Yehuda, Halligan, & Grossman, 2001) or dynamic understanding (Furman, 1984, 1986; Brenner, 2004; Kestenberg, 1982; Fogelman, 1988) further anchored our concern for these children who were being raised in a state of heightened fear and reaction to loss.

The target children in our Project, who were unborn at the time their fathers died, did not experience a direct threat to their lives, yet this was not the only channel of stress transmission. For their siblings already born, there was a direct loss of a beloved father, as well as exposure to a bereaved surviving parent and family members. A relational perspective (Scheeringa & Zeanah, 2001) underscores the potent effects (positive and negative) of parental functioning upon child adaptation. The parent's style of coping moderates the child's stress. For example, various mothers avoided speaking to their children about the actual events of September 11, 2001, avoided reminders of the loss, and/or had a particularly difficult time partnering their children in pretend play which symbolized or enacted themes of loss. Both the older children in our Project and the infants born after September 11, 2001, bore the impact of the "vicarious traumatization effect" (Scheeringa & Zeenah, 2001, p. 809), particularly when caregiving was understandably compromised by the expectable grief of the trauma, and in some families, by complicated grief (Shear et al., 2001).

One essential goal of the Project was to help the child to construct a rich and vital representation of his or her lost father. This process was facilitated with the mothers in the group context (Sossin, 2011; Reiswig, 2011) and in video-feedback consultations with multiple therapists (Cohen, 2011). Moskowitz (2011) has explicated ways in which early maternal functioning was disrupted, depleting the mother's capacity to tolerate her child's feelings. Facilitation of a mother's more complex and multi-dimensional memories of her lost husband in the mothers groups ". . . contributed significantly to the construction and sustaining of vivid and differentiated internalized images of the lost fathers/husbands" (Reiswig, 2011, p. 228). In parallel, our own filmed observations of each mother and child in a play context, as well as of the interactions of the child with a therapist, provided a remarkable window through which to see the resources each brought to the sharing of minds and emotions (Sossin & Cohen, 2011). As we studied the video interactions, we paid particular attention to the self- and interactive regulation of subtle nonverbal features of expression (Beebe, 2000, 2003, 2005; Cohen & Beebe, 2003; Tortora, 2012; Bergman et al., 2012; Sossin & Birklein, 2006), all of which helped us to foster communication and understanding.

In our Project we looked for playfulness that could promote integration of inner and outer realities. We focused on the mother's difficulty, given her own grief, in offering such play with her child, who had his or her own thoughts and feelings. Consistent with Fonagy, Gergely, Jurist, and Target (2002), a child who is impeded in such integration through "unjoined" and "unelaborated" play has a greater likelihood of symptoms. There is a greater chance that the child would experience reality through "psychic equivalence," that is, without fully entering a pretend mode, believing that what is in the mind is real (Fonagy et al., 2002).

We kept in mind the research findings of Steele and Steele (2008) that higher reflective functioning on a caregiver's part greatly enhances the security status of her child, even under duress. The development of a mentalizing capacity, exercised through reflective functioning, is anchored in the experience of a sensitive attachment relationship (Fonagy et al., 2002). Our Project aimed to enhance the mother's reflective stance. As articulated by Slade (2008), an essential ingredient in facilitating ". . . the capacity to understand the nature of mental states, as well as to appreciate their dynamic nature and interpersonal functions" (p. 217), is the therapist's ability to hold in mind the parent's experience of parenting a particular child. In our video-feedback consultations and in our groups, efforts were made to hold the parent's experience in mind, and to help the parent to "contemplate the child's mind" (Slade, 2008, p. 223).

THE CASE OF SUSAN AND GARY

In the following section, we present excerpts from four of the twelve sessions that we conducted with Susan and Gary over the course of ten years in our Project. In our first session with Susan, in September of 2002, she told us that at 8:55 on September 11, 2001, she received a call from her husband saying, "I'm in Tower 2. Turn on the TV. I love you." These were his last words to her. She explained, "I knew he was gone but I still waited for four days in a suspended state of grief and anticipation. My faith is the only thing that sustained me."

After the disaster, Susan forced herself to keep a routine for Gary who was 2¾ when his father died. Susan went through that first year being pregnant and in a daze. She recalls that she would cry constantly and uncontrollably, all the while feeling guilty that Gary needed "to have fun. . . ." One of us commented on Susan's remarkable strength, saying: "It impresses us that you still had the capacity to think about having fun with Gary at a time when you were so distraught." Susan then reflected on her infant who never knew his father saying, "I felt that this baby was a gift. As my husband was crossing over, he asked G-d to give me this gift."

A BRIEF EXAMPLE OF MOTHER-CHILD PLAY JUXTAPOSED WITH THERAPIST-CHILD PLAY

At the Lab in 2002

In their first visit to the lab in 2002, the video reveals warm, mutually pleasurable exchanges as Gary and his mother entered into a positive engagement together. Susan was able to follow Gary's lead, and was patient when his words were not clear. At nearly four, Gary was a persistent and involved player with his mother. He frequently hit high-pitched vocal tones as he expressed his excitement. Susan was highly attentive and responsive, able to participate in joint laughter. Gary took particular interest in a lady falling off a building and in toys he could topple. Susan mostly followed Gary's many play themes. One exception occurred when Gary made comments about a toy toilet, and, as was typical of many mothers, Susan responded, "That's silly!" At another point, Susan "tested" Gary to see what he knew, such as the name of a character stuffed animal, also typical of other mothers who easily took on a teaching role with their children.

Susan asked questions promoting the continuity of Gary's play, like "Where did he go?" when a figure was dropped off the play table. She offered warmly intoned and resonant observations, like "Oh no, he fell down." When Susan observed Gary's flying manipulation of a male doll figure above the play table, she exclaimed, "Hey, that man is jumping all over the furniture. . . . Is he in his own house, or is he just a visitor?" After no answer came, she then asked "What's his name?" and then she pursued, "Who is that?" Gary tensed while smiling, seeming to enjoy his mom's attentiveness and arousal which only increased as he withheld an answer. Eventually, he announced that the man's name was "Mr. Bubbawubba," and they both smiled broadly. Gary became exuberant over “Mr. B.” Overall this play session reflected a robust interchange between Gary and his mother. Little stood out (except, perhaps, for Gary’s hypervigilance to sounds) that would differentiate this play from that of another four year old child who had not suffered such a traumatic loss.

When Dr. Cohen entered the room, Gary immediately introduced the flying Mr. B. His play then quickly moved to putting characters into the potty. He seemed to expand this theme in response to Dr. Cohen’s acceptance and curiosity. The play progressed and became aggressive with figures falling, biting, and then Gary stomping on a doll with his foot. Next Gary spoke about a man being “eaten by a big bear.” Then he pretended to be the killing bear and the man became “dead.” Upon Dr. Cohen’s query, “What should we do?” Gary exclaimed: “Kill that man!” He seemed propelled by Dr. Cohen’s willingness to tolerate his aggressive play. He explained that the dead man was “completely dead, and would never come back.” He underscored that the man was a bad guy, and that the people were happy the man was dead. Gary then simulated the man flying around. This play ended with the building on the play table getting knocked down onto the floor.

Comment: The ways that Gary played with his mother and with Dr. Cohen were very different. He felt freer to elaborate a number of aggressive themes with Dr. Cohen. As with other children in the Project, Gary was tuned in to his mother’s moods. He carefully avoided causing her additional distress. Gary’s play with the therapist gave clues to his own inner concerns, including his effort to process the finality of death, to represent the nature of violent death, and his own phase-appropriate identification with the aggressor. Not all of these themes were introduced in the first feedback session with Susan. Throughout the Project, we were sensitive to the mothers’ states of mind, and to their readiness to understand and respond to their children’s states of mind. In using the video, we asked the mothers to reflect on what they noticed about their own behaviors, and what they might have been thinking and feeling. We asked them to do the same regarding their children. We were careful to highlight positive interactions.

NOTES FROM A 2006 LAB VISIT OF GARY AT AGE EIGHT, WITH SUSAN IN A FEEDBACK SESSION

By the time Gary turned eight years old, we had seen him and his mother in the lab three times since the first session (just described) in 2002. In between lab visits we had occasional contact with his mother, Susan, either by phone or e-mail. The following session took place after Susan called us to set up a time to meet, saying that she was worried about a peculiarly disturbing symptom that Gary had developed. He was now holding his saliva (i.e.

showing avoidance of normal deglutition, cf. Gilmore, 2005). The mother was very worried that he'd been regressing. Her description raised the possibility that Gary's refusal to swallow saliva might be part of a developing obsessive-compulsive disorder.

Susan reported that Gary said "bad oil" was getting into his mouth, so he could not permit himself to swallow. We shared several anticipatory hypotheses with each other, e.g., that Gary was likely trying to exert control through holding saliva, and that having excess saliva was associated with high anxiety. Over the years we had noticed that as children went through different developmental stages, they processed their loss again and again in newly transformative ways.

2006: EXCERPTS FROM THE PLAY OF SUSAN AND GARY AT AGE EIGHT IN THE LAB

Gary began this session with his mother playing with two cars. For a while he did not hold his saliva. He was quite animated, saying: "This one is me and this car is you." Gary started the cars moving and there was a crash. His mother stayed in the pretend mode and reacted empathically, "Oh no! A crash!" and Gary responded: "They had a bad accident." Gary took a tow truck and started the process of moving the cars. He made "grrrrr-" sounds, and his mother laughed. Suddenly she realized that Gary was not joking. She sobered and said: "Oh, it looks like a bad accident." Then Gary left the pretend mode. His play was disrupted. He looked at his mother, pointing to the broken toy on the table: "Look," he announced, "one of the wheels is missing." We wondered, was Gary telling his mother that there was something amiss in their communication? There was a pause as Gary resumed play on a new track. He gave a doll to his mom and said: "Ok. You be the mom and I'll be the boy. No, I'll be the dad. . . ."

Gary perused the doll people and noticed that they were from different racial backgrounds. He said, "This doesn't make sense. They don't go in the same family." Mom explained, "Actually they can be born in a different family; or they can live with them; or we can just pretend. . . ." She was now in a teaching mode. Gary responded: "The dad could be black. They have one white kid and one black kid. A white person can marry a black person," and Mom considered, "Well, they could. . . ."

We (the therapists) thought that this could be an example of a normative developmental awakening to cultural and racial differences and similarities. But, like many normative queries, it might also have been commingled for Gary, with personal uncertainty about who could fit into his family, and who would fit into the role of dad. These were revisited themes, seemingly anchored in his loss and his sense of family-difference. During this portion of the play, Gary began to hold in his saliva. His mother did not seem to notice.

Gary switched his focus to the play people. He said: "We're moving! I'll get a taxi." Mom answered: "We're moving, again? OK. Let's find a house that fits." We (the therapists) noted that this theme paralleled the family's recent move. Gary cheerfully said: "This is the new house!" and we noticed that Gary had stopped holding his saliva. Susan playfully responded, "We're home! In our new house!" Both Gary and Mom made eye contact as Gary left the play mode to communicate directly with his mom. He reminisced: "This is a tiny bit like our special play time that we used to do!" When Gary was younger, Susan used to initiate a special "play time," but now that the family had moved and the children were older, she had stopped. Gary seemed to be telling her that he missed those times.

The play resumed, and Gary unexpectedly said: "I'm driving all the way to Oregon. The baby is sleeping under the car because he's afraid." He has now introduced the place where the family lived when his father was alive. Mom responded: "We're moving again? Why Oregon?" We wondered why Susan didn't acknowledge her understanding of "Oregon?" but Gary explained, "Well it's a nice place to live. . . ." As we watched the video we wondered, did the thought of Oregon bring up too much pain for Susan? There was a long pause (eight seconds of silence), and something shifted. Gary began to hold his head as he said: "My head hurts." Gary had apparently entered a "psychic equivalent" mode (Fonagy et al., 2002) where he got a "headache" after he had referred to Oregon. He seemed to be telling his mother about pain related to what was lost. But Susan didn't respond metaphorically in the pretend mode, nor did she make meaning out of Gary's struggle. Instead, she asked if his head hurt because he was hungry.

Gary returned to the play, and referring to the headache, he said: "I think it's because the lizards are poisonous." He had now introduced the idea that danger lurks all around as in biting and poisonous animals and terrorists, in addition to saliva and bad oil. Once again, Susan responded outside of the pretend mode. She had taken Gary's statement literally and tried to make him feel better. She said, "If you don't like them (the lizards) we can take them off the table." We were particularly interested in this moment because it showed when and how Gary's fears and play were able to meld, and we thought this might have been a link to Gary's symptom formation in his saliva/swallowing fear. This play theme ended when Gary told his mother that he wanted her to take the lizards away. Susan asked where she should put them, and when Gary replied, "Under the chair," she removed the lizards.

Now that Gary had been "heard," he resumed his play. He made roaring noises: "Raa! It's raining cats and dogs in Oregon and I don't like it." Once again he was letting us know that he was thinking about the place where he lived as a young child, and he was afraid. And at that point Gary had resumed holding his saliva. He introduced a bird who was threatened by the cats and dogs. Susan tried to calm down the play, saying: “It looks safe here . . . no cats and dogs.” But Gary re-introduced the cat into the scene. He screamed: “He keeps coming back!” After a brief pause, Gary yelled, “Help, I’m on fire!” His mom responded: “Oh no. No! He’s on fire.” Here Susan had sensitively stayed with her son in the pretend mode. After being on fire, Gary indicated that the bird was now freed up to fly through the air. The mom was relieved as she said, in a sing-song voice, “The birds are flying. . . .” Gary made sound effects simulating a bird flying: “Whoosh! Whoosh!” and he was smiling. Susan’s head movements followed the bird back and forth exclaiming: “Zoom! Zoom! Looks like he’s having a good time flying through the air!” At this point the time was up and both mother and son were smiling, with great relief.

Comment: We (the therapists) were struck by Gary’s aggressive play. It often elicited fear in the past, but in this case his mother was able to tolerate it. Susan had developed rich interactive play skills and she nonjudgmentally followed most of Gary’s themes. Gary showed he was thinking about his father. We wondered whether the poisonous lizard could be linked to his own fear of “bad oil,” and whether the bird “on fire” was linked to flying and death. Did his play reflect an attempt to master “flight” related to his ideas about his father flying around in heaven? Or was Gary’s imagery denoting his identification with multiple family members who have personal connections to planes. We also thought about Gary’s play in light of the horrific events of September 11 with planes crashing into buildings resulting in his father’s death among so many others.

EXCERPTS FROM THE PLAY OF GARY AND THERAPIST IN THE SAME 2006 SESSION

Following the play session with his mother, Dr. Sossin went into the filming chamber to play with Gary, “So, what’s on your mind?” Gary responded by starting to play. Dr. Sossin narrated: “The helicopter is on the ship. . . . The soldier is in front . . .” Gary explained, “The soldiers are fighting.” Dr. Sossin waited and then asked, “Who’s fighting? What’s happening?” Gary stated, “These people are against those people. Boom! Boom!” as he moved the toys around. He got right into themes of danger. Gary announced, “There’s a fire truck—in case someone gets on fire.” We recalled that the theme of fire was also played out in the session with his mother. Dr. Sossin warned, “Sounds like something’s going to happen. There’s a lot of shooting going on. The helicopter is in the air again . . .” as Gary’s war play went on. Dr. Sossin continued, “This looks like a real war. The ship is shooting; the tank is shooting. . . .” Gary made the ship knock the car off the ground. Dr. Sossin was animated, “Got em!” and Gary verbalized “Boom! Boom!” as he shot at the helicopter and it crashed. Dr. Sossin continued: “And the helicopter crashes, . . .” but Gary reassured Dr. Sossin, “Except the people are still alive.” Dr. Sossin responded, “Thank goodness.”

In this play interaction, Dr. Sossin noted that it was unusual to be alive after such an ominous crash, but Gary reassured him that there had been no deaths! Gary continued making war sounds as he resumed the shooting. In trying to join the play Dr. Sossin asked, “You tell me if there’s anything you want me to do,” and Gary assigned a role to Dr. Sossin saying, “You be this guy.” Dr. Sossin clarified, “Do I have a gun?” and Gary’s actions and sounds revealed that both of them had guns. He continued the fighting. Dr. Sossin worried, “Uh oh! What’s going to end this war?” Gary answered, “Don’t know.” Dr. Sossin: “It seems like it’s going to go on and on. Can this guy recover?” pointing to one of the war casualties, and Gary explained, “The people are still alive but they’re injured.”

As Dr. Sossin participated in this war play, he was aware that the end of their time was approaching, while the danger was still being enacted. He asked, “Should the people move away so they don’t get caught in the cross fire?” and Gary responded, “The tow truck will help whoever needs help.” Dr. Sossin acted relieved that there was some help available. Gary now brought in a fire truck that would put fires out on both sides.” The play continued and Gary made the fire truck put out a fire. Although some of the soldiers had been injured, no one had gotten killed. Dr. Sossin sighed, “We’ve been lucky. . . .”

Comment: In this brief segment of play with the therapist, Gary seemed to be working toward gaining some sense of power and control. We sought to understand and make meaning of the play and the themes of trauma and loss which were represented in the play. These themes, took on a reparative quality as Gary expressed his fears, sadness, anger and pain. There was a war going on, with shootings, fires and crashes, but no one actually died. The play themes moved toward resolution and the session ended on a positive note. Gary did not hold his saliva during the play with Dr. Sossin the way he did with his mother.

NOTES FROM THE FEEDBACK SESSION WITH SUSAN IN 2006, THE FOLLOWING WEEK

This session was attended by Drs. Beatrice Beebe, Phyllis Cohen, Mark Sossin, and Dr. Anni Bergman, together with Gary’s mother, Susan. Most of the therapist team had contact with Susan and her children over the years of the Project. As we prepared for this feedback session we recalled that Gary was 2¾ when his father was killed in the World Trade Center and his mother was pregnant with his younger brother. We recalled that recently Susan had broken up with a boyfriend, a man Gary was connected to. Gary was very disappointed; he had hoped he would be getting a “new father.” After that the mother had moved to another state with her children.

Susan began the session crying as she spoke about Gary’s symptom of holding his saliva and how difficult it was to be with him: “It doesn’t make sense. I’ve given him so much. . . .” We said: “Gary is a bright and complex boy. His symptom has meaning. Let’s think about what he’s been withholding in his saliva. . . .”

We aimed to help the mother see her son in a fuller light, and to help her reflect on the meaning of his symptom. The mom berated herself: “I try to understand him. I never hid anything from him. I’ve played with him. So how come everything I’ve done didn’t help him?” After a pause she continued: “He thought he was going to get a new father, but we broke up. Then came the move . . . I thought my break-up and our moving was a way to protect him. . . .”

We responded: “You’re thinking, how did you make this happen?” She laughed and responded, “I know it’s not about me!” We explained, “Gary seems to be holding on-to his thoughts, feelings and fantasies about what happened to him. He needs to sort out his bad dreams from reality.”

Susan then reported that Gary had been having bad dreams of being chased, along with other dreams of getting oil on himself. We explained that many of Gary’s thoughts and fantasies were revealed in the play that he shared with us. Susan recalled, “When Gary was younger and the baby was born, people told him that he had to be the big brother. That was a lot of pressure on him.” In trying to “normalize” Gary’s behavior we said, “Many of the children in the Project feel responsible to take care of everything. . . .”

Dr. Sossin shared with Susan that Gary had told him he wished he were a “baby.” His mother asked: “What does he want to go back to?” After encouraging her thoughts, we offered: “To a time when he was innocent; when no one he knew had died; when there were no bad people before 9/11. . . .”

With Susan’s assent, we moved to look at the videotape. We stopped the tape when Gary told his mother about Oregon. We asked her about it and she showed she “got it” when she responded: “He must have been thinking about where we lived when he was a baby and wishing we could go back to that time. . . .” The session continued as we discussed how children use magical thinking. Susan was working on understanding what had happened to her and her children. We explained that Gary had developed some fears and some unusual ways of managing them. He was upset over things he couldn’t control. Susan resonated with this: “Yes. Gary’s play is always about power and control. And about death and coming back to life. He kills people and then he says, ‘Alive!’”

As we watched some more of the video, Susan noticed Gary holding his saliva. Angrily she shared: “Sometimes I feel like screaming, “Swallow, that’s disgusting! You’re letting dribble come out of your mouth. Stop acting like a baby!” We responded: “He might be wanting to be a baby; babies don’t need to think about their dribble; babies don’t need to think about bad things that happen. He’s letting you know how stressed he is.” Susan wondered whether she was feeding into it? “Am I giving him what he needs in the moment?” and we responded, “You manage so much of your children’s lives, but this is something you can’t control.”

We explained to Susan that as the children in the Project have gone through different stages of development, they have revisited their fears and have had a chance to work through grief and mourning in different ways. We discussed ways Susan might join her son in his fears through entering into his “baby” play. This could take him back to a time before he lost his dad. Susan asked, “Why is his brother so tough? He seems to know what he wants and he’s not afraid of anyone.” We replied, “These two children seem to be very different. He never knew the Dad he lost, but Gary did. Gary has many fears and anxieties.” At this point, we suggested a referral to a therapist for Gary. We said: “Through therapy he can come to know what he’s afraid of, to separate fantasy from reality.” Susan accepted our referral.

Comment: We wondered about the many meanings of Gary’s refusal to swallow his saliva. His symptom began after he had a bout with strep throat, thereby linking swallowing with pain. In Gary’s psychological state, his body-based pain was ripe for a transformation in which pain of all sorts could be avoided by not swallowing. We thought of several possible meanings, including: a) “holding” onto his lost father, wherein the swallowing may have been deemed a destructive/eliminating act linked to losing him again; b) swallowing was an action over which he could exert his own will; i.e., holding onto an illusory sense of control; c) holding saliva may have been an enactment of holding back his anger; and d) the baby-ish mode of drooling could have become an embodiment of Gary’s sense of helplessness and wish to be a baby again, when life was less complicated and painful. We also thought about how Gary’s heightened sense of “danger” reflected his getting older and becoming more aware of the dangers in the world, including those who were responsible for the killing of his father. After sharing some of these possible meanings with Susan, she understood that Gary’s needs to address his anxieties and fears were not a function of her faulty parenting.

2008: EXCERPTS OF PLAY SESSIONS WITH GARY AT AGE TEN AND SUSAN, GARY, AND THERAPIST, AND A FEEDBACK SESSION WITH SUSAN

In their play session we noted that Gary and Susan shared a mutual interest in their joint squiggle images of "a plane carrying a message," "a dive-bomb," and "a man under water." While there was no direct reference to Gary's father or the World Trade Center, we noticed how Gary's emerging ideas regarding events surrounding his father's death were symbolized in the play, and were referenced symbolically between mother and son.

The play with mother was followed by play with Dr. Cohen. She asked Gary what he would like to do, and he asked to play tic-tac-toe. Gary became very focused on the game. Then his pencil point broke. He told Dr. Cohen that he remembered how frequently his pencil points had broken the previous year during his lab visit.

Comment: This was a painful image that the therapists recalled. In the previous year's visit, Gary had been bearing down so hard on his pencil point as he was drawing that it had broken several times. We had understood this as evidence of Gary's anxiety and difficulty harnessing his aggressive feelings. Gary and Dr. Cohen shared their memory of Gary's difficulty, and thus shared an aspect of Gary's inner world. Together they were tracking continuity and discontinuity between past and present.

The conversation with Cohen evolved as Gary told a story about a special group experience he recently had at a summer camp program designed for children who lost a family member on September 11, 2001. He wanted to go again next year because he had enjoyed the interaction with children who understood his experience, since they too had lost a family member. Gary explained that he was in some contention with his mother about returning next summer. There had been a bedbug problem in the camp, and Gary needed to convince his mother that he was right in wanting to return. He said, ". . . I try to tell her all the good things about it [the camp], but my mom says 'You like to argue for sport,' which I don't agree with, but then I'm not going to argue about that because that would make my mom's point."

Comment: Gary's thinking was occupied by the "lose-lose" position he felt he would be in if he were to choose to argue, or not to argue, with his mother. We (the therapists) thought about where Gary was in his own developmental path of differentiation. We noticed him strategizing about how to deal with his mother. We were aware that he was experiencing his self-assertion backfiring. This theme was then woven into the video-feedback consultation with Susan.

This video feedback session was attended by Drs. Beebe, Sossin, and Cohen. Susan began by underscoring how challenging it was to be the sole parent, and her view that had her husband lived, he could have played a vital role in helping Gary find his strength. She was feeling frustrated, sad and depleted. We noted the parallels between how Susan saw Gary and her own struggle to be effective and strong in her family of origin. Susan shared how difficult it was to deal with her strong, overbearing father and her ineffective mother. In Susan's mind Gary should have been stronger than he was, but not so strong as to defy her. We explained how Gary had idealized his fallen father. He had sought to be strong and valiant in his father's likeness, as well as in the likeness of other idealized male family members. At the same time he desperately wanted to please his mother, from whom he was receiving mixed messages. In this session Susan was able to see how she was contributing to a bottleneck in Gary's path toward assertion and individuation.

As we watched the video interaction with Susan, we pointed out an interwoven paradox that was apparent in Gary's words and body language. Gary had developed super-strong goals for himself, of which he sounded confident and determined. However, with his very thin frame, he took on a hollowed posture, and his movement patterns were hesitating, with low-intensity. Not only did Gary seem inwardly conflicted about expressions of strength, but he was ambivalent about his strength in his relationship with his mother. While Susan praised her son's fortitude and vitality when they were in evidence, nevertheless, she did not want him challenging her. But, she also did not want him to be weak. She saw on the video, and acknowledged, her reflexive negative reactions to any signs of weakness that Gary demonstrated.

During this feedback session we learned that Gary's symptom of holding his saliva had abated over the year that he had been in individual therapy. We explored the personal and historical anchors for Susan's strong and at times negative feelings toward Gary. We observed how her new insight in this regard seemed to soften her visceral reactions to Gary's patterns. Following this session, the therapists noted how Susan's unconsciously driven attitudes about her husband and her father had complicated her relationship with Gary. We were encouraged that, with her new awareness, Gary's development might become more adaptive.

2011: EXCERPTS FROM THE PLAY OF SUSAN AND GARY, AND GARY WITH A THERAPIST, AT AGE TWELVE

Gary had grown from a young child to a pre-adolescent boy. He was now more inclined to talk than to play with toys. He engaged in telling imaginative stories with his mother. Susan and Gary collaboratively began a drawing and storytelling game. At one point Susan put a skier on a mountain, thinking this was what Gary was drawing. But he corrected her saying, "What? I was thinking more of a volcano!" In response, Susan refocused and said, "Okay. Yeah, yeah. . . . Wait! It's erupting!" Gary continued his theme: "And the guy is trying to get away now. . . .” In this interactive play sequence, Gary and Susan entered a collaborative dialogue in which they both furthered the play and each took pleasure. They engaged in repeated mutual laughter about the unfolding storyline involving a volcano, a skier, and a helicopter. There was also a drawn image that one perceived as a turtle and the other perceived as a car; hence, they playfully agreed to call it a “Curtle.” Gary and Susan were quite masterful at joining in their humor and imagination.

As Susan left the filming room, Dr. Sossin entered. Gary began by explaining how he remembers things in images. Dr. Sossin was aware that Gary wanted to talk about the past. He thought to himself about how Gary’s loss of his father before the age of three had framed the way he experienced and held memories. He listened, and Gary revealed: “I just think about what happened. . . . I think of random images, one by one, and then I kinda get the whole picture.” Dr. Sossin followed Gary’s words and inquired about why he thinks he does this. Gary answered: “Pretty much because my dad died. I mean I was just kinda thrown off by everything so that every little change scared me half to death. So that’s why my family moving was a huge change. . . .” For the first time Gary spoke directly about his father, and his explanation seemed to be related to his symptom of holding his saliva exhibited several years earlier.

Gary then spoke about how he had initially processed his father’s death: “Because my dad died, I did not ‘get’ that he wasn’t there. . . .” He explained, “I think I was probably more scared when I knew he wasn’t coming back at all . . . I don’t really remember back when I was 3 or 4. What I do remember is tiny bits and pieces. First, I thought, ‘Where is he?’ Then it kinda changed into, ‘Okay he is not here.’ And then I figured out what happened, and I knew he was not coming back. . . .”

Dr. Sossin and Gary spoke of how Gary had coped with his sad feelings through reading and how this had helped him in school, but not in making friends. Dr. Sossin explained: “I think reading is a special place you used to go . . . a place that feels very comfortable for you . . . where you can remove yourself to. So, more recently maybe you’re trying to remove yourself a little less, to be more connected to things. . . .”

Comment: The engagement in this interaction between Gary and Dr. Sossin was intense and reciprocal. Together Dr. Sossin and Gary connected Gary’s way of seeing with his ability to cope with a deeply painful loss from a long time ago. This was the first time Gary had ever spoken directly about his father even though we had seen him approximately ten times over ten years. The nature of this conversation showed his growing capacity to understand and mourn the loss of his father.

DISCUSSION

In this chapter we described a video intervention that involved brief ten-minute play interactions of children with their mothers, and of children with therapists, followed by feedback sessions with the mothers the following week. On September 11, 2001, the mothers were pregnant and their husbands had died. We saw the babies born post September 11, as well as their siblings. Our frame was flexible and evolved to meet the needs of the families. Sessions were approximately one year apart, although toward the end of the decade, some of the mothers came more often without their children. The children were getting older and no longer wished to be taken out of school to attend video sessions. Also, as family structures changed, with a new boyfriend or a remarriage, we offered consultations that addressed new couple issues.

Even though the lab visits and feedback sessions were intermittent, it was evident that both the children and the mothers maintained a continuity from one session to the next, and from one year to the next. To an extent that surprised our therapist team, the mothers and children demonstrated integration of our prior work as they shared remarkable memories of earlier exchanges. They were consistently motivated to pick up from where we left off, despite the significant amount of time between our meetings.

Throughout the Project we looked at both the explicit and implicit, the verbal and the nonverbal, the processes embedded in interactional exchanges, the meaning-laden content of richly imbued play, symbolizations, representations, and many historically-anchored repetitions. In consultations with mothers, we reviewed dynamics in the mother's family of origin as well as her pre-loss marital relationship and qualities of attachment. Linkages between past and present were effective in the multi-therapist format. Mothers seemed to build more elaborated working models of their own minds, and of their children's minds, in concert with our discussions. As we together became more aware of their unconscious processes, the mothers grew more tolerant of their own emotional shifts, and they understood more of their childrens' behavior. They became increasingly more attentive and responsive to their children.

When we suggested possible meanings that a mother may not have considered, we were often able to shift her representation of her child's mind and person into someone more multifaceted. In turn, she became more inwardly driven to know and to understand. For example, helping Susan to think about Gary's motives, feelings, and confusions had a carry-over effect. It elevated her respect for his developmental struggles and for the psychological work he was doing in play and in life, and it helped her look at her own participation. A parallel emerged in the ambivalence that both Gary and Susan felt toward assertion and aggression, and safety and compliance. Helping Susan address her own conflicts offered Gary a greater opportunity to negotiate his own conflicts, express his real sadness, and channel his aspirations.

We aimed to apply what we knew about bi-directional influences between mothers and children, derived from microanalysis research on mother and infant affect sharing, vocal rhythms, pausing, turn-taking, and nonverbal behavior more generally (Beebe, 2000, 2003, 2005). We sought to help the mothers attend to patterns that, often outside of awareness, influenced the quality of mother-child play, and a sense of efficacy in each partner. We pointed out moments when a child's symbolic representations were recognized and elaborated in play with the mother. We also noted moments when mothers left the "pretend" mode in their play with their children. When this happened the "play" was often shifted into a directive or teaching mode. We attended to unfolding themes and considered how they were introduced, absorbed, and elaborated in play. We also attended to moments in which magical thinking might be sustained, when it did not serve the child's capacity for coping and mastery, but rather perpetuated early dissociative defenses.

Our work with the mothers in our Project informed our direct exchanges with the children, and our exchanges with the children informed our work with the mothers. In our case example, we believe that Susan's growth and expansion of her capacity to reflect freed Gary to observe and come to know his own mind as well as he did. In turn, she increased her own capacity for self-reflection. We observed how children's mourning processes take on different forms at different points in their development. A mother and child may experience a mismatch of needs at one particular point in time, with heightened tension and conflict, while at a later point they might achieve an increase in reciprocal tolerance and empathy.

Rather than a child-centered therapy, our model involved a special collaboration with both child and mother following their devastating losses. Some mutative elements may stem directly from the child-therapist contact. However, we believe that our collaboration with the mothers provided the foundation of the prevention and intervention Project. It equipped the mothers to hold the child through a mourning process in which she herself needed help. In retrospect, we believe that our approach of seeing the mothers and children in this way facilitated a trajectory of healing and of increased resilience. Our work incorporated elements of psycho-education for the mothers regarding a child's ways of thinking about death, and his or her need to know about and represent the lost father. Judicious use of normalization regarding the mother's or child's preoccupation with loss was also facilitating.

Our understandings of mother-infant interaction, nonverbal communication, unconscious processes, phase development, and separation-individuation informed our interventions and our ways of thinking about adaptation and coping. While the specific methods that we developed in this Project might be difficult to replicate, the powerful up-close observations of children's play and dyadic processes, the utilization of video to heighten awareness and reflection, and the multiple-therapist team approach, all contributed to helping these families. We hope that aspects of this work can inform professionals who may be called upon to work with families with young children going through experiences of loss and grief.

NOTES

1. Our work on the "Mothers, Infants, and Young Children of September 11, 2001: A Primary Prevention Project" is described in Beebe, Cohen, & Markese (2011); also in Beebe, Cohen, Sossin, & Markese (2012).

2. The eight core therapists working in this primary prevention Project are Beatrice Beebe, Phyllis Cohen, Anni Bergman, Sally Moskowitz, K. Mark Sossin, Rita Reiswig, Suzi Tortora, and Donna Demetri Friedman. Joseph Jaffe was also a valued contributor.

3. Each member of the dyad is seated face-to-face with one camera on the mother's face and the other on the baby's face. A single videotape is generated containing both images simultaneously, in a split-screen format.

4. Screening instruments were employed to alert us to excessive distress in either the parent, or child, such as the Strange Situation to assess child attachment security, the Steele Affect Task to assess the child's knowledge of emotion, and various self-report measures related to depression and anxiety.

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