
FITS AND STARTS: A MOTHER–INFANT CASE-STUDY INVOLVING INTERGENERATIONAL VIOLENT TRAUMA AND PSEUDOSEIZURES ACROSS THREE GENERATIONS

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

RESUMEN: Este estudio presenta en detalle el caso de la evaluación clínica de una madre de 29 años y su hija, la cual se les presentó primero a los especialistas de la salud mental infantil a la edad de 16 meses, cuando ya tenía un historial clínico que hacía pensar en la presencia de trastornos en la afectividad desde que tenía 8 meses. En este contexto, llevamos a cabo un estudio de los datos proporcionados por medio de las evaluaciones siquiátricas y neurológicas, así como también de las medidas obtenidas por medio de la observación de la niña y su madre. Atención especial se le presta a los asuntos relacionados con los trastornos de la afectividad, el trauma intergeneracional, y los factores culturales para esta pareja hispana de madre e hija de un barrio del centro de la ciudad. Fuertes irregularidades en los sentimientos maternos, como resultado del haber estado expuesta a tempranos ataques de violencia traumáticos, se manifestaban como ataques psicogénicos, a los cuales la madre se refería como "ataques de nervios," indicando con esta frase un aflicción comúnmente asociada con traumas y disociaciones en la niñez.

Supported in part by an Eli Lilly Pilot Research Award from the American Academy of Child and Adolescent Psychiatry (Dr. Schechter), and a grant from the Research Advisory Board of the International Psychoanalytical Association (Dr. Schechter). Direct correspondence to: D.S. Schechter, New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons, 1051 Riverside Drive, Unit 40, New York, NY 10032; e-mail: deschechter@psychoanalysis.net.

INFANT MENTAL HEALTH JOURNAL, Vol. 24(5), 510–528 (2003)

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Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/imhj.10070

Exploramos los mecanismos por medio de los cuales la vuelta de la madre a experimentar traumáticas experiencias de violencia, junto con un frecuente despertar, todo ello asociado con sentimientos negativos, se le comunican a la pequeña niña y al clínico observador por vía de la acción y el lenguaje de un momento a otro durante el proceso de evaluación. Este ensayo concluye con una discusión de las implicaciones de diagnóstico y tratamiento de los Drs. Marshall, Gaensbauer and Zeanah.

RÉSUMÉ: Cette étude de cas présente en détail l'évaluation clinique d'une mère de 29 ans et de sa fille qui avait été présentée à des spécialistes de santé mentale du nourrisson à l'âge de 16 mois, avec un dossier hospitalier suggérant la présence d'un trouble dyadique depuis l'âge de 8 mois. Les données d'évaluation psychiatrique et neurologique, tout comme les mesures d'observation de l'enfant et de la mère sont passées en revue en portant plus particulièrement attention aux problèmes d'attachement perturbé, au trauma intergénérationnel et aux facteurs culturels de cette dyade hispanique des quartiers pauvres. Une dérégulation sévère de l'affect maternel à la suite d'une exposition précoce chronique à un trauma violent manifesté sous forme d'attaques psychogéniques, dont la mère parlait comme étant des "crises de nerfs", ces dernières, faisant référence à un désarroi, étant communément associées à un trauma de l'enfance et à la dissociation. Nous explorons les mécanismes selon lesquels la ré-expérimentation des mères d'une expérience traumatique violente, ainsi que l'hyperexcitation physiologique et les affects négatifs qui y sont liés, sont communiqués au très jeune enfant et au clinicien-observateur à travers l'action et le langage d'un moment à un autre durant le processus d'évaluation. L'article conclut avec une discussion du diagnostic et des implications de traitement par les Docteurs Marshall, Gaensbauer et Zeanah.

ZUSAMMENFASSUNG: Dieser Fallbericht zeigt im Detail die klinische Untersuchung einer 29 Jahre alten Mutter und deren Tochter, die sich zuerst einem Spezialisten für die seelische Gesundheit des Kindes im Alter von 16 Monaten mit einer Krankengeschichte präsentierte, die das Vorhandensein einer dyadischen Störung seit 8 Monaten annehmen lies. Die Ergebnisse der psychiatrischen und neurologischen Untersuchung und die Messdaten der Beobachtungen von Mutter und Kind wurden nochmals mit einem besonderen Augenmerk auf gestörte Bindung, zwiischengenerationales Trauma und kulturelle Faktoren überprüft, die diese lateinische (mexikanische, oder puertorikanische) Dyade aus der Innenstadt beeinflussen könnten. Schwere mütterliche Affektdysregulation als Ergebnis von chronischer, früh begonnener Misshandlung zeigte sich als psychogene Anfälle, die die Mutter in Spanisch als "Nervenattacke" bezeichnete. Dies ein Wort das als Bezeichnung für negativen Stress, zumeist in Verbindung mit kindlichem Trauma und Abwehr verwendet wird. Wir untersuchen die Mechanismen mit denen die Mutter die gewalttätige Misshandlung wiedererlebt, in Verbindung mit der physiologischen Überwachheit und den dazugehörigen negativen Affekten, welche dem sehr jungen Kind und dem Kliniker-Beobachter durch die Handlungen und die Sprache in jedem Moment des Untersuchungsprozess weitergegeben werden. Die Arbeit schließt mit einer Diskussion der diagnostischen und therapeutischen Implikation durch Dr. Marshall, Gaensbauer und Zeanah.

抄録：この症例研究では、29歳の母親と、生後16カ月で最初に乳幼児精神保健の専門家に診察された娘の、詳細な臨床評価を提示する。この娘には、生後8カ月から、二者関係の障害があったことを示唆する、病院の記録があった。精神医学的評価と神経学的評価のデータは、子どもと母親の観察から測定されたものとともに、愛着障害の問題、世代間の外傷、およびこの中心市街地に住むラテン系の二人にとっての文化的要因に注目して、検討された。慢性の早期から始まった暴力的な外傷に暴露された結果としての、母親の深刻な感情調節不全は、心因性の痙攣として表れた。それは母親の母国語であるスペイン語では "**ataques de nervios**" と呼ばれ、後者は、悩みの表現であり、一般的には児童期の外傷と解離とに伴っていた。われわれは、母親の暴力的な外傷体験の再体験が、生理学的な過覚醒とそれに伴う否定的感情とともに、評価過程の間の一瞬一瞬で、非常に幼い子どもと臨床家である観察者に、行動と言葉を通して伝達される機制を、探求する。 **Drs. Marshall, Gaensbauer** そして **Zeanah** による、診断と治療上の意味についての討論をもって、論文は終わる。

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

Forty-one innercity Latino and African American mothers who have survived interpersonal violent trauma during childhood and adulthood, physical, and sexual abuse and assault, as well as domestic violence have been interviewed. More than a third of these mothers have had to face child protective service investigations, filing of restraining orders, suicide attempts, and fear of their own violent behavior. More than a half identify their very young children ages 8–48 months as the main stressor in their lives. These are women who are referred to our Infant–Family Service, formerly known as the Therapeutic Nursery, a clinic within the New York–Presbyterian Hospital Division of General Pediatrics that is meant to service families with children under five years of age who are at risk for violence exposure, abuse, and neglect. These are families that are not only referred, but who also present to clinic visits.

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

THE CASE

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

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

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

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

Libby, who had been born as the healthy product of a full-term, uncomplicated pregnancy and normal delivery, and who had unremarkably unfolding milestones, turned out to show no

evidence of a seizure disorder during the continuous EEG monitoring. MRI and CT scans of the brain were unremarkable. The hospital staff described Libby as “alert, awake, and delightful.” Her blood-phenobarbital level was 18.5 $\mu\text{g/ml}$, a nontoxic value (therapeutic range: 15–35 $\mu\text{g/ml}$). The staff held Libby on the pediatrics ward while her medications were tapered and stopped.

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

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

THE EMERGENCY ROOM EVALUATION

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

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

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

Nancy’s terror was clearly fuelled by this history of maltreatment, neglect, violence exposure and sudden, unresolved losses: she recounted that she had been frequently hit by her father with a belt and shoes up to age four. Her mother left her stormy marriage and family behind to seek employment in the United States when Nancy was eight. After her mother left the family in the care of Nancy’s father and his family, Nancy’s paternal uncle smothered and battered her, and forced her to perform fellatio and sexual intercourse repeatedly over the next three to four years, until Nancy was nearly 13. Of note, this uncle, like Nancy’s father, was an alcoholic. Before her 14th birthday, Nancy had already given birth to the first of two children fathered by that uncle. After their birth, she was sent away to New York to join her mother when she was about 15. Nancy never saw those children again, and says that she has difficulty even thinking about them.

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

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

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

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

OUTPATIENT TREATMENT

After a 24-hour observation period in the ER, Nancy was referred to the adult psychiatry clinic for treatment of her depression and PTSD. Alisa was referred to the Pediatric Psychiatry Clinic for psychotherapy, and Libby and Nancy were referred to our Infant–Family Service for an infant–mother assessment. After an initial screening and informed consent, Nancy and Libby—then age 16 months, returned two weeks after her discharge from the ER to participate the first author’s research protocol (Schechter et al., 2001). During this time period, Nancy’s PTSD symptoms had worsened, while at the same time her ataques de nervios had stopped.

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

The third visit is a videofeedback session based on the principles of Interaction Guidance, a form of parent–infant psychotherapy developed by Susan McDonough (1995) with variations by many others (Beebe, 2002; Juffer, van IJzendoorn, & Bakermans-Kranenburg, 1997; Papousek, 2000; Zelenko & Benham, 2000). This method employs videofeedback in a supportive setting with therapist present and active to engage the caregiver in thinking about her own and her child’s actions and reactions. For the purposes of this study, the clinician-investigator

supports the mothers' strengths, asks mothers what moments stand out in their memory prior to any videofeedback, and then show a clip of what is considered to be an optimal interaction for a given dyad: namely, those interactions that show the most shared joy, attention, and spontaneity. The interviewer then repeats items from the maternal perception measure, before going on to show the stressful moments of separation and reunion (in addition to probing for mothers' understanding of what might be going on in their children's mind and their own during the excerpts, as part of efforts to understand maternal reflective functioning as described in more detail below).

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

At this time, Nancy reported significant posttraumatic stress symptoms, with a Posttraumatic Symptom Checklist score of 70 (Weathers, Litz, Huska, & Keane, 1996). Diagnoses of current and past PTSD were confirmed on the SCID (First, Gibbon, Spitzer, & Williams, 1996). Nancy was moderately depressed without psychotic symptoms (Beck Depression Inventory Score of 23) (Beck & Beamesderfer, 1974).

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

The following observations were noted from a microanalysis of that videotaped interaction as coded by an independent coder, using the *Atypical Maternal Behavior Instrument (AMBI-ANCE)* (Bronfman, Lyons-Ruth, & Parsons, 1999). This coder (Dr. Kaminer) was blind to any information about the dyad except for the child's age.

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

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

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

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

LIBBY'S SYMPTOMS AT HOME: WHAT TO MAKE OF THEM?

We know from Nancy's report as corroborated by her sister Alisa that Libby would frequently wake up during the night crying as if she had had a nightmare. She would sit up in bed vigilantly with mother—who also suffers from chronic insomnia; and, according to Nancy, the two would watch the window and door for any signs of an intruder, until exhausted and unable to stay awake. Nancy said that Libby was easily startled by loud noises at home, as had been observed in the clinic. Moreover, Libby had been noted during the assessment to be apprehensive with a restricted range of affect, sparse vocalization, and constriction of exploration and play. We know that Libby had the capacity for a brighter engagement and interest in her environment by her interaction with staff, who she readily engaged. Of note, Nancy denied that Libby had been exposed to any domestic violence, physical and/or sexual abuse, accidents, or medical trauma. So, while Libby does indeed seem traumatized, she cannot tell others directly what has been traumatic to her.

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

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

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

In a study of over 70 Latino patients by the first and third authors (Schechter, Marshall,

Salman, Goetz, Davies, & Liebowitz, 2000), a similar association between ataques de nervios and childhood trauma history was found, such as that between pseudoseizures and childhood trauma by Bowman and Markland. “Ataques” for many individuals likely represent a culturally sanctioned expression of trauma-related affect dysregulation. A very recent study of 40 native Puerto Rican outpatients with high rates of childhood trauma, 16 with ataques and 14 without, has demonstrated an association between presence of pathological dissociation and frequency/severity of ataques, pointing to the possibility of childhood trauma being a necessary but insufficient risk factor for “ataques” (Lewis-Fernandez et al., 2002).

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

In conclusion, this case-study has dramatically illustrated the complexity of one mother’s attempt to cope with the adverse effects of her own severe chronic childhood maltreatment that began during infancy and continued into adulthood. She struggles with her own affective and behavioral dysregulation in the wake of horrific assaults to her body and mind while she is simultaneously attempting to contend with her young daughters’ socioemotional needs during critical phases of their development. In effect, Nancy communicates in multiple modes of action and language from moment to moment her history of violent trauma to her preverbal daughter Libby. The dyad, in turn, communicates their mutual affect dysregulation to me the observer.

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

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

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

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

As further evidence of this difficulty in being able to tolerate, let alone think about what might be going on in her own mind and in that of her daughter at such distressful moments, Nancy scored low in what Fonagy and Target (1996) have termed “Reflective functioning.”

Reflective functioning (RF) is indeed an important measure of an individual's ability to think about thinking of the self and other and has been shown to be positively correlated with maternal sensitivity and attachment security, as well as negatively correlated to hostile-intrusive and other atypical maternal behavior, when the Fonagy and Target coding system for RF was applied to parent perception measures (Grienenberger, Kelly, & Slade, 2001; Slade, Bernbach, Grienenberger, Levy, & Locker, 2000).

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

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

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

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

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

With this coding scheme in mind, Nancy's overall RF score was "3."

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

Nancy, like many of the more than 30 traumatized mothers who returned for a videofeedback session two to four weeks after the play procedure, showed a significant reduction in the degree of negativity and distortion of her attributions toward her child on a rating scale coded blindly by four developmental specialists with interrater reliability coefficients of .75 and .86, respectively (Schechter et al., 2002).

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

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

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

***Videofeedback Excerpt Midway Through Video
Feedback Session***

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

Dr. S: Okay so what happened there?

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

Dr. S: What broke her heart?

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

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

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

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

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

Dr. S: How were you feeling then?

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

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

N: Real sad and angry?

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

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

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

N: Because she threw the puppet.

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

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

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

N: I don't know.

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

N: Yeah because I left, she was angry.

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

N: Me!

Dr. S: How so?

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

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

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

Dr. S: How old were you then?

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

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

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

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

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

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

N: Mean . . . I never knew if my father loved me or hated me because he never told me . . .

CONCLUSION

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

Nancy states to the clinician as her interpretation of her daughter's separation distress, "You broke my daughter's *heart* in pieces." We understood this to mean that the Nancy perceives even momentary separation as both damaging and fragmenting to the child based on her own childhood experiences. The potential for hostile-aggression that would "break" the heart, Nancy attributes to the "mean" clinician who has Nancy do to her child what Nancy's caregivers did to her, namely, leave her behind and neglect her need for protection.

By the end of this feedback excerpt, the "mean" figure who seemingly "likes to hit" Nancy is located in the person of her father and in the past. Yet the multiple meanings of this memory remain unknown. In reviewing this session, we were struck by how this very emotionally intense memory involving her father, albeit negative and violent in nature, is said to have taken place around the time her mother abandoned her family. Could it be that this remembered intensity is preferable to remembered absence of caregiving and the conflicted feelings around the sexual abuse that would later take place while neglected?

Although we cannot know the answer to this question from this single session, over the process of the three videotaped sessions, we do note change in (1) Nancy's localizing her distress from her body to her psyche, and (2) in her increased capacity for abstraction, self-

observation, and reflective functioning. The excerpt, in fact, begins with Nancy's demonstrated capacity to think about the body as object-of-violence in metaphor rather than concretely via the enacted pseudoseizures with headbanging, or other somatic symptoms, as Nancy had done prior to her contact in the Emergency Room. She does this in a friendly, joking manner with the research-clinician, thereby exhibiting her ability to reflect on the events during the taping from an alternative perspective. As noted, her attributions toward her child concomitantly become less negative and distorted following the video feedback.

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

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

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**COMMENTARY BY RANDALL MARSHALL, M.D.:
MATERNAL PTSD OVER THE COURSE
OF THE EVALUATION: DECOMPENSATION
OR CLINICAL PROGRESS?**

Perhaps the best validated psychosocial treatment principle across the anxiety disorders is that exposure-based techniques are highly effective. The various validated forms of trauma therapy have in common procedures that focus on memories of trauma, while providing a new and therapeutic experience that becomes associated with remembering the event(s). Intrinsic to the extinction process is the temporary evocation of highly distressing memories, cognitions and emotions associated with the trauma.

In this case, the evaluation disrupted Nancy's elaborate defenses against remembering her trauma without providing adequate assurance of safety or containment, in part due to urgent staff concerns for the safety of the children. The result was cessation of the attack symptoms with simultaneous worsening of her PTSD symptoms.

It would be simplistic to label this phenomenon as proof that the evaluation was "retraumatizing," however. An alternative explanation is that the patient's psychopathology shifted from nonverbal enactment (pseudoseizures) to reexperiencing of the trauma in a way that could potentially be accessed and organized verbally. This shift occurred when the evaluation, focusing on the children's distress, stimulated reflection on the connection to her own trauma history. The clinicians also provided critical education about the fact that psychological suffering can produce physical manifestations.

The process of untangling past perceptions (of violent and abandoning perpetrators) from present perceptions (her young child's normal affects, communications, and outbursts) was greatly facilitated by a single session of videofeedback, conducted by a clinician using a reflective and affect-focused technique in a supportive clinic milieu. Afterwards, Nancy was able to experience and discuss memories of her own abuse with relative clarity, as opposed to reexperiencing them psychosomatically.

Why did this insightful shift occur at this point, and not four years prior when a similar evaluation led to a recommendation of psychotherapy? The most obvious difference apart from the mere passage of time is that Nancy's reevaluation occurred in the context of the perceived threat of the loss of her children during their inpatient evaluation. The cost of continuing to deny the intrapsychic aspect of her own distress perhaps became too great, thereby motivating change and compliance with treatment recommendations. The alternative must also be considered—that Nancy was merely feigning compliance so as not to lose her children. Based on the video feedback session, however, I do not believe this was the case. Apart from Nancy's report that no further attacks occurred following her emergency room intervention, her affect and verbal content during the research evaluation appeared genuine, spontaneous, and reactive to what she was experiencing, both with her child and while viewing the videotape with the clinician.

The cathartic nature of her experience, and the accelerated process of recovery, is actually typical of what is seen in many exposure-based therapies in persons with chronic PTSD. The fact that, as Dr. Schechter's intervention demonstrates, such dramatic and potentially life-changing improvement can also have transgenerational effects is all the more reason to promote both public health awareness of such treatments and further research in this important area.

**COMMENTARY BY THEODORE J. GAENSBAUER, M.D.:
INTERGENERATIONAL TRANSMISSION OF TRAUMA:
THE INFANT'S EXPERIENCE**

In my discussion, I would like to move beyond the question of what of her previous violent experiences Libby's mother is "transmitting," to examine what the infant is "receiving." In other words, what is Libby's experience of her mother's traumas? As the authors describe, Libby seems traumatized, but cannot tell us directly what has been traumatic to her. How do we conceptualize the multiple ways in which her mother's traumatic experiences are impacting Libby? Are Libby's symptoms best conceptualized in terms of trauma? Can we infer anything about the nature of any traumatic experiences that she may have had, based on her symptoms? What can we say about the overall influence of her mother's traumas on Libby's emotional development? These are the questions I would like to address.

Broadly speaking, we can conceptualize a number of different ways that her mother's very traumatic childhood is impacting Libby's development. The first and most general form of impact would be through the many stressful, if not traumatic, situations that Libby is exposed to, either as witness or indirect participant, as a consequence of her mother's overall psychopathology and difficulties in managing her life. Although we have almost no information about the home environment, we can assume a considerable degree of instability in the living situation and in the mother's availability to the children. There is no mention of a father being in the picture for either of the children, and while domestic violence is denied, we know that Libby's mother is at high risk for abusive relationships. A representative example of Libby's exposure to stressful situations that come about as a result of her mother's traumatic vulnerability would be the dramatic episode in the hospital where her mother was restrained, had a pseudoseizure ("ataque"), and was carried off to the emergency room, all in front of the children. We have no further information about Libby's response to this event or the extent to which it influenced her subsequent behavior, but we can be sure that it was highly upsetting. The unnecessary administration of phenobarbital and diazepam suppositories, while apparently not significantly harmful, would be another example of this kind of generalized spillover effect.

A second manner of influence would be through the direct transmission of her mother's fears. Libby and her mother are described as sitting up in bed at night vigilantly watching for any signs of an intruder. Because at 16 months of age it is unlikely that Libby would have a well-formulated picture of what kind of danger they were watching out for (unless she had witnessed some form of violence already), we can assume that any sense of danger that she is experiencing is being significantly influenced by her mother's fear. This form of social referencing, where the child's symptoms are largely driven by the mother's anxiety, has been described by Drell, Siegel, and Gaensbauer (1995) as "PTSD a deux" and by Scheeringa and Zeanah (2001) as "relational PTSD." In this way, her mother communicates to Libby that the world, with certain kinds of men in it, is a frightening place.

A third, and likely the most powerful form of influence, involves the direct impingement on Libby of her mother's distorted perceptions and affect dysregulation in the form of problematic caregiving interactions. In the article the mother's patterns of interaction with Libby are documented in detail. At times, she is warm and sensitively contingent. At other times she is hostile, intrusive, provocative, overstimulating, and anxiety-provoking. Although clearly distressing to Libby, it is important to ask if these problematic patterns rise to a level that we would conceptualize as "traumatic" from a diagnostic standpoint, defining "traumatic" in the strict sense of the term as an extraordinary event involving actual or threatened harm. Although the laboratory interactions do not reach this level, we know much less about what goes on at home. It is safe to assume, however, that the kind of maternal "frightening-frightened" behavior

observed in the laboratory would not only go on at home, but would occur at orders of magnitude much more severe than were seen in the laboratory.

Separate from this definitional issue, from a diagnostic standpoint a related question would be whether Libby's symptoms are in themselves sufficient to make a diagnosis of posttraumatic stress disorder. The symptoms observed in the laboratory—apprehension, restricted range of affect, sparse vocalization, and constriction in exploration and play—are certainly consistent with PTSD, but can be associated with other causes as well. Similarly, startle reactions and distressed night awakenings are also seen in association with trauma, but are also somewhat nonspecific. Missing for the most part are clear-cut symptoms in the reexperiencing/reliving category, such as behavioral reenactments or doll play, that would point to specific traumatic events reverberating in the child's mind. From the clinical material, I could identify two possibilities. One could speculate, for example, that Libby's head banging during tantrums could in part be modeled on witnessing her mother bang her head during her "ataques." This association is tenuous, however, in that we have no information about how often or over what time period Libby may have observed "ataques" in the home environment and head banging is not unusual with tantrums. The behavior that I believe comes closest to a possible "reliving" experience would be the "frozen watchfulness" observed during the interactional sequences with her mother, a response that has historically been associated with abuse (Frude, 1980). This reaction on Libby's part may not just be, as the authors' describe, "an attempt to cope with her own affective dysregulation." It may also represent her immediate fear of her mother's rage, including the possibility of being hit, triggered by cues that have been associated with escalating anger on the mother's part in the past. For these reasons, despite her mother's denials, the possibility that Libby has experienced some form of physical and/or verbal abuse needs to be a continuing concern.

Concerns about possible abuse are heightened by the fact that the mother's dynamics, so clearly laid out in the article, are characteristic of the dynamics of abusive parents. As described by Steele (1970), abusive parents are seen to oscillate between overidentifying with their children's distress based on their own pain on the one hand, and feeling criticized and attacked as they identify the infant's cries with their childhood abusers on the other. At the moment that these feelings switch and the parents feel criticized and attacked by the infant, the rage they feel toward their past abusers can be explosively transferred on to the infant. Libby's mother's needs to lock herself in the bathroom or leave the apartment when Libby is crying reflect her precarious struggle to contain feelings of pain and anger in the face of her infant's distress. We don't know how often, or in what forms, this pain and anger may have broken through with Libby.

Over and above questions of trauma and abuse, the most salient effects of her mother's traumatically influenced caregiving are probably best formulated under the general category of affective dysregulation. Libby shows signs not only of unusual apprehension, but shows disturbances involving a range of affects in a variety of settings. Examples include a dampening of emotional responsiveness and reduced capacities for pleasure, inhibited curiosity and constricted interest in her environment, gaze and behavioral avoidance, extreme anger, fear, and behavioral disorganization in response to maternal separations with difficulties being consoled, and problems with aggression and temper outbursts in the home setting. That these disturbances have largely grown out of her interactions with her mother is suggested by the fact that Libby can be very different when out of her mother's presence. With staff she is described as "engaged" and "delightful." The repetitive, insidious, and moment-to-moment nature of the problematic interactions are clearly having disruptive effects on Libby's capacity to adaptively regulate her own emotions, over and above any specific episodes of trauma.

Despite these problems, we need to keep in mind that the trauma history of this family is not the whole picture. Libby has many strengths, as does her mother. That Libby is developmentally on target and has the capacity to be delightful and engaged is a reflection of her resilience. It is also a tribute to the positive caregiving that she has received from her mother, confirmed by the observations of her mother's capacities for warmth and mutual pleasure when the dyad is not under stress. Libby shows adaptive attunement to her environment, emotionally responding in flexible ways depending on whether the environmental cues are positive or negative in nature. Her mother is similarly capable of differentiating current situations from past traumatic ones, as exemplified by her ability to make use of therapeutic help. Ultimately, Libby's prognosis will depend on the extent to which she and her mother are able to build on the healthy aspects of their relationship and reduce the "frightening-frightened" aspects that derive from the past. This will largely be determined by the extent to which Libby's mother can continue to obtain help for her own childhood traumas, so that their influence on her current functioning as a mother can be progressively diminished. At the same time, because persisting maladaptive affective responses on Libby's part, such as emotional withdrawal or temper outbursts, will trigger the very feelings of rejection and being attacked that her mother is attempting to change, dyadic work and specific interventions addressing Libby's own affective dysregulation will be crucial components of the therapeutic regimen.

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DISCUSSION BY CHARLES H. ZEANAH, M.D.: COMMENTARY ON "FITS AND STARTS: A MOTHER– INFANT CASE-STUDY INVOLVING INTERGENERATIONAL VIOLENT TRAUMA AND PSEUDOSEIZURES ACROSS THREE GENERATIONS"

In the course of our work with traumatized young children over the past several years, Michael Scheeringa and I have been struck repeatedly, as noted in Dr. Gaensbauer's discussion above, by the importance of the primary caregiving relationship as it relates both to the young child's symptomatology and recovery. In fact, virtually every study that has looked at both parent and child following trauma has found that their symptomatology is correlated. This led us to review the types of associations that we had observed (Scheeringa & Zeanah, 2001).

We described a mediating effect, a moderating effect, and a combined effect of the parent–child relationship on the young child's adaptation. In the mediating effect, the child is not traumatized directly by an event, but rather is profoundly affected by the parent's traumatization. The parent–young child relationship mediates the effect of trauma on the young child,

assuming that the parent's posttraumatic symptomatology compromises his/her ability to care for her infant. In the moderating effect, the young child's traumatic symptoms are amplified or reduced by the parent's response to the child. Finally, in the combined effect, infants are directly affected by the traumatic event, and their symptomatology is exacerbated by the indirect effect of their caregiver's compromised responsiveness to them, which is in part a result of the caregiver's own posttraumatic symptomatology.

We also described three relationship patterns that characterized the combined effect. In the first, the withdrawn/unresponsive/unavailable pattern, the parent is compromised by severe and often chronic posttraumatic symptomatology that leaves him/her less able to read and respond effectively to the child. In the overprotective/constricting pattern, in contrast, the parent is preoccupied by fear that their child will be traumatized again and responds with a smothering overprotectiveness. Finally, in the reenacting/endingangering/frightening pattern, the parent unconsciously reenacts his/her own traumatic experience through exposing the child to dangerous situations in which further traumas are more likely to occur, even though the parent likely believes he/she is acting protectively.

The case of Nancy and Libby illustrates the mediating effect, and some of the complex ways in which a mother's traumatic history may be experienced by both parent and child. What this case adds to our previously described model is that the mediating effect also may be characterized by a seriously disturbed relational pattern that we had previously limited to the combined effect. Nancy's traumatic history, which plays itself out in the form of dysregulated affect, frightening behavior, and negative attributions, lead to a failure in her ability to appreciate Libby's experience or to protect her. Although much is unknown, there is no evidence of a discretely traumatic event that has precipitated Libby's symptomatology, leaving us to conclude that it is related to the ongoing relationship disturbance.

In fact, this case illustrates the original formulation for the link between lack of resolution of trauma (or loss) in parents and disorganized attachment in infants offered by Main and Hesse (1990). Essentially, they suggested that parents with unresolved traumas or losses would respond to trauma "triggers" that would not be apparent to the young child. Because the parent's trauma derived behavior resulted from past experiences rather than from here and now interaction with the child, the young child would experience the parent as frightening or frightened. The "ataques" were the most dramatic but far from the only example of trauma related behavior in Nancy that would have been incomprehensible for Libby.

The case also describes the kind of variability in Nancy's behavior that Libby must have experienced. In addition to her dramatic outburst in the emergency room, the warm, contingent responding alternating with teasing/threatening/intrusive behavior with Libby in the lab suggests unpredictability that must have been compounded by her middle of the night fear of a possible intruder. There also appeared to be oscillations in Nancy's attributions about Libby: ". . . she loves to hit and fight, but she's not really such a bad thing. Well, she's mean . . ." How difficult it must be for a young child to feel safe when the most important person in her life is given to paroxysmal affective and behavioral dysregulation from threats that are often invisible and inaccessible.

The question that this case raises for treatment is the degree to which it is necessary to have Nancy resolve her own traumatic past before she can respond effectively to Libby, versus the degree to which Nancy could be helped to become more empathically attuned to Libby even without directly addressing her past experiences (i.e., as poignantly described in the single-session video feedback session excerpt). The answer to this question for this case and others like it will have substantial implications for how we address intergenerational familial violence and trauma.

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