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## **Psychoanalytic Perspectives On Early Trauma: Interviews With Thirty Analysts Who Treated an Adult Victim of a Circumscribed Trauma in Early Childhood**

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## PSYCHOANALYTIC PERSPECTIVES ON EARLY TRAUMA: INTERVIEWS WITH THIRTY ANALYSTS WHO TREATED AN ADULT VICTIM OF A CIRCUMSCRIBED TRAUMA IN EARLY CHILDHOOD

Information on the long-term effects of early trauma and how such effects are manifested in treatment was obtained through interviews with thirty analysts who had treated an adult patient with a circumscribed trauma in the first four years of life. Childhood traumas fell into four categories: medical/accidental; separation/loss; witnessing a traumatic event; and physical/sexual abuse. Traumatic carryover was recorded in terms of explicit memories, implicit memories (somatic reliving, traumatic dreams, affective memories, behavioral reenactments, and transference phenomena), and global carryover effects (generalized traumatic affective states, defensive styles, patterns of object relating, and developmental disruptions). Linkages between the early trauma and adult symptomatology could be posited in almost every case, yet the clinical data supporting such linkages was often fragmented and ambiguous. Elements of patients' traumas appeared to be dispersed along variable avenues of expression and did not appear amenable to holistic, regressive reworking in treatment. The data did not support linear models of traumatic carryover or the idea that early traumatic experiences will be directly accessible in the course of an analysis. Factors that we believe help explain why traumatic aftereffects in our sample were so heterogeneous and difficult to track over the long term are discussed.

**A**s an outgrowth of our shared interest in early trauma, some years ago we decided to study the analyses of adults who had experienced discrete traumatic events in the first years of life. We were interested in learning about the long-term effects of early trauma and how such

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emotionally powerful early experiences might manifest themselves, either directly or indirectly, in the therapeutic setting. Would traumatic memories or symptoms persist into adulthood? Would an early trauma leave an identifiable imprint on the developmental trajectory? Would representations of an early trauma be identifiable in the adult's transferences, associative material, or character?

Studies of very young traumatized children have demonstrated unequivocally that infants and toddlers have the prerequisite cognitive and emotional capacities for trauma to have persisting effects. Infants by the second half of the first year of life appear capable of demonstrating most of the characteristic symptoms of posttraumatic stress disorder (Scheeringa et al. 1995, 2001; Scheeringa and Gaensbauer 1999). Traumatized young children can also retain some form of internal representation of their trauma for months and even years, as demonstrated through trauma-specific behavioral reenactments, affective responses to traumatic triggers, sensory and somatic symptoms, expressive play, and even verbal recall (Terr 1988, 2003; Gaensbauer 1995, 2002, 2004; Peterson and Rideout 1998; Peterson and Whalen 2001; Gislason and Call 1982; Paley and Alpert 2003). What we do not know, given the lack of systematic studies, is the long-term fate of these trauma-derived symptoms and representations.

Historically, a conception that has had wide currency within the analytic literature is that significant trauma in childhood both interrupts development and stamps it forever. The overwhelming of the ego induced by trauma is thought to leave indelible memory imprints (conscious or unconscious) that cause ongoing flashbacks, affective reexperiencing, traumatically driven behavioral reenactments, trauma-determined fears, and traumatic dreams (Freud 1920; Casement 1982, 2002; Herman 1992; Terr 1987, 1991; van der Kolk, McFarlane, and Weisaeth 1996). The trauma is seen as having an enduring organizational influence on the patient throughout the life span, a conception we came to term a "full-fledged" repetition. Describing cases of adults and children, Herman (1992) observed that "long after the trauma is past, traumatized people relive the event as though it were continually recurring in the present. . . . the

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traumatic moment becomes encoded . . . and breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep” (p. 37). It is not clear whether, or with what frequency, such direct forms of carryover might be observed in adult patients who have been traumatized in the first years of life.

To date, assumptions about the enduring effects of a very early trauma have depended on a small and disparate group of case reports of adult analytic patients who manifested some form of symptomatic carryover (for a review of much of this literature, see Share 1994). Traumatic aftereffects observed in adult analysands have included dreams and visual imagery (Dowling 1982; Pulver 1987; Niederland 1965; Viederman 1995), bodily sensations (Isakower 1938; Lewin 1946; Easson 1973; Leuzinger-Bohleber 2008), affective states (Casement 1982; Alpert 1994; Adler 1995), postural reenactments (Deutsch 1947; Anthi 1983; Engel, Reichsman, and Viederman 1979), strong defensive reactions (Rosen 1955; Segal 1972), and creative products (Terr 1987). Although these case reports have provided evidence that symptoms associated with an early trauma can persist into adulthood in linear fashion (what we have termed a “red thread” effect) and can be accessible to analytic work, many uncertainties remain. The modalities through which traumatic aftereffects were manifested in these reports varied greatly, as did the degree to which the trauma was seen by the analyst to have influenced the patient’s adult functioning and intrapsychic conflicts. In addition, the extent to which a reexperiencing in the transference relationship was seen as central to a therapeutic working through of the trauma also varied considerably. Finally, in several of the cases the linkage between the patients’ symptoms and a specific early traumatic experience seemed ambiguous and dependent on the analyst’s interpretation. In sum, such notable heterogeneity among the individual case reports left us with considerable uncertainty about how representative they were of patients who have suffered early traumas (Pine 2001).

Questions about the carryover of early traumatic experiences are not only of interest in themselves, but go to the heart of what Abrams and Shengold (1978) identified as a core subject of debate within psychoanalytic clinical theory, namely, “conflicting views about very early psychic development and the possibility of its being explored in the psychoanalytic situation” (p. 400). In his review of the many different perspectives that analysts have taken on this issue over the years, McLaughlin (1982) highlighted the many salient issues by contrasting

analysts who hold that “there is direct access to these early experiences in the course of the analytic process” with, at the other end of the spectrum, analysts who see “early experiences as contributing to the matrix of interlocking development of object-relations and psychic structure . . . but not directly accessible in the treatment situation” (p. 229). We felt that the systematic examination of traumatic carryover in a group of adult analytic patients who had experienced a well-defined traumatic event in early childhood would offer a unique opportunity to shed light on this long-standing debate.

### METHOD

We sent a brief questionnaire to a large group of analysts accredited by the American Psychoanalytic Association, asking if they had had patients who had experienced a discrete trauma during the first four years of life and if so whether, if confidentiality could be assured, they would be willing to be interviewed about that patient. To be considered for the study, the patient’s trauma had to meet the traditional DSM-IV exposure criterion for the diagnosis of posttraumatic stress disorder, namely, an event involving actual and/or threatened physical harm to the patient or someone close to the patient. Given the young child’s dependency on adults, we included among traumatic events the abrupt loss of a caregiver for three months or longer. From the responses, we identified thirty analysts who had had such a patient in analysis or intensive psychotherapy and were willing to participate in the study. With each analyst, we carried out a two-hour semi-structured interview in which we explored the following topics: the nature of the trauma and the patient’s age at the time it occurred; the immediate impact of the trauma on the patient and the response of the family; the nature of the patient’s memories of the trauma; the patient’s developmental history; the problems that brought the patient to treatment; how the analyst learned about the trauma; the analyst’s assessment of carryover effects on the patient’s development and current functioning; and how the trauma was handled in the treatment.<sup>1</sup>

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<sup>1</sup>Our initial questionnaire uncovered a very small number of patients with discrete early childhood trauma treated by the psychoanalysts we surveyed. Fewer than half the analysts reported having worked with such patients, and of these, the large majority reported having only one or two cases. By contrast, our respondents reported treating a significant number of patients who suffered “traumatic emotional states” due to early trauma in a chronic form (i.e., repeating physical, sexual, or emotional abuse). We observed that analysts’ memories about whether they had treated

**Description of the Sample**

Two-thirds of the patients on whom data were reported were women; one-third were men. The mean age was 36 years, with a range from 21 to 63. Twenty patients had been in analysis (three to five sessions a week), and the remaining ten had been in long-term psychodynamic psychotherapy (one to two sessions a week). The chief complaints that brought these patients to treatment were typical of the problems one would expect for analytic patients as a whole. These included difficulties with intimacy, particularly sexual intimacy; marital and/or vocational problems; affect dysregulation such as depression, anxiety, or emotional isolation; acting out of sexual and/or aggressive impulses; substance abuse; and problems with developmental progression, such as separating from the nuclear family. Presenting problems were universally not of a specificity from which one would automatically infer an early trauma. At the same time, several patients, particularly those who had experienced quite severe traumas, were very aware that their lives had been profoundly affected and sensed that their trauma was something they needed to deal with.

The types of traumas patients had endured can be subsumed under four general categories: (1) medical / surgical / accidental injury traumas life-threatening or serious enough to require hospital treatment ( $n = 12$  cases); (2) loss of a parent, either temporary (ranging between three months to several years in duration) or permanent ( $n = 16$ ); (3) the witnessing of a traumatic event of an extremely frightening nature ( $n = 6$ ); (4) physical and/or sexual abuse ( $n = 7$ ). The numbers add up to 41 (not 30, the number of patients) for two reasons. Five of the patients experienced a trauma that involved more than one category, such as witnessing the death of a family member, and six had suffered more than one

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such patients were often quite evanescent, a phenomenon we related to both patients' and analysts' difficulties in retaining conscious access to this early period. There were at least five instances in which an analyst indicated on initial contact that he or she had had a patient with an early trauma but when we followed up (often after much delay) could not recall which patient he or she might have been referring to. We also had several instances in which analysts did not recall any patients with early trauma in their initial response, but subsequently remembered that they indeed had had such a patient. It appeared that issues of timing and subjective factors affecting memory strongly influence whether such patients are remembered. For these reasons, among others, we believe that the number of patients identified in our informal survey is likely an underestimation of the total number of patients treated who had experienced discrete early traumas. The sample to be described is thus made up of patients who had suffered such a trauma and in whose treatment it played a role sufficiently significant for it to be remembered by the analyst.

trauma before age four. The traumas varied in severity, ranging from life-threatening with permanent consequences to relatively mild and without long-term physical effects.

In every case except two, the traumas were known to the patient and reported to the analyst either initially or relatively early in the course of treatment, even though details were often reported over time, as the patient's comfort with the analyst increased. Patients were aware of the events through having been informed of them by family members, through being aware of the trauma's consequences, and/or through their own memories. Objective documentation of the traumas was almost universally not available to the analyst, with the exception of a written summary of a patient's early life history prepared for the analyst by a parent of one patient and medical records retained by another patient that documented early abuse. In one of the two cases in which the patient was unaware of any trauma, a medical trauma was reconstructed in the course of the therapy and was confirmed by outside sources, even though the patient had no conscious memory of the event. The other case was the only instance of "recovered memory" in our sample. In this case, incestuous sexual abuse could not be confirmed independently and was denied by the patient's parents. Interestingly, even though objective data was generally lacking, over half the patients had either before or during treatment attempted on their own to obtain further information that would validate and/or correct memories and feelings they had retained about their early experience.

Although based on a much larger sample, our data share the problems of the typical case report, in that data were gathered from the analyst's perspective. The amount of treatment documentation that analysts had available, such as process notes or summaries, varied greatly. Much of our data therefore depended on analysts' memories of the cases and their interpretation of the material, with the additional uncertainties that these factors introduce. In addition, as we listened to the clinical material, we found a number of cases in which varying degrees of uncertainty arose in our minds about whether events could have occurred exactly in the way the patient described them. The reasons for our uncertainty reflect the whole spectrum of factors that can complicate therapists' ability to assess the reliability of patients' reports, such as the shadowy nature of early memories, likely memory omissions and/or distortions, strong emotional coloring, retrospective elaboration, possible secondary gain, cognitive processing factors, and lack of outside information. Our findings should be considered with these limitations in mind.

## CARRYOVER EFFECTS OF EARLY TRAUMA

We examined the carryover effects of adult patients' early traumas from three perspectives: (1) explicit (conscious) memories of the trauma; (2) implicit (unconscious) relivings/memories of the trauma; and (3) global patterns of functioning influenced by the trauma.

### *Explicit Memories*

Explicit memories were narrowly defined as conscious memories for specific traumatic experiences. Since many of the patients were aware of their traumas not only by direct knowledge but by hearsay, the sources of their conscious memories were not always clear. Apart from this issue, the quantity and quality of patients' conscious memories seemed most dependent on their age at the time of the trauma. For traumas that occurred before two years of age a few images were reported, but none that we could agree with confidence were memories of the trauma. For events beginning around age two, a few patients reported visual memories that were distinct, but isolated and fragmentary. By age three and beyond, traumatic memories were more verbally accessible and coherent and were reported in greater detail. Traumas involving the infliction of strong physical sensations such as pain, or those that involved dramatic, emotionally powerful discrete events such as witnessing a death, were the most likely to be remembered, whereas traumas that were less severe or less discrete, such as parental separations, tended to be less well remembered. Overall, the kinds of explicit memories reported in relation to the age at which the trauma occurred were consistent with reports of children's memories for early trauma (Terr 1988) and adults' recall of early childhood events (McNally 2003).

It is noteworthy that the explicit memories described for our sample, rather than having the emotionally intense and intrusive quality usually associated with traumatic reexperiencing, tended to be reported as mental images unaccompanied by a remembered feeling. When strong affects did accompany the mental images, they tended to reflect the adult patient's profound empathy and emotional resonance with the childhood experience and its impact in later life, rather than an emotional reliving of the original experience. For example, a patient who lost her father at three and a half had only a vague memory of how she learned of his death; she was unable to remember who told her, and had no memory of crying at the time. In her analysis, however, she would cry



as she imagined the scene, as the impact of the loss of her father was increasingly felt. Patients' conscious memories of an affect or physical sensation experienced at the time also tended to be reported without an accompanying feeling in the present (e.g., "I remember I felt sad," or "I remember having the sensation of pain")

*Under one year (n = 8).* No conscious memories were reported by any of the eight patients who experienced a traumatic event in the first year of life.

*One to two years (n = 8).* Five out of eight patients in this group had no conscious memories of the trauma. Three patients reported conscious memories, but of a nature that left considerable room for doubt as to whether they were actual memories. One patient who at eighteen months accidentally spilled hot wax on her leg had a conscious memory (not felt but remembered) of the physical sensation of pain. This was accompanied by a visual image of her surrounding environment and the people present at the time. However, the patient wasn't sure this was an actual memory or the product of subsequent family descriptions of the event. Two patients reported vague images of separation traumas. One woman who at age two was abruptly given up by her mother to be raised by a relative had vague images of a fight with her mother beforehand, plus a memory of later seeing a picture of her mother in the relative's house; she remembered thinking, "Mother doesn't love me anymore." Another patient, who experienced a three-month separation at nineteen months of age due to his mother's involvement in an auto accident, retained a visual image of seeing his mother across a room during a visit to the rehabilitation center. As he remembered it, it was almost immediately after returning home that his mother left again for an out-of-town consultation. He had a memory of standing by a tree as his mother left, experiencing a profound sense of despair: "It felt like I was dying" (age twenty-three months).

*Two to three years (n = 9).* Three of the nine patients in this group had no conscious memories to report, and one had very vague memories of the traumatic event. Five cases, however, had clear and conscious memory fragments of their traumas, including two patients traumatized very close to their second birthday. One patient who suffered a burst appendix at age two reported a series of very clear but isolated memories of his emergency treatment, including going to the hospital, being strapped to a board and poked with needles, and seeing his mother next to his bed. A patient who at twenty-seven months saw a sibling killed by a gas stove explosion vividly remembered sitting on a blue rug and seeing a flash of light as she

watched her sibling at the stove. Another patient remembered her throat hurting, being tied to her bed, and wanting to be picked up and held during her hospitalization for a tonsillectomy at age two years, seven months. A fourth patient, who had a congenital deformity, had to wear a double leg brace that from eighteen months to three years left her unable to move about except by crawling. She had a memory of a time between two and three when the brace broke and she was lying on the couch without it, terrified to move lest her body “fall apart” without the apparatus. In the car on the way to repair the brace, she remembered feeling terrified as she saw “something” (she thought perhaps a screw from the brace) flying out of the little “wing” window near her seat. On the day the brace was removed, she had a memory of crawling up the stairs, feeling proud, to greet her happy, tearful grandmother. A fifth patient reported sequential conscious memories for a terrible trauma that occurred around his third birthday. This patient recalled being told to stay in his room by his mother, who then went to the bathroom and shot herself. He remembered finding his mother’s body, seeing blood and bone fragments, hearing sirens, and watching the police and firemen arrive. He also remembered feelings of horror, guilt, and anger at his mother. This patient also had memories of domestic violence between his parents and of interactions with his mother such as sitting in her lap before the suicide.

*Three to four years (n = 11).* Ten of the eleven patients in this group reported conscious memories of their trauma. These memories, though often still fragmentary, generally involved considerably more detail than those from earlier on. One patient was nearly four when he witnessed his older brother fall to his death from a Ferris wheel. He remembered standing beside his mother and seeing his brother fall, had vague images of chaotic movements immediately following, and retained a subsequent specific image of the brother’s casket. Six of the seven patients who experienced physical and/or sexual abuse before the age of four recalled specific instances of their abuse. A patient who experienced a medical procedure between the ages of three and four had fragmentary but sequential memories of that procedure, and a patient whose father died when she was three and a half had several isolated memories from around that time.

### ***Implicit Memories***

Implicit memories were broadly defined to include a range of clinical phenomena that appeared to be trauma-specific but where a conscious

link between the symptom and the trauma was absent. Since by definition the link to the past was outside the patient's conscious awareness, the inference that a clinical phenomenon might be a manifestation of an unconscious traumatic memory depended to a large degree on the interpretive activity of the analyst. Not only did analysts differ significantly among themselves in their readiness to infer such memories, but our own impression of an inference's validity was not always in accord with that of the analyst we were interviewing. Our inclusion criteria leaned on the side of conservatism.

For purposes of organization, we categorized implicit memory phenomena under the following categories: (1) somatic memories; (2) intrusive thoughts and/or traumatic dreams (i.e., return of repressed or dissociated memories); (3) posttraumatic fears and other affective memories; (4) behavioral memories (reenactments); and (5) transference phenomena. With the exception of two cases where essential elements of a traumatic event appeared to have been replayed in what we called full-fledged reliving, the clinical manifestations of implicit memory in our sample seemed to reflect isolated components of the trauma rather than the trauma as a whole. As was the case with explicit memories, the older the patient at the time of the trauma, the more coherent were the symptomatic manifestations and the more readily could they be linked to the traumatic experience.

*Somatic memories.* In four cases, somatic relivings were reported. The somatic sensations were experienced rarely and inconsistently. Although they were triggered in the context of emotional themes and/or environmental stimuli linked associatively to the trauma, this was not predictably so.

The most dramatic case of a somatic memory was that of a patient who during an analytic session reported a strange sensation of "fluid leaking out of [her] eye." This dramatic sensation in combination with suggestive dream material prompted the analyst to ask if there had been an early hospitalization. The patient had no awareness of a medical problem in childhood but subsequently asked her mother, who confirmed that at eighteen months of age she had undergone surgery for a periorbital and maxillary sinus abscess and that the hospital stay had been a traumatic separation. In the course of her analysis, the "leaky eye" sensation occurred only twice: on the eve of the first major separation in the analysis and a second time during the termination phase. At numerous other points in the analysis where separation issues arose, this symptom did not appear.

The patient who had suffered a burst appendix at the age of two experienced sensations of abdominal pain and bloating intermittently during his analysis, seemingly triggered by feelings of anger or loss. His medical crisis had occurred in the midst of a “terrible twos” battle with his mother. A third patient, who had been exposed to repeated physical and sexual abuse before the age of three and a half, described a physical sensation in her breast and oppressive feelings of “being back in the room” (where she was abused) on several occasions when her husband attempted to suck on her nipple. In an analytic session she also experienced a sensation in her throat as she described being forced to perform oral sex. A fourth patient experienced waves of nausea as she described a similar subjection to oral sex (although in her case such abuse persisted beyond age four).

*Intrusive memories and/or nightmares.* Only one patient reported flashbacks of the traumatic experience, and these were remembered from childhood rather than experienced as an adult. This was the man who at age three had found his mother dead after she had fatally shot herself in the head. A year later he lost a tooth and had a fit of hysterical screaming when he saw his bloody mouth in the mirror. His terror was so inconsolable that he was taken to an emergency room for a sedative. As an adult he recalled this incident without a recollection of a specific flashback, yet he “knew” that the incident was connected to the trauma. This patient also described a recurrent dream throughout childhood of being surrounded by stars that came in and out of focus. The analyst was convinced that this dream derived from the patient’s trauma, representing either the shattered remains of his mother or a trauma-induced dissociative state with his vision going in and out of focus. During his analysis, no flashback experiences or traumatic dreams were reported.

There were in our sample no reports of classic posttraumatic dreams—dreams that replicate parts of the traumatic experience in close to literal form. However, dreams suggestive of a link with early trauma were reported in three cases. The patient whose appendix burst at age two reported nightmares as an adult in which his stomach was bloated, ants were eating his insides, or people were poking at his abdomen. The patient who experienced periorbital surgery at eighteen months reported vague dreams in which “white stuff” and “long halls” appeared, as well as a dream in which she was standing in a tub with water being poured over her. These dreams were suggestive of a hospital setting and provided the background context that prompted the analyst, when some months later

the patient reported the uncanny sensation of fluids leaking from her eye, to ask about the possibility of an early hospitalization. In the third case, based on a series of dreams of a symbolic nature, an early sexual molestation was reconstructed and then remembered, with the uncertainties that such “recovered memory” reconstructions can entail.

*Posttraumatic fears and other affective memories.* Seven patients in our sample described fears and avoidance of trauma-related situations persisting into adulthood. Among the eleven patients who experienced medical traumas in our sample, only four retained a fear of doctors. One woman feared medical appointments throughout her adult life and also feared falling asleep at night, which she connected to a memory of terror on the operating table that she would not wake up. Despite the obvious continuity, we were hesitant to attribute persisting fears of doctors solely to these early medical experiences, since each of these patients had had subsequent surgeries and/or significant interactions with doctors that affected them.

Persisting posttraumatic fear was seen in the woman who was two years old when she witnessed the death of her sibling by fire. As an adult she was hypervigilant, a person who kept herself safe through constant anticipation of danger situations. She routinely checked for the location of the exits whenever she was inside a vehicle or building. She had an aversion to matches or any form of fire, to the point that she refused to have a working fireplace in her home. The patient who experienced a burst appendix at the age of two had been physically restrained in the emergency room after an intense and prolonged struggle. He experienced this as a frightening and violent assault, as confirmed by his mother. As an adult he could not tolerate being physically held down in any form, including being on the bottom during sexual intercourse.

One woman had a panic attack in a restaurant with green walls, which occurred during a period in her analysis where she appeared to be associating affectively to her infantile trauma. She had spent the first six weeks of her life in a hospital isolation room enduring painful medical treatments. The analyst interpreted, based on his knowledge that many hospital rooms were green during the era when this patient was an infant, that the panic attack was an affective memory of overwhelming anxiety in the hospital. To us this is an example of a “soft” link between an early trauma and an adult symptom, since the symptom was both isolated and nonspecific, and admitted of other explanations. Yet patient and analyst were convinced that the interpretation, in the context of other work, was helpful in reducing the fear of hospitals and doctors that had plagued her since infancy.

*Behavioral memory / reenactment.* In sixteen cases, there were enactments within or outside the analysis that we felt could arguably be tied to a patient's early trauma. Depending on the specificity and scope of the links to the trauma, we categorized these as full-fledged, partial, or generalized enactment patterns. The differences we saw in these categories can best be illustrated with case examples.

Two cases manifested what we categorized as possible full-fledged enactments. One was the case of the woman whose mother abruptly left her with a relative at the age of two. As an adult, she adopted a six-year-old girl whom she carried around in her arms. Over time she and her daughter had increasingly painful aggressive struggles, with the patient alternating between feeling that her child was bad and that she was a bad mother. After several years she chose to return the child to foster care, after which the patient was hospitalized for depression. This experience felt traumatic to her and was consciously and unconsciously linked in her mind with memories of her own mother.

A second patient had been removed from her home at the age of one year by social services. A neighbor had repeatedly found her crying in her crib with no one at home, the mother having gone out with friends to do drugs. In adulthood, when the patient was married with young children, she began acting out a pattern of leaving at night to go to bars, where she paired indiscriminately with men. She told her analyst that her longing was not for sex but to kiss and be kissed by them. The analyst interpreted this as an affective and body memory of her infantile hunger to be picked up and nuzzled by whomever came through the door, combined with an acting out of the mother's abandonment behavior.

In both of these cases, the behaviors and reported affects appeared to us to be sufficiently recognizable as repetitions of the major elements of the original trauma as to be arguably categorized as full-fledged enactments. At the same time, we felt that attributing these reenactment behaviors solely to the patients' early traumas was potentially problematic, in that both patients experienced subsequent rejections and/or emotional neglect that powerfully reinforced the original trauma-based affective constellation.

Five cases demonstrated what we call partial reenactment: behavioral replays representing isolated aspects of the traumatic experience. Of these, three were cases of sexual abuse, where sexual acting out during adolescence or adulthood was common. Complicating the inference that the earliest sexual traumas were determinative was the fact that in two of these cases the patient experienced abuse that persisted

beyond age four. However, supporting the powerful role of early experience was the fact that in the one case where there was incontrovertible evidence that such experiences stopped before the age of three and a half, sexual promiscuity and other forms of acting out were marked during adolescence and young adulthood. Partial reenactments were observed in this patient when as a young adult she established an ongoing sexual relationship with an older woman. In this relationship she allowed herself to be stimulated in ways that appeared to reenact aspects of her past sexual abuse, but in a pleasurable context and without the feelings of helplessness and fear associated with her original experiences with men. Such stimulation of the patient had multiple functions in that it was associated at times with fantasies of being a baby and being held and touched in a caring way by a maternal figure. For all of the sexually abused patients, their sexual acting out seemed to reflect a generalized heightening of sexual drives and sexualized modes of relating, rather than repetitive sexual behaviors that could be specifically tied to the childhood experience.

A notable example of complex partial enactments was a woman who was sexually molested for several years starting at age three by an older cousin who had been taken in by her family. In adulthood, various aspects of her traumatic experience were acted out separately with different objects in her life. She played out the boundary violations with her husband. She felt stunned and enraged when her husband would enter the bathroom unbidden, and felt helpless to prevent it, just as she had with her cousin. She also felt helpless to say no to certain sexual acts with him. Meanwhile, in another series of enactments, she seduced men who she felt cared for her tenderly and then dropped them after several meetings. This sequence replayed a different aspect of her experience with her cousin, in that she initially felt loved as a result of her cousin's attentions, only to feel dropped later on when she realized he was using her. In dropping her lovers, she was aware of seeking revenge on her cousin. With her analyst, she played out another aspect of the trauma by alternately withholding and abruptly disclosing secrets about her sexual life (including the history with her cousin), fearing that the analyst would reject her for her misbehavior the way her mother had done.

We labeled a third category of enactments "possible generalized enactments." Nine patients were seen to fit this category, in which general behavioral patterns as opposed to specific behaviors could be hypothetically

linked to a patient's trauma. An example of behavior in this category is the man who at four witnessed his brother fall to his death from a Ferris wheel. After that incident an inquest was held. Although the patient had "no feelings" about these events and only a few fragmented memories of them, he grew up to choose family law and child advocacy as a career. A patient who experienced a life-threatening reaction to a bee sting at age two became a doctor. The patient who experienced the early periorbital surgery and traumatic separation from her mother chose work at a preschool. In each of these cases, as well as the six others, many factors in addition to the trauma could be cited to explain the patient's behavioral choices.

*Transferences.* When transferences that appeared to be connected to a trauma did occur, they were generally partial, compartmentalized, and relatively transient, rather than reflecting a full transference reliving. In many cases the analyst was not the primary transference object. Rather, trauma-derived affects were triggered most powerfully by outside figures such as children, a spouse, or the original object, with the analyst being seen in a defined and limited role. One woman as a very young child had been terrorized by a brother while her father, whom she idealized, was busy at work. With her analyst she experienced feelings she had toward her idealized father-protector; with her son she felt the rage and helplessness at the hands of a brother out to hurt her; and with her husband she experienced the hurt associated with the father's absence. The patient who was molested by her cousin starting at age three and who had demonstrated split and partial reenactments of the trauma as an adult also presented a split transference picture. As noted, different aspects of the relationship with the cousin were transferred onto separate objects in her adult life. The transference toward the analyst centered on only one element of her trauma, the lack of intervention by her neglectful mother.

When the analyst was a transference object, he or she often represented not the central player or "perpetrator" of the trauma, but a figure on the sidelines. From this vantage point, the transference perception of the analyst was often of a person who would turn away from the patient's suffering because emotionally burdened by it. In a number of the medical trauma cases, the analyst was cast not as a potential inflictor of harm but rather in the role of the parent who witnessed the treatment and failed to protect the child. In cases where the trauma was at the hands of an abusive family member, the transference to the analyst was often not as the perpetrator but as a family member who failed to prevent the abuse. The transference interpretations in such cases centered on patients' feelings of



abandonment and betrayal by the “nonperpetrator” parent. For example, the patient whose mother committed suicide in his presence did not manifest a mother transference toward the analyst, but did feel convinced that the analyst, like the family who had “buried” the trauma along with the body, could not tolerate hearing his emotions.

We believe that the patients who transferred feelings toward a parent on the “sidelines” were essentially transferring a separation trauma. Consistent with this conceptualization, it was our impression that the most frequently transferred feelings within the group were those related to issues of abandonment and loss of trust. Such feelings appeared to resonate with the feelings of “betrayal” and “aloneness” that traumatized young children universally experience, feelings stemming from the realization that their parents have been unwilling or unable to protect them. Tellingly, it was in cases where the main trauma was an actual separation or abandonment that we most frequently heard about a transference to the analyst as a central player in the trauma. In these cases a significant focus of the work was on various permutations of the patient’s feelings of abandonment by the analyst, often associated with intense rage. For example, one man had been sent away from home at sixteen months of age while his mother underwent medical treatment. He had intense angry feelings toward the analyst, expressing the urge to kill her and accusing her of making him physically sick. At the same time, he deeply feared that the analyst would be hurt or lost if he became attached to her. Another patient with an early loss experienced almost uncontrollable rage during his analyst’s absences and was so preoccupied with the personal comings and goings of the analyst that it verged on stalking.

In over one-third of the cases, the most prominent transference attitudes involved keeping the analyst within a “reality-based” role as empathic and helpful and/or viewing the analyst as an idealized figure posing no danger of retraumatization. In several cases the analyst served primarily as a developmental object who provided the empathy and understanding that had not been available in the patient’s early childhood. Viewing the analyst as a consistently supportive presence outside the traumatic situation (i.e., someone who was not going to be hurt, lash out, or abandon them) not only did not preclude these patients from exploring their difficult childhood experiences, but often seemed helpful in facilitating the expression of affectively difficult material.

Obviously, such transferences served defensive purposes as well. In some cases a defense transference was implacable to the point that it

appeared to prevent any reworking of the traumatic affect. An example is a man who, having lost his father at age two, grew up relating to the world through a character style that was calm and detached. As a child he chose friends who were also missing a father so that he could avoid awareness of his own lack. In treatment he perceived the analyst not as a father figure he feared to lose, but as a distant and unshakable authority. He and the analyst agreed that his stance was geared to preclude his re-experiencing the conditions of the trauma. In this case and twelve others, an analysis appeared to have taken place without the patient experiencing any identifiable trauma-associated affects in the consulting room.

### ***Global Carryover Effects***

In contrast to the relative infrequency of specific posttraumatic symptoms, a global carryover in some form was reported by almost all the analysts we interviewed. Many pointed to affect states, defensive patterns, self/object representations, or alterations in the developmental trajectory that seemed to them derivative of the trauma. We were mindful, however, that in moving from specific symptoms to general categories of personality functioning, multiple forms of influence can come into play, particularly since human emotions have qualitative continuity over the life span and can be elicited by a wide variety of stimuli (Emde 1980).

*Traumatic affective states as global carryovers.* By far the most common form of carryover, described by fourteen of our analysts, was the persistence of raw and overwhelming traumatic emotional states. Examples would be bottomless feelings of loss and “terrible loneliness” in patients who had experienced parental separation, or recurrent feelings of panic, inner chaos, and rage in patients who had been physically traumatized. The affects generated by the trauma were seen to have an organizing effect on the patient’s psyche, shaping psychological themes, pathological beliefs, and modes of self-regulation that persisted into adulthood. In cases of separation trauma, it was common to hear of lifelong expectations of abandonment, accompanied by struggles with rage and difficulties with self-definition, creating intense internal conflict and deeply troubled personal relationships. The patient whose mother committed suicide at age three had the conviction that he was cursed: “If I get close to someone, they die.” In several cases of medical trauma, the patient had persisting views of the world as a dangerous place, associated with ongoing feelings of helplessness, vulnerability, and fears of physical harm. For a few, a sense of victimhood had been generalized into a part of their core identity.

*Defensive/adaptive style as a possible global carryover.* While there was no question in our minds that the patients' traumas would have mobilized strong defensive mechanisms, the retrospective nature of our data and the fact that defensive operations are by their nature relatively inconspicuous made it difficult to clearly delineate defensive carryover from the early trauma. While this meant that the role of the patients' early traumas in shaping defenses observed in adulthood was likely underappreciated both by us and by our analysts, we felt that any generalization we made would be highly speculative and not do justice to the multiplicity of variables and complex interactions that likely influenced the patients' coping mechanisms over the course of their development. That said, at least a few patients developed a reliance on extreme defenses that appeared to have come about as a result of their trauma. At least three patients handled affects with a marked dampening of emotional expression, yet could at times be vulnerable to affective flooding. The very detached woman who had lost her sibling at age two was unaware of emotions about this early trauma. However, one day by happenstance she was exposed to a reminder of her sibling in a way that was mundane but completely unanticipated. She was suddenly caught in a wave of overwhelming anxiety, feeling as if she had been "punched in the stomach." Another early separation victim had organized her relationships, including her relationship with the analyst, so that she would always be the "leaver" rather than the "leavee." Some patients were described as using dissociation combined with splitting. In one case extreme dissociation in the form of dissociative identity disorder was triggered by a trauma in adulthood that appeared to release repressed affects deriving from multiple traumas in the patient's childhood.

*Patterns of object relating as a global carryover.* As noted in the section on transference, a trauma is almost universally experienced by a young child as a betrayal of the parent's protective role. The reestablishment of trust and the overall quality of the caretaking environment in the aftermath of a trauma are crucial factors in a child's long-term outcome (Scheeringa and Zeanah 2001). In an ideal situation, parents will recognize that the trauma has left an emotional template in the child's mind that subsequent events may trigger and will be able to respond with empathic attunement and understanding to a child's trauma-related distress. Such attuned responsiveness will help restore trust, facilitate affect regulation, and promote psychological integration of the traumatic events, likely ameliorating the long-term consequences. Less ideally, it is extremely common for well-meaning parents to fail to recognize the persisting nature

of this template for the child because they believe the child is too young to remember the trauma, and/or because they want to leave the trauma behind. Even so, the empathic responding and developmental guidance of nurturing parents will likely have reassuring effects on the child's emotions, even in the absence of trauma-specific attunement and intervention.

Unfortunately, for all but two of the cases in our sample, parents' difficulties in addressing their child's traumatic symptoms extended beyond simple lack of recognition. Even when parents were able to provide "good enough" parenting under ordinary circumstances, they seemed unable to provide adequate containment or soothing under the strain of heightened regressive anxieties and rage in themselves or their child. As a result, ten patients consciously traced their lifelong emotional withdrawal from parents to their early trauma. In twenty-two of our thirty cases, parents' denial and avoidance led them to attempt to eradicate the trauma experience from family memory, resulting in damaging relationship patterns. In four extreme cases, a gruesome death could not be talked about.

An example of parental denial is the case of the patient who began analysis with no conscious memory of her periorbital surgery at eighteen months. When she asked her mother whether she had ever been in the hospital, the mother confessed that she had intentionally never mentioned the surgery to her, hoping that the painful ordeal would be erased from memory. At the time, extremely upset to hear her daughter screaming, she had fled the hospital and did not return during the entire twelve days of her daughter's stay. The combined effect of the medical trauma and the mother's withdrawal appeared to have been pivotal: as an adult the patient was single, affectively constricted, and disconnected from her family, personality characteristics dramatically different from those of her siblings.

In some cases, the parents went beyond denial to engage in destructive narcissistic or dissociative reactions. Other parents appeared to have reacted to their child's fear and anger with punitive or disapproving responses, to the point where the child carried the label of "crybaby" or "difficult child." In other cases, patients described narcissistic parents whose responses to the child appeared more oriented to the effect of the trauma on themselves. In the case of the eighteen-month-old girl who spilled hot melted wax on her leg, the parents had incorporated the incident into family lore as a way of lamenting what a nuisance their daughter was to raise. It was only in treatment that the patient was able to recognize that the traumatic episode reflected a pattern of parental neglect and externalization of responsibility that had pervaded her childhood.

In four cases, the parents seemed to have responded to their child's early difficulties with anxious overprotection. In one case, a general pattern of parental overprotection appeared to have magnified a relatively manageable surgical procedure into a terrifying experience. The patient retained frightening images that carried over to adulthood and contributed to a sense of victimhood, disability, and sexual vulnerability.

*Developmental alterations.* Confidence in the inference that a traumatic symptom or emotional state has persisted into adulthood would be enhanced to the degree that one could follow the "red thread" of that state or symptom over the course of development. Unfortunately, in our interviews developmental data were almost uniformly scant. We asked our interviewees such questions as, How long did PTSD symptoms endure? Were there heightened fears about bodily integrity and castration anxiety during the patient's oedipal phase and beyond? Were there difficulties with aggression or sexual acting out during latency, or persisting traumatic states that interfered with learning or socialization? Were separation issues ongoing? Unfortunately, in almost all the cases this kind of information was either not remembered by the patient, was not discussed in the patient's family, and/or was not gathered systematically by the analyst. In the absence of this kind of detailed developmental data, links between the early traumatic experience and patients' symptoms and transference feelings tended to be based on contextual and affective correspondence, with significant gaps in the developmental picture leaving open the possibility of alternative explanations.

In the few cases where specific information was available, it generally consisted of vignettes capturing an isolated moment in time, as opposed to a linear developmental progression. At the same time, the vignettes that were reported tended to support the assumption of an ongoing disruptive influence of the traumatic experience on development, at least in the months and years immediately following the trauma. These disruptive effects were generally nonspecific in nature. In one case of the early loss of a father, a number of vignettes during latency and adolescence were identified that helped the patient recognize how much she had searched for father figures throughout her life. At least five patients (two who experienced medical traumas and three who experienced separations) reported persisting anger and defiance toward their parents dating from their traumas. The patient who lost her sibling at age two was later known as an "incorrigible terror" in nursery school, though as an adult she showed few problems with aggression. Several medical trauma patients

described themselves as shy and fearful from elementary school on. One patient who experienced a parental death before his first birthday recalled suicidal thoughts around age five, while another patient with an early loss remembered a plan to run away from home around the same age.

### **MULTIPLE PATHOGENIC INFLUENCES**

Despite the compelling nature of many of the carryover effects reported by our analysts, we were equally struck by the fact that the histories of the patients in our sample were characterized by multiple pathogenic influences, influences that not only complicated the child's processing of the early trauma but, more important, appeared to have powerful effects separate from the trauma. These influences included lack of emotional support (around the trauma and in general), problematic parent-child interactions, the occurrence of subsequent traumas, the presence of emotional disturbances in the family, and the patients' own biological predisposition to emotional illness.

Maladaptive caregiver-child interactions were the rule rather than the exception in our sample, often appearing to be a prominent contributor to persistent symptoms and affective dysregulation in the child. These either grew out of the trauma or, in many cases, existed independently of the trauma. Although data on the patients' experiences before the trauma were almost universally absent, almost every one of the patients in the sample reported significant parental and family problems, including parental mental illness and/or substance abuse, emotional neglect, and significant family discord that included parental divorce and problematic sibling relationships. For example, at least fifteen of the patients reported a pattern of interaction with their parents that we would categorize as neglectful and/or emotionally absent, with an additional seven patients reporting various degrees of emotional abuse. The dynamics that surrounded the patients' traumas often appeared to reflect a larger set of family themes, complementary to the traumatic experience, that set the stage for emotional vulnerability and/or reinforced the traumatic effects.

An additional complicating factor in our patients' histories was the fact that more than one traumatic event was the rule in our sample. As noted earlier, five patients experienced a compound trauma, and six additional patients experienced at least two separate traumas during the first four years of life. Even more striking, between the ages of four and nineteen, seventeen of the thirty patients reported experiencing at least one

additional trauma, with five reporting more than one. In sum, twenty of the thirty patients in the sample had had more than one traumatic experience before the age of nineteen. The effect of repeated trauma was particularly evident in cases of early physical and sexual abuse in which a discrete and identifiable incident of abuse occurred before the age of four, but was followed by subsequent experiences of abuse. The patients' early traumas no doubt made them susceptible to greater distress and disorganization in the face of a subsequent trauma, but exposure to multiple traumas makes it difficult to tease out the specific effects of each.

Another major influence in a number of cases was a biological propensity toward pathogenic emotions. In eighteen cases a family history of a diagnosable psychiatric disorder was either documented or could be confidently inferred based on the patient's description of family members. Eleven patients reported substance abuse patterns in a family member, and nine had themselves had substance abuse problems. Interpreting whether intense emotional states (and/or maladaptive attempts to regulate such states, as through substance abuse) were the product of early traumatic experiences that were being relived or were the result of other causes, including strong genetic predispositions, was often extremely difficult. For example, several patients who had experienced early parental separations also had strong family histories for depression. Persisting feelings of "inner loss and inaccessible hunger" could be attributed not only to an early childhood loss but also to depressive mood states to which they were biologically vulnerable.

An oversimplified but prototypical example of how these various factors might come together to produce enduring affective symptoms is a patient who underwent several frightening corrective surgeries that were only partially successful, the first one before the age of four. She experienced significant difficulties with trust and self-assertion, as well as persisting anxiety symptoms specific to doctors and her medical condition, but experienced in a variety of other situations as well. There was a strong family history for anxiety that included both parents. Beyond this biological predisposition, the parents' anxiety strongly influenced their responses to the patient's surgeries and more generally, resulting in overprotection, an inability to address important issues with the patient, and intolerance of the patient's negative affects. The fact that the patient was intimidated throughout childhood by a physically bullying older sibling played an important role in her anxiety condition as well. She also experienced a frightening attempted sexual assault in adolescence.

In summary, the emotional disturbances that the patients showed appeared to resonate closely with the emotional functioning of their parents and the family atmosphere in which they grew up, implicating both biological and social-emotional factors in addition to traumatic ones. It was our impression that rather than being the primary cause of the adult patient's symptoms, even when the trauma may have initiated or exacerbated a particular set of emotional and behavioral patterns, the persistence of these patterns depended to a great extent on the existence of both biological and environmental factors that reinforced and/or independently promoted a similar set of affective structures.

## DISCUSSION

At the outset of this paper, we pointed to the widely held conception that trauma both interrupts development and creates an enduring stamp. Our data suggest that this may be true, but that traumatic aftereffects are far from predictable and far more subtle than traditional views of traumatic carryover would suggest. Historically, expectations about the effects of trauma have had strong linear elements. Freud's regression/fixation model, Anna Freud's concept of developmental lines, and the more clinically near concept of "following the red thread" all have strong linear elements. They rest on the assumption that development follows from a template set down by early history, with emotional expectations from childhood carrying over into later experience and providing the structures that mold adult character. Repetition compulsion has been a cornerstone concept for understanding the impact of early trauma in the regression/fixation model. The child's development is thought to be shaped by a trauma because it is imprinted on the child's psyche and is reenacted compulsively. Fixation on the overwhelming experience and repetition of its literal details are thought to be a central mode of defense and ultimately of mastery. Recurring conscious or unconscious memories and holistic enactment of the trauma scenario are an expectable outcome in this model. The model generates the expectation that an analyst should be able to trace the red thread of posttraumatic repetition over the course of development (Terr 1981).

Consistent with contemporary psychoanalytic theorists who have written about nonlinear processes as they relate to the lack of predictability in the carryover of childhood experiences into adult analyses (Stolorow 1997; Palumbo 1999; Coburn 2000), our data do not provide much support



for linear models as applied to early childhood trauma. The lack of validation of the regression/fixation model was particularly striking. In our sample, aftereffects of an early childhood trauma were not absent, but differed in form and content from what might be expected if a PTSD picture had been carried forward through development. Symptoms that many authors have considered hallmark aftereffects of trauma—relivings in flashbacks, nightmares, and behavioral repetition—were practically nonexistent (van der Kolk, McFarlane, and Weisaeth 1996; Terr 1991; Herman 1992). Although explicit memories of the early trauma were often present, particularly from age three and up, they were generally not accompanied by intense affect. Implicit forms of carryover, which were by far the most frequently reported, carried with them all the ambiguities associated with interpreting such phenomena and their origin in the clinical situation. Correspondences between childhood and adult symptomatic structures were often more suggestive than clear-cut. Symptoms or emotional currents having potential specific links to a trauma were likely to surface fleetingly and then be dispersed or submerged in follow-up material in ways that made conclusions about a definitive link difficult to verify.

Although some form of direct linkage between an adult symptom and the early trauma could in many cases be reasonably posited, the clinical phenomena supporting such linkages tended to be isolated, relatively rare, fragmented, and inconsistent. It was as though varying aspects of the patient's traumas had been parceled out and dispersed randomly along different avenues of expression. To the extent that the traumas were factors in the etiology of the adult trouble, they seemed to be registered via allusive ripple effects, "baked in the cake" as the adult personality was formed. One would have a perceptible sense of the trauma contributing its unique flavor, yet it would be difficult to specify exactly where that flavor was coming from or what it had gotten mixed with.

An important qualifier of these conclusions is the fact that our data are limited to traumas occurring in early childhood. The closer our patients were to age four when their traumas occurred, the more detailed and sequentially coherent were their memories and the more readily interpretable were their implicit behaviors. Projecting those capacities forward, it is reasonable to assume that the long-term impact of a trauma might have a very different quality in older children and adolescents and that their symptom picture might more closely approximate traditional conceptions of traumatic carryover, including more direct forms of continuity into adulthood. Keeping this caveat in mind, we believe that

the following factors can help explain why in our sample traumatic after-effects were so heterogeneous and so difficult to track over the long term.

***The Nature of the Traumatic Experience***

PTSD diagnostic thinking is consistent with a linear model and predicts literal carryover of the trauma representation, yet inherent in the definition of trauma is a contradiction of this model. Trauma is by definition an ego overwhelmed—that is, the ego's representational capacities have failed to contain it, and the external auxiliary ego provided by the parent has likewise failed. Thus it follows that the fallout from this should be a fragmented picture, not an experience represented as a coherent transference construct or internal schema. Saporta (2003) has described how trauma may be registered in the form of perceptual and somatic fragments that can remain unintegrated for years because processing at the neuronal level has been disrupted. Fragmented representation is particularly likely with young children, whose capacities to construct a coherent narrative about any experience, to say nothing of a traumatic one, are very limited.

***The Complexity of the Developmental Process***

Even if seen for significant periods of time immediately following a trauma, over the long term posttraumatic symptoms and behavioral reenactments will likely be superseded by other processes and submerged into more general patterns of functioning. This is particularly true since developmental processes themselves are not always linear or continuous, but rather are characterized by periods of rapid change and reorganization (Spitz 1959; Emde, Gaensbauer, and Harmon 1976; Shapiro 1976) at both the neurological and psychological levels. At each major developmental stage between early childhood and adulthood, traumatic memories and feelings will be seen from a new perspective, will take on new meanings, and will be reintegrated within a whole new set of psychic structures. Conceptions about the nonlinear nature of the developmental process, strongly influenced by dynamic systems theory, have been incorporated into contemporary psychoanalytic developmental thinking by a number of analysts interested in early development (Beebe and Lachmann 1994; Sander 2002; Tyson 2002).

Even in the short term, the degree of trauma-induced deflection in a young child's development can show great variation. Emotional aftereffects may be limited to situations with very close stimulus links

to the trauma, or they may extend to influence a broad range of experiences and situations. They can also exacerbate preexisting problems and generate maladaptive patterns that take on a life of their own. Alternatively, the reactivation of trauma representations can over time lead to the detoxification of traumatic effects through desensitization, cognitive reprocessing, new developmental perspectives, the blending of traumatic memories with other memories, and caregiver responses. To use Anna Freud's concept, one can think of a trauma as introducing a new developmental line, one with the potential for interacting with other lines and for creating the kind of "developmental disharmonies" that she thought underlie childhood psychopathology (Miller 1996). Over time the various lines will become intertwined and synthetically integrated, creating a process that is no longer linear. In Anna Freud's words, "It is the hallmark of the synthetic function that, while doing its work, it does not distinguish between what is suitable and unsuitable, helpful or harmful for the resulting picture. Thus every step on the developmental line, besides being a compromise between conflicting forces, also represents an amalgamate of beneficial with malignant ingredients" (1979, p. 129).

This amalgamation into more general developmental processes can happen even over a relatively short period, as demonstrated in a recent follow-up study of traumatized children by Scheeringa et al. (2005). They found that a year after the trauma more general disturbances in affective regulation (e.g., increased distress on the one hand and emotional numbing and avoidance on the other) tended to increase over time, whereas trauma-specific reexperiencing symptoms significantly decreased over the same period.

#### ***The Presence of Multiple Pathogenic Factors***

As discussed earlier, multiple pathogenic influences were the rule in our sample. There was not a single patient for whom the early trauma was the sole disruptive influence in development. The persistence of patterns seemingly initiated by the trauma appeared to depend on the existence of both biological and environmental factors that reinforced and/or independently promoted a similar set of affective and behavioral structures.

#### ***Cross-Modal Processing and "Supramodal" Representation of Experienced Events***

Perhaps the least appreciated reason for the lack of linear effects is that young children encode and process not only trauma but all experiences

through a variety of modalities, the different elements of which are distributed to different parts of the brain (Stern 1985; Sander 2002). As a result of neurologically mediated capacities for cross-modal processing, young children are able to integrate the different elements of an experienced event into a common, or “supramodal,” representation incorporating multiple modalities: cognitive, perceptual, sensory, motoric, and affective (Meltzoff 1990, 2002). They use this supramodal schema as a basis for expressing their understanding of their experiences through a variety of channels: physiological, affective, multisensorial, behavioral, verbal, and symbolic. Observations of trauma-driven play in children suggest that even when a theme is recurrent, the play itself will not be static or unchanging, nor will it necessarily be a veridical replication of what the child experienced (Gaensbauer 1995). Behavioral reenactments of a trauma in early childhood are characterized by the “creative” use of cross-modal expressive pathways that capture central elements of the experience, often from a variety of perspectives (first- vs. third-person, victim vs. aggressor, etc.), while at the same time incorporating elements derived from other experiences (Gaensbauer 2002, 2004). It is as if once this overarching representation or schema has been established, the child can “take it apart” and metabolize it in pieces. Because cross-modal processing disperses the original trauma experience as well as reconfigures it, it works against the holistic preservation of the original template.

## CONCLUSION

We began with McLaughlin’s paradigmatic dichotomy (1982) between analysts who hold that early experiences can be directly accessed in the course of an analysis and those who believe that, while contributing importantly to adult structure, they are not directly accessible in the treatment setting. Our data support the position that for the most part early experiences are not directly accessible.

Although there were cases in which a specific symptom seemed clearly to have been derived from the early trauma, such symptoms were highly delimited. In the vast majority of cases symptoms or affective states appearing to have links to an early trauma were manifested implicitly, were quite general in nature, and/or were susceptible to multiple influences. Although there was no question that the patients’ traumas, especially the severe ones, had had profound effects on their developmental trajectory, the inference that a specific conflict in adulthood can be traced back to a specific

traumatic experience in early childhood was not supported by our data. Rather, our findings suggest that in adulthood direct links to an early trauma can be present, but they are likely to be rare, fragmented, and unpredictable. Such links can be quite useful in creating a therapeutically valuable, though not necessarily veridical, reconstruction of an early trauma and its likely carryover effects, in the service of helping patients validate their emotional experiences and develop a meaningful life narrative. The early trauma itself, however, is not likely to lend itself to holistic, regressive reworking in treatment, either in the transference or in the form of a full reliving.

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