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ABSTRACT

A selection of psychoanalytic literature on childhood traumas is reviewed. Reported are specific observable experiences or circumstances which have been followed by psychopathological development or behavior. Among the experiences and circumstances investigated were: childhood observation of adult intercourse; childhood bodily illness; hospitalization and surgery; congenital deformity; childhood bereavement; and childhood observation of murder. It is hoped that the study of emotional response to easily defined and verified realistic events will emphasize an increasingly rare type of methodology in recent psychoanalytic reporting: observation where hypotheses are in the background rather than the foreground. (Author/CS)

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September 20, 1965

To: Members of the Kris Study Group (Dr. Beres' Section)

From: Secretary

The enclosed material, "Specific Traumas: Selective Review of Literature", is submitted by Dr. Gilbert Kliman in preparation for the Meeting of Dr. Beres' Section of the Kris Study Group on Seotember 21, 1965.

Note: We regret that because of the volume of material and its late submission, this paper could not be distributed in time for thorough study prior to the September 21st meeting.

SPECIFIC TRAUMAS: SELECTIVE REVIEW OF LITERATURE

by Gilbert Kliman, M. D.

(for K/Beres - 9/21/65)

Introduction

It was not the task of this review to define "traumas". However, a working definition was needed in order to select relevant literature. It was therefore decided to review psychoanalytic literature on specific observable experiences or circumstances which have been followed by psychopathological development or behavior. Among the experiences and circumstances which fit this admittedly post hoc ergo propter hoc definition of trauma are:

childhood observation of adult intercourse
childhood bodily illness, hospitalization and surgery
congenital deformity
childhood bereavement
childhood observation of murder

It is hoped that the study of emotional response to easily defined and verified realistic events will emphasize what Hartmann points out as an increasingly rare part of recent psychoanalytic reporting: observation where hypotheses are in the background rather than foreground (1958).

A more extensive list of traumas could be compiled, but even with considerable selection, literature covering the above experiences is too vast to permit adequate presentation in a brief communication. Conspicuously absent in this review are considerations of trauma in adult life, such as conjugal bereavement, concentration camp and battle experiences, sensory deprivations, neurologic damage and toxic states, to mention a few which were left unexamined.

Primal Scene Trauma

The patient Freud described in "From the History of an Infantile Neurosis" (1948) observed parental coitus at age 1½, but that event only gradually took on a pathogenic significance by age four. By then, a phobia had been partly determined by these earlier impressions. In the interim another fateful event had occurred — sexual excitement with a servant who threatened the little boy with castration. The child's wishful fantasy of passive submission to his father in place of his mother were abandoned when the child concluded that the price of such a fulfillment would be castration.

Abraham (1913) and Waelder (1946) also dealt with the pathogenicity of primal scene observations. Abraham, reporting on a nine-year-old girl's night terrors subsequent to a primal scene, notes that the child's recent heterosexual masturbatory experiences had sensitized her to the incident. Waelder notes that the night terrors of a seven-year-old boy depended not only upon his having regularly observed parental intercourse, but that the terrors occurred in a matrix of sadistic fantasies about coitus. The neurosis was not precipitated until the boy himself engaged in forbidden sexual pleasures. Furthermore, he was in the midst of intense oedipal problems at the time of the terrors' onset.

Selma Fraiberg (1952) provides vivid information concerning the development of symptoms following verified observation of grandparents having intercourse. Fraiberg's detailed material, like Freud's, illustrates how a multifactorial predisposition to be traumatized by this particular event existed when primal scene observation occurred.

The clinically evident neurosis began at age 26 months, shortly after the child's visit to her grandparents in another city. She began to awake screaming inconsolably, after a brief sleep, then remaining "rigid and watchful the rest of the night", complaining that "de noises" bothered her, when no one else heard sounds. During the day she was terrified even of slight noises. Soon she seemed "completely out of touch with reality", insisting that her family's house was "not our house". Genital masturbation was abandoned. She began compulsive thumb-sucking and rubbing just above the genital area. A strange ritual developed of handing her mother a certain waste basket. She discarded her toys and refused to play.

Other events predisposing to the traumatic influence of the primal scene were the following, all of which preceded the fateful visit to her grandparents: 1) A pattern of frequent but cheerful nightwaking since earliest infancy. 2) Precocious verbal intelligence, with a recently acquired vocabulary of sexual and anatomical terms such as "the vulva" and "the genitals" and "pregnancy". 3) A series of genital examinations by the pediatrician, accompanied by presumably pleasurable genital sensations. 4) Overt envy of the penis of her new-born brother, who was born when the patient was 23 months. Narcissistic injury was evident in the form of disappointment in her own penis-less state. She made explicit complaints regarding her deficient condition at age 24 months. 5) Discovery by the patient of mother's bloody sanitary napkins in a waste basket (cf. the strange wastebasket ritual noted above), with subsequent explanation by the mother that the patient, too, would use such napkins when she grew up. 6) Mutual masturbation with a little boy, discovered by mother who thought the children were fighting. In alarm, the mother urged the boy to stop hurting her girl.

Important predisposers to the pathogenic influence of observing parental intercourse were the patient's pre-existing fantasies. These were, of course, a major part of the perceptual and cognitive framework with which the little girl viewed and misunderstood the grandparents' intercourse. Analysis revealed the child was filled with oral sadistic urges toward her brother. During analysis she actually tried to bite her brother's penis. She had a fantasy that she had once been a boy who had been castrated a birth. Later these fantasies changed to the idea that females are castrated during penetration by the male -- then, that females damage the penis during penetration. She considered the used sanitary napkin evidence of her mother having a piece of penis still left inside her vagina, a piece removed from her father.

When the patient viewed her grandparents' sexual act, her immature ego was not yet possessed of a strong sense of reality. It was not easy for her to be sure whether or not she was dreaming. Further, her observations appeared to be perceptual confirmation of castration being a real process. The grandfather appeared to her to be making

a hole in the grandmother. It is also significant that the little girl, who was then away from home, lacked the parents' presence to support her frail reality-testing activities.

Childhood Bodily Illness, Hospitalization and Surgery

Anna Freud (1952) goes beyond a discussion of the separation problems which occur when hospitalization takes place. She discusses the effects of nursing, medical and surgical procedures. First, there is a change of parental emotional climate during illness so that the child experiences unexpected handling such as deception, forcible feeding, or forcible bowel evacuation. He may react to such unexpected handling "as to traumatic experiences", and feel helpless and bewildered because he notices that formerly "immovable emotional and moral standards" are broken.

At another extreme there may be unexpected indulgence of the child's wishes, which makes it difficult for him to give up the incidental emotional gains after recovery. The experience of being nursed may be harmful to children who have, because of their early stage in life, recently been mastering various bodily functions. The nursing experience in which the child is fed, cleaned and washed and assisted with excretory activities, his nakedness on view, is experienced as a loss of control in a variety of areas only recently controlled, with resultant pull toward earlier and more passive levels of development.

Two extremes of pathology may result. Children whose defenses against passive leanings and regressive pulls are very strong become very obstinate, intractable patients. Others may all too easily lapse into a state of helpless infancy from which they reluctantly or never fully emerge.

Another category of trauma is restriction of movement and diet during illness. A number of other authors have observed the consequences of extreme restraint to physical activity. Tic-like movements elsewhere in the body have been noted upon extreme restraint of limbs (David Levy, 1928, 1944). In contrast to this involuntary and rather automatic limited muscular response, there may be more global involvement of the organism in rages and temper tantrums. These latter especially appear when mechanical restraint is partially but not wholly lifted or when additional deprivations beyond the expected medical procedure are unexpectedly heaped upon the child.

Miss Freud cites the work of Bergmann (1945) who notes that the restraint placed on one limb may spread to inhibition of movement in other unaffected parts. On the other hand certain ego skills such as speech may undergo a rapid development, apparently in compensation for motor restriction of even one limb. Miss Freud also discusses the effect of surgical operations. It is well known that many such procedures may act as a crystallizing point for precipitating the activation or reactivation of ideas concerning being attacked, overwhelmed or castrated. The actuality of surgery lends "a feeling of reality to the repressed fantasies, thereby multiplying the anxieties connected with them". When the child's defenses for whatever reason are unable to deal with the

massive anxiety released, then and only then the operation becomes a trauma for that particular child.

Reviewing emotional reactions of children to tonsillectomy and adenoidectomy, Miss Freud cites that the "traumatic potentialities" of such procedures lie in three factors principally: the anesthesia experience; the hospitalization experience; and the operative procedure itself. She finds that it is not "the castration fear, but the feminine castration wish in a male child" which most often leads to a traumatic psychological effect of a surgical procedure. The child either submits to the surgery as if it were seduction to passivity or else has to build up "permanent pathologically strong defenses" against his passive wish. Miss Freud here does not comment upon the traumatic effects of surgery in little girls. Regarding the effects of pain on children, Miss Freud notes that children she has observed who are "tough" in the face of pain are so because their "latent unconscious fantasies are less dominant and they are less apt to be connected with pain".

In 1958, the American Psychoanalytic Association had a panel on "Psychological Consequences of Physical Illness in Childhood", reported by Victor Calef (1959). The participants focused on an instinctual vicissitude under circumstances of varying bodily insults. Anita Bell described a compulsive, emotionally withholding and masochistic "bobbysoxer" with intractable asthma dating back to age two. At age five months, the patient's mother began holding a small receptacle to the anus whenever signs of defecating appeared. At ten months, upon development of eczema, the child's hands were bound, food was restricted, and she was kept in bed. Dr. Bell postulated that the girl was deprived of adequate anal zone discharge opportunities. Oral zone "premastery" was interfered with by the motor and food restrictions which followed the onset of eczema. Regression to the earliest respiratory phase then occurred -- the phase in which "the child could be in control by holding her breath". Interference with the development of premastery activities in the anal and oral sphere was thought to have prevented fusion of libidinal and aggressive energies, with interference of object relations and development of a masochistic pattern.

Much of the material presented by other participants was an elaboration and extension of Anna Freud's schematic work on the same topic (1952), to which Jessner gave especially rich documentation and confirmation. Jessner added that since child's parents are devalued through the helplessness to prevent the child's suffering, and also are separated from the child, a kind of grief reaction occurs on both counts. The outcome, through reincorporation of the loved object, may spur maturation and improve realistic relation to the self and the parents.

Sylvester emphasized the traumatic effect of mechanical contraptions which diminish pleasure and increase tensions in a body area. Unless alternate channels of discharge develop, redistribution of cathexes may occur regressively to "resomatization of the sense of self, reversal of outgoing libidinal strivings, primitivization of ego functions and modes of object relation". The degree of trauma will depend on 1) whether there is a specific interference with a libidinal need which

happens to be ascendant, 2) the magnitude of mechanical restrictions, 3) capacity for adaptation. The latter parallels the stage of object relations formation, strength of tension tolerance, and flexibility of energy discharge modes. Reactions to mechanical gadgets may be fairly specific to the gadget's location. An infant whose severely infected mouth was stuffed with medicated cotton and who was fed by dropper later avoided exploring the world by putting things in his mouth. Other reactions are unrelated to the gadget's location, depending on the phase of development. For example, a two-year-old boy with hip deformity mastered braces in a few hours, but lost his recent phase-specific achievement of bowel control. Although the panel did not apparently discuss this point, it is clear that the first case, where the reaction was considered specific to the gadget's location in the child's mouth, might just as well be considered specific to the then ascendant phase, the oral.

The panel noted that further study of psychological consequences of childhood illnesses should proceed more vigorously, due to the considerable opportunities for illuminating their effects on differentiation of ego functions. Furthermore, the paucity of recorded observations in the area may be a reflection of cultural attitudes toward handicapped and physically traumatized children, including deep-seated horror and resentment which may be shared by analysts as well as parents. Marianne Kris, in a personal communication on this subject (1964), notes that viewing of weakness in another human being creates in the observer a conflict over his own aggressive impulses, which may lead to an inhibition of constructive intellectual activity.

Jessner, Blom and Waldfogel (1949) demonstrate again that the prior state of the child is a major determinant of his reaction to a particular burden -- in this case a common surgical procedure. Observations on 143 children aged three to fourteen revealed that tonsillectomy was stressful for each child. It generally activated fantasies of abandonment, mutilation and death, as well as of bodily transformations and pregnancy. Most children integrated the experience successfully so far as immediate reaction went. Prior experience with surgery sometimes heightened anxiety but sometimes improved the children's ability to "cope with the later operation". The authors suspect these children knew that the "reality of such an event was not as terrible as their anticipating fantasies".

In contrast to the findings of Levy (1945), who studied younger children, age and sex did not appear to be significant factors in the severity of reaction to tonsillectomy. However, there was a marked shifting in the focus of anxiety with age. Below age five, the event of hospitalization together with its implication of separation from the family was the main source of dread. However, by age ten to thirteen, the anesthesia experience was the focus of anxiety. Where the operations became a disturbing or disruptive experience, there was generally a pre-existing neurotic trend. Where there was not a prior neurotic trend, the newly disturbed children tended to have experienced "but not integrated" some threatening life situation such as death of a relative. The authors believe that for children with pre-existing neurotic trends or disastrous

life experiences not yet integrated, "preparation of the conventional kind did little to increase their capacity to withstand" the surgery. For such children preventive intervention is advised in the form of "working through some of their deeper anxieties. Where there is evidence of a personality disturbance or a history of recent traumatic events in a child's life, careful consideration should be given to his emotional status with the view of postponing the operation or of taking psychotherapeutic measures." Failure of a child to indicate anxiety is also a bad prognostic sign. Over-control of fear, suppression, denial and avoidance of anxiety-related topics are measures which are liable to "collapse with a bang."

Regarding the prevention of pathological consequences, the authors conclude that the presence of his mother overnight is not necessarily helpful to the child. The mother's presence certainly comforted against "fear of abandonment". On the other hand, "if the mother was anxious, the child felt it". The fact that the mother could not prevent "the needles" and other dreaded manipulations sometimes aroused the child's hostility against his mother, which in turn frightened the child much more than aggressive acts or words against a stranger like a nurse or the doctor. "On the whole it seemed that a mother substitute...was a more adequate solution. A nurse might very well substitute for the mother. The child should feel that one nurse in particular was his protector although he could share with other children."

Other preventive measures used to protect against psychological trauma from tonsillectomy include the acknowledgment "of fear and expression of anxiety in play and talk... Encouraging the child to express his feeling should, however, not be understood as inviting the child to give up control completely." An exceptionally helpful mechanism is the reversal of passive into active roles. Children should be helped to play "the surgeon or protecting mother" in regard to a doll or another young child.

Psychological Trauma of Leg Amputation

Two reports of this experience have been found in psychoanalytic literature -- one each by Pearson (1941) and Plank (1961). Plank's account is more detailed. Her four-years-and-two-months-old patient, Ruthie, was observed before and after the amputation. Preventive psychotherapy in a hospital play group several times a week for five weeks was administered to prepare her for loss of her limb. By that time she was suffering from gangrene below the knee and had no sensation left in that area. Ruthie strenuously changed the subject when this fact was mentioned verbally. However, she spontaneously spoke of a doll who was going to have an operation, and this lead was followed by the therapist who then constructed a special prosthesis doll which would undergo amputation and receive an artificial limb. With this doll Ruthie revealed denial that she wished to walk again, plus a hope that another leg could be grown. Actively mastering the surgery in advance, Ruthie spent hours examining the doll, removing and replacing its artificial leg.

Following surgery, Ruthie occasionally wet and soiled herself. On occasion she refused food. Masturbation become more overt, a phenomenon also reported by Joyce Robertson (1956) in an account of her daughter's tonsillectomy. Like the Robertson child, Ruthie also wished to actively throw away the diseased body part. Five months passed before a prosthesis could be fitted, but it was accepted avidly and used with agility. The author leaves an impression that the regressive phenomena cleared, and "a warm, likable little girl emerged who could form positive trusting relationships to the unavoidably large number of people who had to care for her."

Congenital Deformity: A Case of Phocomelia

Anna Freud, in commenting on the case of a congenitally deformed boy, states that disabled people tend to "masochistic satisfaction, passivity, or self-pity..." (in Lussier, 1960). However, a contrary case is reported by Lussier, that of a boy whom Miss Freud examined and found to be actively oriented and not seeking pity. Peter, age 13 when analysis began, had been born with "malformed shoulders and abnormally short arms terminating in hands having only three fingers and no thumbs". At 13 years, this shoulder to fingertip length was only eight inches. Presenting problems included enuresis dating to surgical preparation for artificial arms at age nine, backwardness at school, depressive tendencies, and an intense involvement in fantasies. Analysis revealed powerful denial of handicap, with fantasies of superior physical abilities, such as becoming champion tree climber, tree cutter, bicyclist and trumpeter. He had a strong desire for his mother to be "thrilled" by his frenzied physical fantasy performances, which usually ended with a fantasy of a broken leg. Sexualization of physical activity fantasies was so intense that he would "feel too hot and excited" to sleep if he thought them in bed.

A special feature of this boy's psychology was the amount of constructive use he made of fantasies. Instead of being a substitute for real gratifications, they became springboards for them. He really learned to play a trumpet, got into a band, rode a bicycle, became a fisherman, swam and became a certified life-saver -- transforming pre-existing "fantasies into ego abilities".

One result of his (Peter's) congenital handicap was "an unconscious feeling of incompleteness" and femininity "expressing itself endlessly in attempts to compensate for his deformity". The author predicts this tendency will continue with repetition of achievements needed throughout Peter's life. Peter also had a special intolerance of passive wishes, which led to his termination of analysis to assume independence of the analyst.

Childhood Deprivation of a Parent

This is an area with a vast literature, not always rich in observation. A comprehensive review will not be attempted at this point. Certain aspects related to problems of separation have already

been covered by the 1963-1964 Kris Study Group. Bowlby's reviews and original contributions in this field, although major, mainly reflect upon observations made by others. His views will therefore not be dealt with here although they should be considered when the concept of trauma is under scrutiny. Rene Spitz (1951) considers all disease-producing psychological influences during infancy are essentially unsatisfactory mother-child relations, either the wrong kind of relations or insufficient amounts. The wrong kind is called "psychotoxic", including severe rejection of the child, anxious over-permissiveness, and hostilities disguised as anxieties. Insufficient or emotionally deficient mother-child relationship included partial and total deprivation of relationship to the mother or mother substitute. In cases of total emotional deprivation, particularly where the mother-child relationship has gone on for at least a few months, total cessation of such relationship leads to a wide variety of profound mental and physical damage. Such children at the end of an additional year's time sometimes achieve only 50% of the normal expected developmental level. They often do not sit, stand or talk until age four. Bizarre finger movements and spasmus nutans are observed in some. Many such children die of physical disease and marasmus. Thirty-four of ninety-one children followed by Spitz for two years died. Provence and Lipton (1962) have documented the effects of institutional environment on seventy-five infants. Deprivation of a constant maternal influence was one factor which led to marked developmental retardation. Deficiencies or retardations were apparent in motor development, impulse control, verbal abilities, and social relationships. In addition to retardation in those areas there was also conspicuous disuse of available functions. Bowlby, Spitz, Provence, Lipton and other workers have been primarily concerned with absence of a mother in the pre-oedipal phases of life. However, this review will now highlight more of the oedipal phase reactions, lingering in the early areas only to touch upon Anna Freud's work in this field because it is also applicable to some extent when considering the reactions of older children.

Taking a broad overview of the immediate pathological effects of separation, including death of a parent, Miss Freud (1960) lists four sets of difficulties:

1) Psychosomatic problems ranging from sleeping, feeding and digestive disturbances to increased susceptibility to upper respiratory infections.

2) Instinctual regressions in both libidinal and aggressive expressions, and at worst a "diffusion of libidinal and aggressive elements which allow the latter to dominate".

3) Regressions of ego functions, usually the functions most endangered being those which have most recently been acquired. Very impressive to Miss Freud were loss of speech, bowel and bladder control, and decline of social adaptations.

4) Disturbance of libido distribution. During the process of withdrawal of libido from the mental representative of the mother, hypochondriacal disturbances result from the use of this newly available libido to cathect the child's own body. When the self-image is increasingly cathected a variety of problems may result, including omnipotent ideas. If the child already has a crude inner fantasy world, this may become over cathected with a resultant autism. If separation from the mother is permanent as in death of the mother, these pathological developments may become irreversible.

Miss Freud stresses that the state of the child's psychological development, considered from all points of view, at the time of the loss is crucial in determining whether pathological consequences will ensue. Particularly decisive is the matter of whether at the moment of losing the mother the tie to her is primarily narcissistic or whether personal and affectionate elements had begun to predominate, transforming the attachment into object love..." If a love of "object constancy" had been attained, then the painful "disengagement process known to us as mourning" will be necessary before libido can be removed from the mental representative of the lost object. With the advent of strong object constancy, the child is usually already grappling with later developmental problems, including those of guilty reactions. Upon bereavement some of the child's ego functions may be overwhelmed by the problem of dealing with the painful affect of grief, or he may develop pathological solutions of his oedipal problems. These areas will be touched upon below.

Freud, in Mourning and Melancholia (1917) noted that the loss of a loved person is pathogenic in proportion to the pre-existing degree of ambivalence toward that person. Severe pre-existing guilt feelings lead to a pathogenic outcome, often ending in suicide. He does not comment here on the special trauma children experience through death of a parent.

Helene Deutsch (1937) describes cases in which loss of a parent is associated with absence of affective response whether in childhood or adult life. Further, economic changes then occur: massive defenses with absence of affect throughout all fears of object relations; displacement of affect in a shallow fashion to other areas of object relations; or increased narcissistic investment of libido. She presents four illustrative cases. Deutsch conceives of parental death in childhood as frequently traumatic not only because of intellectual inability to comprehend the finality of death or weak development of object libido. It is also, and perhaps more frequently traumatic, because of the immature ego's inability to bear the prolonged painful affects of grief. Deutsch postulates an undescribed mechanism by which the ego recognizes that an overwhelming quantity of affect is about to be released when a parent dies. Second, a primitive mechanism of defense is postulated which, having been set in motion by a signal, begins massive defense against the emergence of the painful affects. Furthermore, object cathexis is transformed into narcissistic cathexis. Still further, the defensive work transforms some mental events from a secondary process state into a primary process state so that there is a highly displaceable quality to the cathexes which have been withdrawn from the object representative. Affects formerly associated with the object representatives are liable to reappear inappropriately. There

is chronic pressure for discharge of the defended against affects, which often reappears as "unmotivated depressions", sometimes for a lifetime.

Deutsch's thinking about unmotivated depressions as a consequence of absent affect following parental death is strongly confirmed by Beck's statistical study of depressed and non-depressed patients (1964). Beck notes that childhood bereavement is significantly more frequent in the depressed group. Also, the profoundly depressed group has significantly earlier age of parental death than the mildly depressed group.

Loretta Bender (1954), in a seldom noted contribution to literature on childhood bereavement, describes a series of eleven children who poignantly illustrate Deutsch's point that "the ego is rent asunder in those children who do not employ the usual defenses, and who mourn as an adult does". Deutsch notes that quantitative factors as well as qualitative developmental factors may determine whether damage occurs. "If the intensity of the affects is too great, or if the ego is relatively weak, the aid of defensive and rejecting mechanisms is invoked". If an adult's ego strength happens to be diverted at the time of parental death -- for example, by exhaustion or because of some immediately preceding painful occurrence, "the residual energy is unable to cope with the exigent demands of mourning". In a child, the ego is usually weak for developmental reasons and a pathological outcome is, therefore, more likely to be inevitable.

Deutsch's writing on this subject, although brief, is packed with observations and formulations important for preventive work. She believes it is essential to later emotional health that every real loss of a loved person must be reacted to with a complete process of mourning so that no "early libidinal or aggressive attachments persist". Whenever any form of affect exclusion appears, for whatever reason, "the quantity of the painful reaction intended for the neglected direct mourning must be mastered."

Ernst Kris (1956) reports the case of a young female psychologist whose mother had died when the patient was three. Kris noted a "libidinization of the function of reminiscing itself". Investment of libido in the function of memories seems to be a result of desiring "to be close to those she had loved early in life". In addition, "talk of the past served to counter-balance the drab present". Further, "while the tensions of the present were threatening, she was master of those she conjured in recollection". Kris notes that "a repressed unconscious fantasy can be treated like a possession or a loved object..."

Specific Oedipal Problems Following Parental Loss

Freud (1910) noted that Leonardo Da Vinci suffered the absence of a father until age four. Being the only solace of his mother, he was open to her "tender seductions". Da Vinci's later homosexuality was attributed partly to the mother's reciprocated libidinal tie to him in lieu of her husband. Five years later (in his Three Essays on the Theory of Sexuality), Freud stated "the early loss of one of their parents

by death, divorce or separation...(produces the) result that the remaining parent absorbs the whole of the child's love, determines the sex of the person who is later to be chosen as a sexual object and may thus open the way to permanent inversion". Ferenczi (1914) notes that the loss of a father and the resultant lack of "unavoidable conflicts between father and son" dispose to male homosexuality. Fenichel (1931) emphasizes the guilt which results from fulfillment of oedipal wishes through death of the same-sexed parent; and the danger of idealization when the opposite-sexed parent dies.

Anna Freud (1943, 1944) observed fatherless children at the Hampstead Nurseries during World War II. These children were strongly involved with a fantasied father even where no father had been known to them at all. Superego development proceeded to some extent with a fantasied father. Nunberg (1955) notes, however, that fatherless children often behave as if they have no guilt feelings and behave ruthlessly, as if revenging themselves on the world which has failed to provide a father.

Margaret Meiss (1952) describes the analysis of a five-year-old boy whose father had died when the child was three years, three months. At the time of entering analysis, Peter showed evidence of being in the phallic period and having considerable difficulty resolving his oedipal problems. He suffered from insomnia and the fear that his mother would die. He heard voices inside his head which said, "Daddy is angry," and told "about times I didn't like Daddy, times when Daddy was angry at me".

It was Meiss' purpose to point out the specific effects of this particular trauma as it influenced a child who would have become neurotic in any event. Features of the neurosis which could be attributed at least in part to the specific trauma are the special focus of her essay. Meiss believes that the child's anxiety about his mother dying probably would not have appeared without the father's death. He had a fantasy that through the mother's death the parents would be reunited forever, and he would be entirely alone. Unlike usual fears of a parent's death, this symptom was not largely the result of antagonism toward the mother but stemmed more from the child's oedipal rivalry with the dead father. Meiss believes that anxiety about the death of the mother is generally rare among boys in the oedipal period and may be uniquely associated with the death of the father prior to the beginning of latency.

Another special feature of this child's analysis was the quality of his transference. He was excited sexually during his analytic hours though calm and detached at home. Meiss believes that "the death of the father...promoted a precocious internalization of his (father's) prohibitions". "There was no actual father present to reassure the child that wishes are not the same as deeds, or to continue giving and evoking affection; his fearsome image could not be tested against reality." This excessively harsh fantasied father figure, and its contribution to the superego through an unusually intense identification due to the object loss, contributed to superego functioning of a sort which heightened transference reactions. The child consistently used the analyst's husband as a "substitute for a father" in the analytic fantasies. Meiss believes that the

child's overwhelming fear of his dead father may have made it too dangerous for him to return to his original object (the mother). The analyst was safer because her husband seemed less threatening than his invisible and omniscient parent.

Meiss cites a variety of other factors which went into the formation of this child's neurosis, including multiple separations beginning at age nine months, a tonsillectomy at nineteen months, the loss of a brother through institutionalization at twenty months, and the death of a newborn brother when the patient was twenty-four months. Meiss does not comment on the terrible guilts which the two fraternal losses may have engendered prior to the death of the father for which the patient also felt guilty.

The event of the father's death was fused in the child's mind with memories concerning other people who have left him. The little boy, it was noted, was occupied with thoughts that his Daddy was angry at him. However, he attributed to an absent German maid the statement that his penis could be bitten off. He could not be reassured about the impossibility of such a thing happening to him until told that his father, if alive, would explain to him that his penis could not be bitten off. It should be made clear, too, that Peter's oedipal rivalry with his father antedated his father's death considerably. For that reason the child might well have been troubled by sleeplessness and prowled about at night.

The question of what factors led to the outbreak of Peter's symptoms, about age five, is interesting since the death occurred twenty-one months previously. Meiss speculates that physiological increments in his phallic drive exacerbated the latent conflict. Another factor disposing to this particular timing of neurotic outbreak was that the mother had entered therapy, which led to a diminution of her sadistic treatment of the child. As she became more truly affectionate with him, the child must have felt a dangerous gratification of his wish to replace the father in his mother's love life. Again, whether these last two factors would have been so dangerous in the presence of a real father is problematic.

Reviewing literature from 1930 to 1954, Neubauer found five female and five male analytic cases with material centered about a one-parent relationship. All but two had lost a parent before the oedipal phase and all ten had only one parent during the oedipal phase. Eisendorfer (1943) described two fatherless women with increased primary homosexual attachment to their mothers. They identified with their absent fathers to keep their mother's love during their oedipal phases. Annie Reich (1954), in describing a paternally bereaved girl, notes that desexualization of fantasies about her dead father was not possible. "No stable identification was possible with nonsexual qualities of objects that existed in her fantasy only. The normal impact of reality on this fantasy object...(left) the unsublimated phallic character of the ego ideal and its megalomanic scope." "...(When) sexual characteristics as such remain an ego ideal, a fixation on or regression to primitive, aggressive, pregenital levels is frequent, which leads to a persistence of particularly cruel superego forerunners."

Neubauer's own published case (1960) is one of nearly total absence of a father. Rita, the three-and-a-half-year-old girl described was a week old when her father left. Her presenting problems included excessive eating and "sexual confusion" with an "expressed wish to be a boy". Her father returned for two visits at the mother's importuning when the child was already in treatment. He added to Rita's burdens at that time by yielding to her pleas that she be allowed to watch him urinate. He also teased her by calling her "Hey, boy!" tauntingly, undermining her frail sense of conviction as to whether she had ever possessed a penis or was born a girl.

Like Meiss's patient whose opposite sex parent was absent before phallic development began, Rita became anxious with the onset of that development. She began to long for her father and in her loneliness wished to be a male herself. While not suffering from separation problems before, she -- like Meiss's motherless boy -- began reacting with severe anxiety. Castration anxiety was now apparently reinforcing separation anxiety. Rita became unable to attend a day nursery where she was party to other children's sexual play. She pleaded to stay home, complaining she had been a boy the week before but now had lost her penis.

In panic and fury after two weeks of school she attacked her mother, screamed for hours, undressed and urinated on the floor. It was at this point the father made his addition to Rita's burdens. After father's visit Rita apparently turned even more to him rather than to "regression to a demanding oregenital relationship to mother". However, father implicitly expressed the demand that she be a boy, and this she strenuously strove to be in play. Never fully at ease with her wish for a penis, she retreated at times from related issues. She decided never to get married. Reality testing was seriously threatened by her over-idealization of the again-absent father, whom she thought of as a protective, all-powerful, all-loving person. When he cynically broke a promiseto visit her at the therapeutic nursery she attended, Rita claimed he had really come but had been refused permission to enter.

Neubauer believes that events may "have an extraordinarily traumatic effect for a child suffering from oedipal deficiency". Lacking the "day-to-day interplay between the child and each parent", lacking the "synchronization and dosing of oedipal experiences in a continuous reality content", lacking observations "of the primal scene with all its social equivalents -- developmental forces crystallize too suddenly around events rather than being slowly but continuously interwoven in experience."

Shambaugh (1961) has made a special contribution, as Furman (1964) later did by describing the reactions of a child to death of a parent where the child was well known to the therapist before the death. Some problems of retrospective distortion were thereby avoided. Seven-year-old Henry was seen by Shambaugh for five months, having been brought by his father for preventive work during the mother's terminal months.

The dying mother's refusal to allow treatment, and the father's rapid remarriage to an immature woman, suggest there may have been significant pre-existing psychological weakness in the parents' psychological health. Before the mother interrupted treatment, it was observed that Henry started to "suppress" angry feelings toward her which had been excited by her increasingly stern demands for high school performance.

After a seven-month interruption, Henry resumed treatment shortly after his mother's death. He was then pathologically hyperactive, distractable, gay and even euphoric. Any attempt by the therapist to discuss his mother's death was met with anxiety, anger and avoidance, even running out of the office. He felt cheated in all games played in sessions and made countless demands for toys and food. Play themes were violent. Object relationships were profoundly altered. He began to treat his four-year-old sister with parental tenderness and concern, often consoling her. Toward his father he became clinging and exchanged baby talk while simultaneously belittling the man and denying that he needed him. His attachment increased as father found a woman. Then Henry imagined lying in the sun all day with father, or riding on horses, also sharing the father's bed. Simultaneous with this homosexual trend, an anxiety laden desire for physical closeness to the male therapist developed. Henry then welcomed his new stepmother (married after a four-month courtship) and gave up his homosexual orientation with apparent relief. It was only following this marriage that Henry went through some mourning work. He became sad, serious, recalled his mother's chest surgery and tried to obey her injunction to stop treatment. He began treasuring a few objects she had given him, but also learned to accept his stepmother's taste in refurnishing the home differently from his mother.

Henry's reaction had thus included "regression to orality, anger and fantasies of violence. He withdrew libidinal investment from his remaining objects with an increased narcissism, "to the point of megalomanic fantasies of independence". His efforts to mourn by consciously thinking of his mother and gradually decathecting memories of her foundered because of his childish ego's inability to bear the associated painful affect. Instead he had to regress.

Observation of Parental Suicide Attempt

Although it might well have been considered under the heading of other traumas, childhood witnessing of parental suicide efforts includes among its multifactorial impacts the element of anticipated loss, and therefore will be discussed here. Rosen (1945) describes a patient whose sense of reality was damaged in connection with his mother's suicide attempt and surrounding circumstances.

The patient was a twenty-seven-year-old man whose presenting problems included a feeling that the world around him and his own self were "fragmenting" and seemed unreal. His symptoms were of recent onset, and associated with depression and suicidal fantasies. The acute episode had been precipitated by a broken engagement. A regular psychoanalysis was not undertaken because the patient seemed to be schizophrenic. After an

interruption of treatment due to the patient's persistent nonpayment of bills, the patient developed a wry neck and the sensation that his head felt as if it were being "twisted from my body". Fantasies of Venetian blind cords looking like "hangman's ropes" then appeared, together with remarks about how iodine was never kept in the medicine chest in his family, nor had there ever been keys with which to lock the bathroom door. The analyst deduced that the patient's mother must have made a suicidal attempt in the bathroom, probably by hanging. Suggestion of this possibility to the patient brought forth a "remarkable and violent flood of affect...convulsive sobbing...lasting for about ten minutes". A marked relief from derealization occurred, with increased accessibility to treatment as well. The patient's father confirmed that the mother had made suicidal attempts several times during the patient's pre-school years. The father reported that on one occasion when the patient was three, he had gone to work and an older brother had gone to school. The patient's nurse heard sounds in the bathroom and just managed to prevent the mother from strangling herself. It is unclear what the patient viewed at this time. The nurse was later discharged because her presence was a reminder of the episode, according to both parents. Furthermore, the father and nurse tried to convince the patient that he had only imagined the event or had experienced a "bad dream". The father believed it would be harmful to the patient to remember this episode and also wanted to keep it secret.

Rosen notes that Freud's concept of "traumatic fixation" has not been abandoned. This particular case illustrates an unusual outcome of the ego's adaptive efforts following a trauma. Repression failed, Rosen believes, and the patient simply felt that he had been given permission to speak of a memory of which he had known "in some way all along" and had not been truly restored. The patient lived under constant "threat of being overwhelmed by his affect" associated with the experience. Since important figures in the child's life had insisted the event was unreal, a special variant of defense was forced upon the ego, a reversion to an older process -- primitive identification with the hanging mother. Rosen believes that when affects stimulated by a trauma cannot be dealt with through repression, they are then invested in the child's body image and "thus little of the original object cathexis of the experience is retained". As a consequence of this "traumatically fixed" process, sensations in the body occurred with each mental repetition of the event, with concurrent partial decathexis of the outer world and consequent experience of derealization.

There are similarityies between Rosen's case and that reported by Selma Fraiberg in "A Critical Neurosis in a 2½ Year Old Girl". Derealization was an outcome following a deeply disturbing observation. In both cases the child's sense of reality was quite tentatively developed and easily succumbed to the perplexing special features of adult responses which were part of the traumatic observation. Fraiberg's child witnessing a primal scene in the dark, in the absence of her own parents, heard the sexual partners expressing doubt as to whether the child had seen anything -- thus reinforcing her own doubts as to the actuality of her observation. The child was also horrified by what she thought was a confirmation of her sadomasochistic fantasies regarding intercourse.

In Rosen's case, the significant parental figures actually preferred the patient to use denial and foisted on the child a pattern of confusing reality with dream. Rosen believes that in the transition from the pre-oedipal to the early oedipal phase, it is likely that there is a transition in the character of the ego's utilization of identification. This process is parallel to the development of reality testing. Both reality testing and the state of identification are quite vulnerable to regression during this transition stage.

Observation of One Parent Being Murdered by Another Parent

The loss of a major love object for any reason has been shown to be capable of undermining all future emotional development. Observing the violent ending of a parent's life adds a crushing load of conflict over the child's own homicidal impulses, which have been stimulated by the real life example. When the murder of one parent has been committed by the other, the calamitous example of the murdering parent's weakness in respect to homicidal impulses further undermines the child's ability to control similar impulses of his own. These at least are expectations which seem reasonable.

Dr. Jack Wilder, in a personal communication, reports a case in which a five-year-old boy's father stabbed the boy and the mother ferociously through the lungs and flanks -- the father then immediately leaping to his death. Evaluation by a very well-trained child analyst shortly thereafter revealed no signs of illness. However, the boy became schizophrenic thirteen years later in the midst of academic success away away from home.

Mary Bergen (1958) describes the treatment of a four-year-old girl whose mother had been murdered by her father. The child was in an adjoining room at the time of the murder, and heard her mother screaming. She then saw her mother running away from her father, partly covered with blood, telling the little girl to get away. As in the case mentioned above, the father attempted suicide immediately, but in this case did not succeed.

Prior to this complicated profound trauma, the little girl had already been noticed to have "the pinched face of an old woman", was "quarrelsome, impulsive," plotting and scheming to be in charge of other children and grown-ups. She had expressed her dread over her father's murderous intentions just the day before, and had warned her mother that the father would kill her. Bergen believes this realistic assessment of her father's behavior reduced "the element of surprise" and thus protected her from a significant factor in the "development of a traumatic neurosis". Among the child's pre-existing problems were bedwetting until age four, and a rather dangerous, possibly counter-phobic behavior of jumping from high places. Previous stresses and strains to which she had been subjected included being "strapped in her pram" a great deal until age 18 months. She slept in her parents' bed until age four, a time at which she was given her own bed and simultaneously ceased her enuresis. (It might be worth while to compare this child's history and course with that of Selma Fraiberg's case of a 2½ year old girl who suffered severely from primal

scene trauma). Following the murder of her mother, Ellen began using a pre-existing channel of tension discharge, to a greater extent. She began "to take refuge in motility". There was no effort on her part to overtly deny the realistic facts. She organized other children in playing the "murder game". This game, which lasted only a few days, was one which she directed, thus keeping herself at a distance from a process which she controlled and which contained no falsifications. Also, in an active direction, Ellen frequently mentioned to strangers that her mother was murdered by her father, but as in the play activity kept some distance by avoiding discussion of the murder with anyone to whom she was emotionally close. In the hearing of adults, she told other children that they should not benaughty, and indicated that her own mischief had caused the parents to fight. After a few months Ellen began washing her hands in a ritual involving a wringing motion together with staring at them and moaning "Me 'ands, look at me 'ands". She had considerable separation anxiety and began dangerously darting into traffic.

Analysis began nine months after the murder and continued for eighteen months. It disclosed that a particular aspect of the murder took on special significance. The mother's order to the little girl that she get away was considered a symbol of "all the exclusions from intimacy with the parents, from the loss of the mother who turned to the new baby to being shut out of the parents' sexual relations and their actual experiences of violence and death". Bergen believes the child's oedipal conflict was at its height when the mother's death occurred and therefore her guilt about that death was extreme. The author states that Ellen was "not old enough when treatment began to have a truly internalized conflict" and that the analysis therefore prevented a serious neurosis from developing. It seems to the reviewer that the handwashing ritual was suggestive of internalized conflict, but that in any case the analysis was most timely and had a preventive function of real importance. Bergen notes that Ellen relived her traumatic experience intensely, and this was possible for the child because her reality sense was so good that she did not feel threatened with regression of this function when reliving. The analyst was able to help Ellen face feelings of helpless loneliness for her mother and father (the latter being hospitalized). As in Meiss's case of a fatherless boy a special feature of the analysis was the child's readiness to form an analyzable transference, probably because of the absence of parents in her real life. Ellen also was apparently able to relinquish fantasies that her mother was really still protecting and watching her from heaven, a wishful bit of denial of death's actuality, which often proves damaging when the split persists.

As in other papers reviewed, Bergen reports on the fusion of pre-traumatic problems with the traumatic episode. For example, this child had noticed signs of menstruation in the past and these memories were mingled with those of her mother's deadly injuries. It was possible for the analyst to explain to the child how two burdens were present in her mind although most children "had only one". Ellen was also relieved by dealing with her pre-traumatic wishes to get rid of her mother and have her father for herself, understanding how the murder had seemed to make her wishes come true. This element of burdensome wish fulfillment is a regular part of the traumatic events reviewed.

Maternal Death during Childbirth

Among other special forms of parental deprivation, only one more will be considered, and that most incompletely. It is death of a girl's mother during the girl's own birth -- a circumstance which has not yet been made the subject of organized inquiry. Although fateful consequences might regularly come from a little girl's association of feminine and maternal function with death, no literature could be found on this particular trauma except the too little appreciated contribution of Marie Bonaparte (1939). Unnoticed in literature on bereavement, Bonaparte's autobiographical "Five Copy Books" describe with great documetnation the profound dreads of female sexuality she suffered as an apparent consequence of her own mother's death at her own birth.

It is of interest in her theorizing, Marie Bonaparte believed "the little girl seems to have an organic intuition that sexuality is a menace to her, the vital interior of her body". "...Even in the absence of (frightening) experience, a kind of instinct of self-preservation seems to pre-exist in the female mammal, an instinct which causes her first reaction to be flight from the male pursuit." (Volume 2, page 235.) In my opinion the theory is dictated less by observation of female mammals than by the author's early life experience of her mother's death shortly after childbirth, a fact frequently told to her and coloring her early attitudes toward sexual activities. She speaks also of a "biological" fear, namely, the vital fear of penetration of the interior of the living substance. "Women envy the penis, because it alone permits the longed for return to the mother's body and because it alone permits a centrifugal sex act. Thus it appears as the counter-offensive weapon best adapted to avert the centripetal threat to the interior of the body."

Bonaparte describes hallucinations of "dyed" creatures she had at age nine, of which she made a note on the day that they actually occurred: "I was writing in my diary and I saw horrible faces, some square and some pointed, and bodies without heads. In short, all the most horrible things that one could imagine coming into the room..." "On another occasion in the same month, in waking up I was on my left side and in turning to the right I saw on the prie-dieu the Chateinier (an imaginary dyed animal); I immediately hid under the blanket with 'closed eyes' and that is how I avoided it." In discussing these hallucinations of age nine, Bonaparte reports that she also had a previous episode of hallucinations at age 4 (Vol., 2, p 42). At that age she awoke one morning and spat blood. She then saw a multi-colored stork perched on her abdomen. Although the author does not comment on it, it seems clear that her vision of a stork at the time of spitting blood must have been over-determined by her own mother having died of tuberculosis in connection with her own birth. The stork representing the birth and the spitting of blood reminding her of her own mother's hemoptysis. The hallucination at age nine of an imaginary animal, the dyed Chateinier, has to be understood, amongst all its implications, as including the idea of a cat that has been killed (dyed). The already multi-lingual nine-year-old may have been making a pun unconsciously on the double-meaning word in relation to death.

Rather than delve further in this rich document, the reviewer will rest with Bonaparte's own words, written after her analysis by Freud: "The real fact of my mother's death and my father's survival made a strange impression on me which still survives in my unconscious: namely, that all women are more or less dead, or at least candidates for death, while men, the bearers of the phallus, are immortal. Sometimes in certain hypnagogic states, I find myself astonished that there are innumerable women on the face of the earth, and not men only." (Vol. 1, p. 212)

REFERENCES

Abraham, K. (1913) Mental After-Effects Produced in a Nine-Year-Old Child by the Observation of Sexual Intercourse between the Parents
Selected Papers. London, Hogarth Press

Beck, A. T. et al. (1963) Childhood Bereavement and Adult Depression
ARCH. GEN. PSYCHIAT. 9:295-302 (Pt. 3)

Bender, L. (1954) Children's Reaction to Death of a Parent
A Dynamic Psychopathology of Childhood, Springfield, Thomas, pp. 172-195.

Bergen, M. F. (1958) Effect of Severe Trauma on a Foud-Year-Old Child
PSA. STUDY CHILD 13:407-429

Bergmann, T. (1945) Observations of Children's Reactions to Motor Restraint
NERV. CHILD 4

Blom, G and Waldfogel, S. (1952) Emotional Implications of Tonsillectomy and Adenoidectomy on Children
PSA. STUDY CHILD 7:126-169

Bonaparte, M. (1939) Five Copy Books
London, Imago, 1950-1954

Deutsch, H. (1937) Absence of Grief
PSA. Q. 6:12-22

Eisendorfer, A. (1943) The Clinical Significance of the Single Parent Relationship in Women
PSA. Q. 12

Fenichel, O. (1931) Specific Forms of the Oedipal Complex
Collected Papers I, New York, Norton, 1954

Ferenczi, S. (1914) The Nosology of Male Homosexuality
Sex in Psychoanalysis, New York, Basic Books, 1950

Fraiberg, S. (1952) A Critical Neurosis in a Two-and-a-Half-Year-Old Girl
PSA. STUDY CHILD 7:245-246

Freud, A. and Burlingham, D. T. (1943) War and Children
New York, IUP

Freud, A. (1944) Infants without Families
New York, IUP

Freud, A. (1960) Discussion of Dr. John Bowlby's Paper
PSA. STUCY CHILD 16:53-62

Freud, A. (1952) The Role of Bodily Illness in the Mental Life of Children
PSA. STUDY CHILD 7:69-82

Freud, S. (1910) Leonardo da Vinci and a Memory of His Childhood
STANDARD EDITION 11:59-137

Furman, R. (1964)
PSA. STUDY CHILD

Hartmann, H. (1958) Comments on the Scientific Aspect of Psychoanalysis
PSA. STUDY CHILD 13:127-146

Jessner, L. and Kaplan, S. (1949) Emotional Reactions to Tonsillectomy and Adenoidectomy: Preliminary Survey
Problems of Infancy and Childhood, New York, Josiah Macy, Jr., Foundation, pp. 97-118

Kris, E. (1956) Recovery of Childhood Memories in Psychoanalysis
PSA. STUCY CHILD 11:54-88

Kris, M. (1964) Personal Communication

Levy, D. (1945) Psychic Trauma of Operations in Children
AM. J. DIS. CHILDR N 49

Lussier, A. (1960) Analysis of a Boy with a Congenital Deformity
PSA. STUDY CHILD 15:430-53

Meiss, M. L. (1952) The Oedipal Problem of a Fatherless Boy
PSA. STUDY CHILD 7:216-229

Neubauer, P. (1960) The One-Parent Child and His Oedipal Development
PSA. STUDY CHILD 15:286-309

Panel (1959) On Psychological Consequences of Physical Disease
J. AM. PSA. ASSOC. 3:155-162

Pearson, G. H. J. (1941) Effect of Operative Procedures on the Emotional Life of the Child.
AM. J. DIS. CHILDREN 62:716

Plank, E. (1961) Leg Amputation in a Four-Year-Old
PSA. STUDY CHILD 16:405-422

Provence, S. and Lipton, R. (1962) Infants in Institutions
New York, IUP

Reich, A. (1954) Early Identifications as Archaic Elements in the Superego
J. AM. PSA. ASSOC. 2

Ribble, M. (1938) Clinical Studies of Instinctive Reactions in Newborn Babies
AM. J. PSYCHIAT. 95

Robertson, J. (1956) A Mother's Observation on the Tonsillectomy of Her Four-Year-Old Daughter: with Comments by Anna Freud.
PSA. STUDY CHILD 11:410-436

Rosen, V. (1955) Reconstruction of a Traumatic Childhood Event in a Case of Derealization
J. AM. PSA. ASSOC. 3:211

Shambaugh, B. (1961) A Study of Loss Reactions in a Seven-Year-Old
PSA. STUDY CHILD 16:510-522

Spitz, R. (1951) Psychoanalytic Diseases in Infancy: An Attempt at Their Etiologic Classification
PSA. STUDY CHILD 6:255-275

Waelder, R. J. (1946) Analysis of a Case of Night Terror
PSA. STUDY CHILD 2

Wilder, J. (1959) Personal Communication