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Case Study

Bodily Distress, and Inter-Generational Transmission of Trauma - A Case Study

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Abstract

This paper explores inter-generational transmission of trauma presented in a patient with bodily distress that she could not symbolise. The bodily distress was sustained by a quality of imitation and served a lack of a feminine identification. Psychic symbolization posed a threat to psychic survival. Bodily distress is conceptualised as a compromise solution, where early developmental trauma and transmitted attachment were contained, as well as expressed through physical symptoms. The paper explores how the patient psychologically secured an unspoken femininity whilst preserving the fantasy of masculinity, a psychological conflict that negatively impacted on her physical health. Transference was complex, oscillating between different figures in the patient's life - ghosts of the past, and creating an overwhelming sense of anxiety in the therapist. The patient who was hostage and carrier of inter-generational transmission of attachment/trauma had been helped to gradually break free of 'ghosts from the past' by owning her femininity through a process of working through her trauma. She developed a reflective function and through internalising a responsive, empathic therapist, the ability to mentalise and symbolise, therefore making sense of her trauma.

Keywords: *Inter-Generational Transmission of Attachment/Trauma; Bodily Distress; Femininity; Masculinity*

Introduction

All emotions are felt physiologically. When we are anxious, sad, excited the physical arousal from our emotions is experienced physically and can be witnessed through facial expressions or other physical behaviours. Even in the presence of organic illness there is a psychological component facilitating it. The study of physical illness with no evident organic causes, has been studied since Sigmund Freud and various conceptualisations attempted to explain psychological factors causing or maintaining physical illness.

Hysteria is an old-fashioned term, replaced in contemporary literature with 'somatization', 'psycho-somatic distress', 'medically unexplained symptoms' (MUS) and 'bodily distress (BD). As clinicians working with patients presenting with BD we sometimes come across a type of matrilineal and patrilineal colonization containing inter-generational transmission of trauma and attachment [1], contained through bodily distress. This can include unreflective functioning in early caregivers and lack of responsiveness to their infant's needs, as well as unmodulated affects [2]. Transmitted trauma from mothers to infants can include shame, (as this case study will highlight), insensitive responsiveness to the infant and abuse in mothers (physical, sexual etc).

The literature on trauma and the transmission of attachment from one generation to the next is associated with a mother's own trauma: 'A mother's unresolved trauma may interfere with her ability to sensitively respond to her infant, thus affecting the development of attachment in her own child, and potentially contributing to the intergenerational transmission of trauma [1]. Research studies [3-5] found that unresolved trauma or loss in mothers compromise their ability to be effectively responsive to their infant's needs, increasing the development of an insecure attachment. A study by Grienenberger., *et al.* [6], found that the level of disruption in mother - infant affective communication was inversely related to the level of maternal reflective functioning. 'A crucial mechanism in the intergenerational

transmission of attachment, a parent's capacity to comprehend the developing mind of the child, gives the child a sense of his own mind [2] (In Grienenberger., *et al.* [6], p. 299). Where this is lacking, a child is adversely affected by having difficulties reflecting and mentalising.

Family secrets associated with shaming and rejecting the feminine, ripe in some cultures, are important factors in the internal working model of the patient in this case study. Unlike the void felt by patients with a narcissistic, depressive or borderline personality, patients with inter-generational transmission of attachment carry emotional and psychological weight uncontained and unmodulated in early life and passed on through their caregivers. They become the carriers and containers of family anxieties, negative attitudes of the feminine and insensitive parenting associated with trauma. In an attempt to take control of inter-generational transmission, patients unconsciously embark on a quest to communicate their psychological distress, in ways available to them, such as through bodily symptoms. For example, the therapist could be used as the container of the patient who is a container of family trauma, using her/his body as both the vehicle and the container.

According to Grienberger, Kelly, and Slade [6], 'Unresolved trauma and loss in mothers may result in multiple and incoherent internal working models of attachment that are often characterized by unintegrated fear, anxiety, or hostility. Frightened and frightening maternal behaviour emerges as the intensity of the attachment relationship stimulates the emergence of dissociated affect left over from the parent's own early attachment relationships' (p. 300). Maternal hostility can contain rejection of the infant's gender and a lack of positive mirroring due to the mother's own rejection of herself, which can be associated with a negative impact on the infant's sense of gender identity and can lead to depression [7]. Dissociated affect often finds expression through bodily distress as was the case with the patient in this case study.

In therapy, the therapist's affective or bodily response to patients presenting with inter-generational transmission of attachment expressed in BD, is an important tool in understanding and helping patients symbolise their distress. As therapists, it is difficult, if not impossible to appreciate and access the complex psychic world of our patients without reference to how we emotionally react to them. Without delving into the task of clarifying ambiguities in the use of countertransference, which is not the aim of this paper, I will employ Kernberg's [8] concept of totalistic countertransference to refer to therapists' emotional reactions to inter-generational transmission of attachment. I consider therapist reactions and interactions with patients a means of achieving fuller appreciation of the specific use a patient makes of the therapist in these cases.

The paper will examine, through the use of clinical material, the manifestation of BD and the specific nature of the therapist's affective responses, in a patient who presented with inter-generational transmission of attachment located through the patient's use of her body.

The Literature

Conceptualisations on the mind-body question that explain bodily symptoms as a psychogenic manifestation, fall into two separate strands. There were those [9] who were drawn to psychosomatics with an emphasis on the role of the body in hysteria, and those [10] who were interested in the structure of hysterical fantasies. Monique David-Menard sought to redefine Freud's postulations of hysteria with the formulation that the language of the hysterical body could be understood in its relation between the erogenous body and linguistic structures. In her review of Freud's famous case histories, she observed an inherent contradiction, 'that the hysteric has no body, owing to a lack, in her history of symbolisation of her body. Yet at the same time, he (or she) has too much body' (David-Menard [10], p. 103). In a similar vein, Welldon [11] suggested that in the hysteric the thought is in the body. These formulations describe the missing link between symptom and idea, more recently captured in the concept of mentalization [2].

McDougall [12] argued that repressed psychic representations of the body, associated with hysteria are accessible to conscious experience through analytic work. This is a good point to present conceptual differentiations made between hysterical and psychosomatic manifestations. Among the earlier analysts who sought to explain hysteria was Felix Deutch [9]. In quoting Freud's concept that 'the majority of hysterical symptoms, when they have attained their full pitch of development, represent an imagined situation of sexual life' (p. 39), Deutch suggests that the basis of hysteria lies in the imagined longings with associated prohibitive thoughts, i.e. the incest taboo. McDougall [13] makes the incest taboo explicit: 'hysterical symptoms refer to dysfunction when a body part or a sense organ takes on an unconscious symbolic meaning… and results from unconscious anxieties about forbidden libidinal longings' (p. 16). The sufferer there-

fore relates to an imaginary body. In contrast, psychosomatic manifestations concern the real body that often over-functions excessively. Bell [14] cited Wisdom's [15] formulation that '… in hysteria the subject embodies a bad element while in a psychosomatic disorder he reacts to a bad object' (p. 173). The bad element can be a 'strangulated affect' or 'repressed trauma' [16]. Others [17,18], ascribe the bad element to transgenerational haunting. Scott exemplified this point by quoting Rashkin: Should the child have parents 'with secrets'… he will receive from them a gap in the unconscious, an unknown, unrecognised knowledge… The buried speech of the parent becomes a dead gap, without a burial place, in the child. This unknown phantom comes back from the unconscious to haunt and leads to phobias, madness and obsessions. Its effect can persist through several generations and determine the fate of an entire family line (Scott [18], p. 402).

The idea of the unknown phantom(s) contains the derivatives of raw psychic experience, that is, transmitted experience that has not been gathered together, organised and metabolised and is in some people contained in the body without mental reorganisation to help the person mentalise. Such disorganisation of feelings and thoughts consists of phantoms from the patient's past that colonise the internal psychic space and manifest in bodily distress. In the words of Fraiberg., *et al.* [19], 'In every nursery there are ghosts. They are the visitors from the unremembered past of the parents (p. 387).

In the last twenty years literature uses the terms medically unexplained symptoms (MUS) and somatisation to refer to a physical illness with no organic medical cause [20-24]. There is a recognition that MUS has a psychological component, but conceptualisations shift away from notions of libidinal and forbidden longings expressed through the body. Payne and Brooks [25] recognised the psychological aspects of MUS and developed a therapy approach for the condition, they claim to be effective, as it focuses on body awareness.

Davis [26] described medically unexplained symptoms (MUS) as 'signs of physical distress or malfunction that cannot be accounted for by any physical disorder a patient is known to have' (p. 11). Boone [27] claimed that MUS is created by psychosocial distress that is not acknowledged by the patient. Somatisation is also a label used to describe such symptoms [28]. MUS is a condition that weighs heavily on National Health Service (NHS) resources (estimated £8.5 billion per year, Davis [26], p. 12) and one that psychological therapists find difficult to work with. The belief, held by some MUS patients that symptoms are purely physical, perpetuates this difficulty. Although much has been published in the field [29,30] on the aetiology and manifestation of MUS, 'somatization remains a complex concept' (De Gucht and Fischler [31], p. 1). Although conceptual frameworks have been developed on MUS [32] little is known about the types of psychological interventions and therapeutic activities that therapists use with MUS patients in primary care. A recent comprehensive review of interventions with MUS argues that 'although MUS are common in primary care, most studies up to 2000 were not carried out in primary care' (Sumathipala [33], p. 897). Carson, Ringbauer, Stone., *et al.* [34] stated that 'One third of new referrals to general neurology clinics have symptoms that are poorly explained by identifiable organic disease. These patients were disabled and distressed. They deserve more attention' (p. 207).

Bakal., *et al.* object to the use of MUS thus: 'We prefer the term BD [body distress] as it directs attention to psychobiologic processes that underlie the symptoms and that need to be recognised and self-managed by the patient. The term BD mirrors patients' symptom experiences and avoids the psychocentric 'all in the head' implication often associated with MUS (Bakal., *et al.* [21], p.1).

The term BD encapsulates any type of psychological distress expressed through the body. The term will be used in this paper in relation to inter-generational transmission of attachment/trauma. According to Iyengar., *et al.* [1] who discussed the dynamics in this term, 'A mother's unresolved trauma may interfere with her ability to sensitively respond to her infant, thus affecting the development of attachment in her own child, and potentially contributing to the intergenerational transmission of trauma' (p. 966).

Case Study

Therapist approach

My therapeutic approach is inter-subjective and relational, using transference interpretations to increase patient awareness and showing empathic understanding and an integrative attitude of interpersonal engagement, attentive listening and flexibility in the use of technique. Body to body unconscious communication is also a valuable tool in understanding bodily distress, which helps me use my bodily felt sense to access the patient's bodily pain. I involve patients in devising psychological formulations, which is about them, an approach that activates agency and helps in collaboratively identifying the salient points in the patient's presenting issues. I treat formulations as

fluid and with therapy progressing and therapeutic understanding deepening. I re-formulate, inviting the patient to think about and respond to tentative understandings I offer. I utilise research outcomes to help me identify treatment aims known to work well with certain issues [35] so that my formulations are contextualised. My experience in working with patients presenting with bodily distress has shown that if the patient is not believed when they say they feel physical pain, it can negatively impact on the therapeutic alliance. I therefore communicate to patients that I believe them when they say they are in physical pain and distress. For example, saying to the patient 'the pain is all in your head' is not helpful because they feel the pain physically.

Ethics

I use the pseudonym Adriana to refer to the patient, a 34 year old married woman who had been referred by her G.P. for therapy following medical investigations for an array of physical symptoms, depression and anxiety. The patient consented to the use of material from therapy for publication once treatment was completed on condition that biographical details would be disguised for confidentiality purposes. The treatment had been delivered in the NHS and it was for a year.

Presenting problems and initial psychological formulation

Adriana complained of paralysis of the left upper limb, reported numbness and pain in her left breast and also suffered from irritable bowel syndrome (IBS), some sporadic panic attacks, anxiety and depression. She experienced low mood affecting her ability to function as before at work, in everyday tasks and in socialising. She spent several hours in bed due to severe pain in her left upper limb and left breast that drained her energy. Her motivation to see people greatly reduced as a result. For the first time in her life she felt bloated after meals and often suffered from diarrhoea that caused embarrassment when she joined others for a meal. These symptoms appeared soon after the death of her mother and intensified with a termination of pregnancy.

Adriana met the criteria for bodily distress [21] and inter-generational transmission of attachment/trauma [1,6]. Her bodily symptoms made it difficult for her to function in all aspects of life.

Therapy with the patient

The case material presented here is selective and only used to highlight some ideas that emerged from my work with this patient. However, I hope to be able to show the complex manifestation of inter-generational transmission and how it found expression in bodily distress, through the use of exploration and some reference to the transference/ countertransference relationship. I use these terms in a relational way, as I am of the view that conceptualisations of direct transference, and countertransference, in a reductive sense are limiting. Experiences with early attachment figures influence the patient's psychological template and relational style with others, but do not determine it. My understanding of these processes is that the therapy interaction becomes a vehicle of understanding and reconstruction and the therapist's subjectivity plays a part in the nature of their response, in the same way the patient's later life mediates their early experience and shapes it in ways that are presented in therapy. Therefore, the model I apply is not reductive and intrapsychic, characteristic of cause and effect but relational and collaborative.

Adriana was the first born and her mother was not able to have any more children and produce a son and heir, as Adriana's father had expected. Therapeutic work with her, highlighted a lack of a feminine/bodily awareness and confusion on the meaning and manifestation of being a woman. She related to her body as simply being there, in-itself and devoid of any affect. At least she was unaware that she had feelings.

Inter-generational transmission of attachment

As discussed in the literature review unresolved trauma in main carers interferes with their ability to be sensitively responsive to their infant. This affects the development of attachment in their child contributing to the intergenerational transmission of trauma.

During the course of therapeutic dialogue we tried to unravel Adriana's internal working model consisting of early attachments and identifications with important figures in her life, including the legacies of distant ancestors. It gradually transpired that a hidden femininity she linked to danger, fragility and disgust was in conflict with a masculine identification she associated with power, value and safety.

Adriana's sense of gender identity was intertwined with a paternal and grand-paternal investment for her to exist in their own image, that of the powerful, intellectually adept and strong male. Both father and grandfather, like a lot of other men in their culture, devalued women. Their narcissistic investment for Adriana to grow up in their own image was perhaps a compromise solution for their devaluation of women and their misogynistic attitudes. If Adriana embodied male characteristics and behaviours, father and grandfather could love her. In Adriana's early history, the apparent paternal investment stood unchallenged of any early, secure maternal attachment [36]. With a suicidal mother who seemed to have internalised a devalued femininity herself due to cultural values, who also suffered from mental illness that led to several hospitalisations, Adriana was left alone with father for extended periods. Not only did she feel abandoned and rejected by her mother in her early years, she also harboured hostility and disapproval for her mother's weakness and vulnerability. It seemed that an early inter-generational transmission of mother's trauma through early attachment with her was at play.

Adriana dressed in neutral colours, wore trousers, no make-up and had short cropped hair. Her confident demeanour, assertive voice and the way she carried herself communicated an air of assurance. In her appearance the feminine aspect seemed to be a powerful adhesive, an imitation that had not been firmly embraced in Adriana's subjective sense of self. The impact of her early attachments both with her father, grandfather and mother on Adriana was significant. In order to be loved and accepted by the powerful figures in the family who were available to her she denied her feminine identity. The question, 'what is a woman?' was central in Adriana's mind and it became apparent that she had come for therapy to address her confusion. Throughout our work, she made references to her fear of the feminine, whilst acknowledging that her feelings were essentially flawed. What was most painful and difficult to accept was her gradual recognition that her father rejected her femininity and that she herself could not see anything positive in her mother. Her efforts not to replicate the hated mother-figure led to her also rejecting her own femininity. There seemed to be a problem in Adriana's early mirroring experience. Her mother was raised in a culture that actively devaluated women and her mother's own parents wanted a boy. Hence, Adriana's mother mirrored hostile rejection of her little girl's femininity, who grew up confused and frightened and rejecting of her own sense of being a woman.

Adriana had been colonised by paternal, grand-paternal and maternal transmissions she had been carrying in order to receive acceptance and recognition by males in her family line and to avoid becoming like her vulnerable, rejecting and rejected mother. Her feminine identity remained elusive and consciously inaccessible to her.

Bodily distress

The paralysis and other bodily symptoms were Adriana's constant companions since the death of her mother and the termination of her pregnancy. Her body felt foreign to her and she was determined, as she put it, to understand herself and deal with her symptoms. She was hopeful that therapy might help her manage her depression, even though she had doubts whether anything could be done regarding her physical symptoms. She felt led down by medical doctors, who seemed to suggest that her symptoms were linked to psychological stress.

Adriana described that she had always been the architect of her own life, but since the two losses she felt besieged by fears. She spoke of the devastating loss of her baby, who was to replace her father as she put it. Her decision to terminate had been made mostly as a result of pressure from her husband that it was not the right time for them to become parents. She never challenged her husband's attitude; on the contrary she complied, giving the impression that she was on the same page as him. I wondered how, had she gone ahead with her pregnancy might she have compromised her ideal masculine self, giving rise to anxiety that like mother, she might become mentally ill.

In the course of therapy, whenever early memories produced feelings of shame and fear that threatened psychic survival, Adriana returned the following week reporting violent outbursts of physical pain and IBS. Remembering overwhelmed her, compromising her sense of control of her life. A premature softening of her survival defences very early in our work produced flooding affects with a traumatic quality to them. The patient remarked that remembering opened up a wound that threatened to engulf her. The intensity with which Adriana expressed her emotional pain suggested a difficulty in containing and processing emotions, especially if these were associated with inter-generational trauma. Transference with Adriana oscillated between maternal, paternal and idealised. Invariably, the flooded affect appeared in maternal transference, as an anxiety of burdening me. For example, she would often ask how I managed to unburden

myself of the distress my patients caused me. I interpreted the transference as associated with her fear that like her mother, I would not be strong enough to be there for her, a feeling I felt was linked to her mother's absence, mental illness and rejection of her little girl's needs to be carefree.

In one session she remarked on a dress I was wearing as 'lovely' and added that she never perceived herself as a 'normal woman'. It was obvious to me that she had placed me in the camp of normal women whom she idealised, (idealised transference), an attempt for reparation through a second chance at a more positive maternal, mirroring experience. Her own view of herself on the other hand consisted of ideas of maleness associated with worth and value, but which nonetheless, she felt to be a façade, covering aspects of herself she disliked or feared. In her attempts to deal with her distress, Adriana turned attention away from her feelings and took refuge in intellectualising, assuming I enjoyed and admired her articulate and active mind (paternal transference). The intellectualising defence often appeared whenever Adriana felt threatened or was in touch with emotional distress that her physical pain intensified.

Adriana attended her sessions religiously and on time. She held her head high and walked steps of confidence, despite her psychological distress. She was well composed and her speech was assured and assertive. Her intellectual precision and clarity camouflaged a confusion of identity and revealed not a hint of physical pain. Her words were charged with intellectual rigour and intensity. There were no pauses, just words leaping out to the extent that I felt unable to speak myself. I was witnessing a drama tinged with theatricality and at the same time I was aware that neither Adriana, nor I could access her psychological distress directly. It was presented as a narrative conjuring up colourful images, but no feelings. I wondered whether by dissociating from her feelings, Adriana maintained an identity imposed on her through inter-generational transmission, and by implication avoided experiencing any negative feelings towards her family, particularly her father and grandfather for rejecting her as a woman. Countertransferentially I felt engaged with Adriana's narrative, but disconnected, wondering where her pain had gone to.

Transference and countertransference

Transference is defined as the repetition of past experiences played out in interpersonal relationships, including with the therapist. Countertransference is the therapist's response to the patient's transference [37]. As mentioned earlier my approach is inter-subjective and relational, 'characterized by the focus on the inner and outer reality of the patient's self and object representations and the aim to increase the patient's capacity to differentiate between reality and fantasy by enhancing self-reflection (In Buchheim., *et al.* [38], p. 681).

Adriana's transference was from the outset idealised, turning me into what she perceived to be her own ideal image as a woman. She often commented on my career, whether satisfying or not, my lipstick and how much she liked it, commenting that she felt unable to wear it herself and a general fascination with me as a woman, whether I had children of my own and if so how I managed to balance career and family. It seemed that these were questions rooted in a fascination with femininity that she had been secretly harbouring. Her curiosity to intimately know me, perhaps contained the secret question of what it is to be a woman, but fundamentally she needed a mirroring experience that reflected a positive image of a woman, contrary to what she had perceived her own mother to be. Most importantly she needed me to value her as such.

I used my own countertransference responses to understand Adriana's lack of mentalised affectivity [2], a sense of opening up and getting in touch with her emotional wound. My interpretive interventions were aimed at enhancing her awareness into her conflicted internal working model, associated with family relationships, identity confusion and how these maintained her bodily distress. At times my interventions were supportive aimed at strengthening her abilities that were temporarily inaccessible to her owing to chronic and debilitating physical pain. I hoped that this approach could eventually help Adriana fear her wound less and trust herself to stay with it to allow a working through process to unfold.

Early trauma and its manifestation in bodily distress

In times of self-reflection I wondered where the secret wound that Adriana struggled against resided. In a moment of implicit knowing [39] during a session in the middle phase of our work, I had a felt sense [40] of connection with her. The elusive sense I previously experienced had dissipated and replaced with a sense of Adriana being embodied; tears streamed down her face, she looked sad and turned

her gaze away from me, even though she was allowing me to feel her wound. She remembered her mother being away, as her absence was associated with the pleasure of spending quality time with her father, who resided endless stories of heroes to her; she prayed her mother would not return. This feeling of wishing her mother dead was littered with unbearable guilt. I was aware that she took a risk in sharing this with me, a moment of trust and openness that led to more guilty revelations.

From as early as Adriana could remember, her cultural education had begun. Father and daughter stole times when her mother was hospitalised to immerse themselves into the pursuit of cultivating a heroic quality in her, an experiment that lasted a lifetime and saved her from feelings of anger in being abandoned by her mother. This had been reproduced in therapy, with Adriana telling me fascinating stories about herself that were devoid of feeling. My holiday breaks too were met with rational justifications that she had plenty to catch up with, the meaning of which lay in her having respite from what had been for her psychologically overwhelming. As therapy progressed I noticed an oscillation in the transference. Sometimes Adriana related to me as if I were the weak mother, given that she could see the evocation of emotion in me. Other times she presented a narrative so eloquently, that the protagonists leaped out of every word that I became her child-self listening to father's stories.

There had been many occasions when Adriana's mother had been absent that she found solace in sleeping in her father's bed, holding hands. As she grew older she said that the hand-holding became frozen due to tension. I invited her to think about the paralysis of her limb and how it perhaps symbolized the frozen hand-holding experience of her childhood. She certainly resonated with my interpretation and became more engaging and collaborative, but embarrassed. It seemed that her early experience was not only a source of anxiety, but also a source of comfort. The symptom of paralysis of the left arm seemed to mimick 'an element in her (own) past, and thereby offered a route to the past' (Scott [18], p. 403). The death of her mother had been the trigger to debilitating guilt and physical pain linked to being mother's rival. This was heightened by her own pregnancy, as becoming a mother herself was inevitably a major source of anxiety.

In the final phase of our work and in view of the pending separation I listened attentively but consciously steered away from offering interpretations which could leave Adriana isolated after therapy ended, with an open wound that might have overwhelmed her. With the termination of our work approaching, Adriana developed a stammer, she seemed more childlike and her narrative lacked the quality of stories she had been sharing early on in our work. This held the quality of a maternal transference, associated with the anxiety of me abandoning her. She recalled an incident at the age of six where her legs were paralysed, she could not stand on her feet and it was during one of her mother's hospitalisations. With the increased awareness and understanding, Adriana herself made the connection of the increased bodily distress and linked it to the termination of our work. She acknowledged that although she wanted to be unlike her mother, she now felt she was a more robust version of her. Empathising with her own vulnerability gave Adriana permission to forgive her mother's weakness and let go of the fight against her own femininity. By internalising her therapist as a positive alternative attachment figure, she was able to work through a negative image of her internalised mother and slowly began to feel comfortable in her feminine skin.

Conclusion

Therapy takes patients through a process of remembering and reliving the past. Adriana struggled through therapy initially by defending herself against getting in touch with her feelings associated with early trauma. She thought about her childhood traumas, allowed memories to surface and grieved for her mother. She acknowledged her denial of her femininity with immense courage. The inter-generational transmission of early attachments had a colonising and paralysing impact on her. However with time, phantoms of her past lost their power. She was less a carrier of family transmissions, had no further need to embody them and became less burdened by them. Therapy revealed that Adriana's bodily distress had been the locus of unconscious unsayable and unthinkable traumas. By giving bodily distress a voice, Adriana learned to symbolise. As a result her physical pain gradually decreased and she began to embody feminine aspects of herself.

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