Post-Traumatic Stress and Coping in an Inner-City Child

Traumatogenic Witnessing of Interparental Violence and Murder

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Violence today appears to be ubiquitous: it even enters the clinical session, deeply internalized within child victims who were exposed to often unspeakable horror. Violence and its pernicious, horrific effects are observed in the streets, schools, parks, playgrounds, and homes of some inner-city communities. This article introduces the use of Anna Freud's Diagnostic Profile system with an inner-city child who, at the age of four, witnessed his mother fatally stab his father with a kitchen knife and at age eleven was assessed and treated by the author. Clinicians may wonder whether any kind of therapy could ever undo the serious fixations, regressions, developmental arrests, and integrate trauma-shattered ego functions observed in children exposed to virtual horror and effective terror. Application of the Profile may offer some direction with these children: a panoramic view of their painful mood, their hypervigilance and distrust, fears, separation and annihilation anxieties, nightmares (with murder imagery), developmental anomalies and arrest is presented with clarity and force. The therapist uses countertransference responses to monitor the affect tolerance in the child and to determine the appropriate dosages of awareness the child can integrate from one moment to the next. The therapist also serves as the child's external stimulus barrier and explores feelings about media-driven portrayals of violence, stereotypes, and inner-city children and youths. The unsurpassed utility of the Profile as a diagnostic system that documents vital economic, dynamic, structural, genetic and adaptive-coping information about the child is discussed in detail as is the Profile's added benefit of possibly guarding against misdiagnosis and charting a course for psychotherapy in difficult city-violence trauma cases.

BIOPSYCHIC TRAUMA

The question of the pathogenicity of psychological trauma has had an important history in the annals of psychoanalysis and in the etiology of mental disorders (Breuer and Freud, 1893–1895; Freud, Ferenczi, Abraham et al., 1921; S. Freud, 1918, 1919, 1920). Freud found traumatic neurosis to be a most interesting and perplexing area, and early in his career had understood the trauma response as a problem of memory; he wrote that the victim suffered "mainly from reminiscences" (Breuer and Freud, 1893–1895). The precipitous decline in the capacity of contemporary culture to neutralize and regulate the aggressive drive has led many to paint a bleak picture of children's lives in the inner city. Though American inner cities are not officially designated as military theaters of war, the violence and carnage that exist in some inner-city communities today can be equated to the devastation and tragedy of loss and death on the battlefield. These "killing fields" or "combat zones" expose children to painful losses, unspeakable terror, and violence—in the streets, parks, playgrounds, in the school, and in the home. Paradoxically, these potentially traumatic locations are the very places society once viewed as bastions of tradition, safety, and values. Traumatic harm to children's minds and bodies from random violence (Timmick, 1989) and from witnessing parental murder (Malmquist, 1986) is expected to increase (Bell and Jenkins, 1991).

Child victims of intrafamilial and community violence who suffer traumatic ego anomalies in many ways resemble those who suffer the traumatic neurosis of wartime (Parson, 1994a). Over two decades ago, Meers (1970, 1972, 1973a, 1973b) spoke about violence and its contributions to cultural distortion and psychopathology in children of the inner city. He thus noted that "since traumatization is endemic in the ghetto [that is, the inner city communities]. . . . this might produce in the

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child some equivalent of ‘combat fatigue,’ i.e., a further overloading of the ego because of the constancy of dangers” (Meers and Gordon, 1975, p. 586, italics added).

Child victims of trauma represent an area of great interest to clinicians, the criminal justice system, and policymakers (Fish-Murray, Koby, and van der Kolk, 1986; Furman, 1986; Terr, 1984; Green, 1983; Gislon and Call, 1982; Newman, 1979; Pynoo and Ehr, 1986; Thompson and Kennedy, 1987; and Yorke, 1986).

Albert Solnit and Marianne Kris (1967) defined psychological trauma as “phenomena that reflects a reaction of the individual to an inner or outer demand or stimulus that is experienced as overwhelming the mediating functions of the ego to a significant degree” (p. 123). These buffer functions of the ego are literally knocked out of operation after trauma. Like adults suffering from “traumatic neurosis,” children overwhelmed by “violence neurosis” show a particular pattern of traumatic symptomatology. “Biopsychic trauma” (literally, “wound to the body and mind”) refers to the ego psychological state in which there is a rupturing of normal mental protective shielding as a consequence of an overwhelming event that overtaxes the victim’s psychic and biologic capacities. Freud (1920) called this shielding function the “stimulus barrier” or Reisschutz, which is understood to be a biological structure that regulates internal and external stimulation (Parson, in press; van der Kolk, 1987). For Freud (1916–1917) the term traumatische referred to “an experience that within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the usual way, and this must result in permanent disturbances in the manner in which energy operates” (p. 175). Traumatogenetic disturbances alter a wide range of immunologic functions, nervous system (CNS) changes, and endocrine activities that produce restlessness, irritability, sleep disturbance, hypervigilance, and hyperarousal in the child.

The clinical utility of Anna Freud’s Diagnostic Profile (A. Freud, 1962; Nagera, 1963; Thomas, 1966) has been demonstrated for many years in providing conceptual clarity, diagnostic accuracy, and informational guidance to planning psychotherapy for a variety of neurotic developmental manifestations (A. Freud, 1965), borderline, psychotic, and “traumatic psychotic” disorders in children (Thomas, 1966), convulsive disorder (Meers, 1966), and organic dysfunction (Burlingham, 1972). The Profile also has been used in the clinical descriptions of babies (W. E. Freud, 1967, 1971), blind infants (Burlingham, 1972), adolescent disturbances (Laufer, 1965), psychopathic personality dis-
psychoanalysis useful to the largest number of people in need of assistance. While psychoanalysis is a general theory of psychopathology that focuses on etiological and dynamic assessment of the personality irrespective of culture, "the need for research on black [and other ethnic-cultural] norms . . . and psychopathology has been stressed for over three decades" (Meers, 1973b, p. 37; see also Kardiner and Osgood's [1962] psychoanalytic study of the black personality). Despite Freud's position "some contemporary analysts still view the poor and socially traumatized . . . as posing problems that are incompatible with the procedures and requirements of psychoanalysis" (Parson and Gochman, 1994, p. 145). Other writers have made modifications of the Profile's original format in the past (for example, Brinich's [1987] modification for deaf children).

This writer's many years of assessment, psychotherapy, consultation, and supervision of cases of inner-city children in New York City, Baltimore, and other parts of the country indicate that the Profile can be meaningfully applied to this population. Most of these children and adolescents with traumatic ego pathology are "biopsychologically traumatized [and] suffer secondary conditions like sleep disturbance, disturbed attachment behavior, conduct disturbance, hyperactivity, concentration and attending deficits, cognitive and academic dysfunctions (e.g., learning disabilities, pseudobipolarity, pseudoamnesia), self-doubts, phobias, helplessness, depression, and low self-esteem" (Parson, 1994a, p. 240). The Profile can facilitate a panoramic unfolding of a synergistic blending of personality, cultural, and trauma elements that are always present in these children. When the diagnostician does not recognize these elements, diagnostic inexactitude and ineffective treatment planning may result.

1. Sources of Information

Psychiatric Interview Date: current (Dr. P.) and two years ago (Dr. T.)
Psychological Diagnostic Assessment Date: current and six years ago (Dr. W.)
Medical History Date: current (Dr. S.) and two years ago (Mr. O.)
Social and Family History Date: current (Dr. F. and Ms. Q.), and three dates over past eight years (Dr. A.)
Neurological Examination Report Date: current (Dr. E.) and three years ago (Dr. U.)
School History Date: current (Dr. L.), and three years ago (Ms. Y.)
Therapy, Assessment, and Notes from Interviews (of Significant Others): Author's Records

II. Reasons and Circumstances of Referral and Case Presentation

The ubiquitous rise in intrafamily and community violence in the presence of children and the increase in child sexual and physical victimization makes the development of better diagnostic methods imperative. Children affected by overwhelming events are now being referred in large numbers by parents, school guidance counselors, the courts, the churches, and protective child services. Such methods could conceivably increase early detection and diagnostic accuracy, as well as guide effective treatment planning.

The name of the child discussed in this article is Eric Smith. He is an eleven-year-old inner-city boy who witnessed the fatal stabbing of his father by his mother. The writer interviewed the boy in a series of diagnostic-evaluative sessions and consulted with many health-care professionals who had seen the child for psychological, psychiatric, medical, and psychosocial evaluations over some years.

After the traumatic event at age four, of watching his mother fatally stab his father, Eric underwent sudden changes in his mood and general behavior which were baffling to those who knew him, including his foster parents, who had known him from birth. From a relatively positive and contented child (despite his early deprivations) he changed to a jittery and irritable boy who had crying spells and could not easily be consoled when distressed. He was extremely nervous, had trouble sleeping, and suffered frightening nightmares. He developed a generalized negative attitude toward himself, his family, friends, school, and people in general. Eric also regressed in development; for example, he lost bowel and bladder control. Though the child and his siblings had been given some medical and mental-health care immediately after the tragic event, when Eric was seen initially by this writer his traumatopathology seemed imbedded in his personality structure. The chronicity of ego pathology seen in the child may have been averted had he been offered secondary preventive services in the aftermath of the murder.

Eric's foster mother, Mrs. Eva Thomas, encouraged by child protective agency and social services personnel, brought the child to me for assessment and possible treatment. Together with her aged husband, she had been caring for the child since the stabbing. She outlined the following symptoms and complaints: aggressive behavior in the home, school, and larger community; hyperactivity; and inability or unwillingness to accept and benefit from adult guidance. Mrs. Thomas also reported enuresis, encopresis, and poor social and academic functioning. Having known the child and his family before the tragic event, Mrs. Thomas felt she could state with confidence that Eric's traumatic
experience at the age of four was largely responsible for his current problems. This writer both conducted the diagnostic evaluation sessions and treated the child. The treatment approach was psychoanalytically oriented in nature, with two sessions per week.

III. Description of Child
At the time of assessment Eric was eleven years old, a light-complexioned black boy, who appeared jovial, carefree, and behaviorally spontaneous. He smiled “almost” constantly. Though shorter in physical stature than most boys of his age, Eric was sturdy built and physically agile. He liked to play and did so regardless of place or occasion. Thus, in the therapy sessions he would take any inanimate object within his reach, or leave his chair to get one, then speedily transform it into a toy with which he would play in a self-absorbed scenario. He seemed to experience autistic enthrallment with the sounds and sensations he would generate. At such times, he was involved only with himself and the toy—with no one else and no other object. Almost every spontaneous activity was directed toward play. For example, he would pick up a pencil from the desk or table and suddenly it would become a jet bomber or a violent projectile, jetting through space at high velocity. He opened and closed my desk drawers in a rapidly alternating pattern, accompanied by sounds of a truck, train, or jet. According to Eric’s foster mother, he had wet his bed “just about every night” and soiled his pants twice a day since the time of the trauma.

IV. Family Background and Personal History

Mother. She was thirty-seven years old when she gave birth to Eric, her last child. Most of the information about Eric’s relationship with his mother was provided by his foster mother. Mrs. Thomas reported that Eric’s mother wanted him but was emotionally unprepared for a new child. She was emotionally unavailable and behaviorally inconsistent and would abandon the child for hours or days at a time. A confused, disorganized, and self-destructive person, she used alcohol excessively and was violent with members of her family. Thus she was unable to provide the child with the emotional holding and consistent care essential to promote his psychological growth and social development.

Eric’s earliest feeding was by bottle and breast, and both were reportedly harshly and inconsistently provided. His feeding came from many persons. Though the presence of multiple nurturing persons is a characteristic of African-American families, in Eric’s home extended-family transactions were chaotic and confusing to the child.

Eric’s mother killed his father with a kitchen knife. Each of her five children was deeply affected by this event. She was sent to prison for several years for the crime.

Upon discharge, Mrs. Smith got a job and lived in an apartment very close to where Eric lived with his foster parents. This created a very difficult problem for Eric: he was torn between wanting to be with his biological mother and, at the same time, wanting the love and stability his foster parents provided for him. There was some evidence that Eric had begun to get close to his mother emotionally but, after suffering from an unspecified illness, Mrs. Smith died suddenly and unexpectedly. Eric’s symptoms were reportedly exacerbated by his mother’s death, which occurred a few months prior to the assessment and the beginning of his treatment.

Father. He was thirty-eight when Eric was born and was described as a wanderer, a lost person with no sense of direction in his life who had very little to give his son. Like the mother, he drank heavily, and he would disappear for weeks at a time. His whereabouts often unknown to his family. Eric still idealized his father and intensely missed him, as though he had died just a few days or weeks before.

Siblings. Eric’s eldest sister, Toni, was twenty-three. She was described by the Thomases and two professionals who had worked with Eric as lacking in motivation and drive to improve her life and as having a penchant for a good time. At fourteen, she had given birth to a son, whose care was taken over by Eric’s foster parents, then in their late sixties and seventies. Recently she had had a second child. Eric’s second eldest sibling, Natasha, four years before, at age thirteen had begun to refuse to leave the apartment because, she said, she feared “getting into trouble with some man” or having people “accuse her of something bad” were she to be seen “in the streets.” Natasha’s phobic avoidance appeared to be related to pathological fears of either killing a man, as her mother (with whom she was symbiotically merged) had done, or being killed by a man, in retaliation for her mother’s crime. She was later hospitalized on two occasions in state psychiatric institutions.

Norman, Eric’s eldest brother, was in a residential home for boys. Eric idealized this seventeen-year-old brother and displaced upon him feelings he had had for his father. At the age of thirteen Norman had been expelled from school after he severely beat a woman teacher who he claimed had spit on him while she reprimanded him for inappropriate behaviors. He seemed to be the most disturbed of the five children, with a history of severe ego disturbance that included fire setting. He had set the homes of both his mother and his cousin on fire after the
traumatic murder of his father by "a woman," his mother. Like his other siblings, he was impulsive and hyperactive and acted out violently. He made a serious homicidal attempt against his younger brother, Michael.

Michael, fourteen months older than Eric, was on tranquillizers at the time of Eric's referral and appeared to be more disturbed than Eric. Both children had been considered for placement in psychiatric residential treatment settings. Michael and "Tookie," the older of Toni's children, lived with Eric at the Thomases.

*Friends.* Eric reported that he wanted friends "to play with me," but he didn't have friends. In a diagnosticotherapy interview, Eric verbalized his loneliness in a series of hypothetical scenarios. For example, he asked the therapist, "How would you like it if no one wanted to play with you?" To this the writer replied, "I would feel very hurt, upset, and maybe even angry about the whole thing. How would you feel, Eric?" He replied, "I don't care if nobody wants to play with me; I won't force them. I like playing by myself, anyhow." Much of his difficulty in making even one friend was due to his hyperaggressive demeanor and to his problems with sharing and the give-and-take of age-appropriate play.

*Personal History.* According to historical and current medical and psychological records, Mrs. Smith reported that her pregnancy with Eric was a planned one, and that he was a wanted baby. She stated that she "didn't believe in abortions." She was reportedly happy during the pregnancy because she was separated from Eric's father at the time.

Eric's foster parents also reported that he had been wetting his bed since the age of four, "just about every night," and the boy also soiled his pants two times every day even up to the current age of 11. Familial and medical reports show no evidence of disturbance prior to the age of four, and his enuresis and encopresis were not found to have underlying organic causes.

V. Possible Significant Environmental Factors

**TRAUMATOCGENIC WITNESSING OF INTERPARENTAL VIOLENCE**

The child who is an eyewitness to murder experiences the event as too shocking to be truly felt and comprehended. The bits of traumatic data are too internally fragmenting and disorganizing to be managed by the child's ego. This single event may produce a loss of a sense of self, while setting up a pathologic response paradigm in all areas of personality functioning.

The witnessing of parental murder and the responses to that event are the cardinal environmental factors in profiling this child. Consistent with Laufer's (1965) recommendations, this section of the Profile deals with "external factors [which] may have had a special impact on the child's . . . life (e.g., . . . events which may have been traumatic, crises in the history of the family)" (p. 103). The current posttraumatic child profile documents the impact of Eric's traumatic witnessing in shaping symptoms and organizing coping capacities.

The significant environmental influences in Eric's life were as follows: (1) maternal and paternal deprivation and abandonment; (2) the stabbing of his father by his mother; (3) the breakup of his family and dispersal of his siblings and his awareness of his siblings' instability and psychiatric illness; (4) ridicule and humiliation from peers at school and in the community due to bowel and bladder dyscontrol; and (5) loss of his mother for a second and final time, following a brief period of positive contact with her.

Even prior to the age of four, Eric lived in a home that was unstable and lacking in predictability. His parents were incapable of nurturing and promoting healthy, adaptive developmental experiences in their children. Eric's mother interacted with him in ways that were deeply hurtful and damaging: she seemed unable to give her son the love he needed and failed to protect him from being overstimulated by exposure to the sounds of sexual activity with her male friends.

His father's murder produced pathological internalizations depicting all men as women's prey: men are always vulnerable and passive; women are always dangerous victimizers.

Eric's school performance was very poor, and he did not have familial models to instill in him the importance and value of learning. Most members of his family were chronic underachievers—low in motivation, angry, and full of feelings of deep deprivation.

VI. Possibly Significant Non-Environmental Factors

In order to correct a deviant orthopedic problem in both legs that his pediatrician had discovered, at age two Eric underwent an elective therapeutic fracture. This experience may have produced an engram predisposing him to certain vulnerabilities, such as castration anxiety. When Eric would speak of the many enuretic episodes he had experienced at home and at school, he gave the impression that he had lost total control of his emotions, his thoughts, and of the very contents of his being. These enuretic loss-of-control experiences left him with an
empty feeling and were in part symbolic of a broken cistern that was incapable of containing water; that is, lacking in capacity to contain what is inside—powerful traumatic affectivity. From the age of four, Eric suffered from nightmares that featured a knife and images of "someone being killed and needing to be saved." The diagnostic-evaluative process revealed that he was troubled several times per month by traumatic dreams involving his "father's ghost" which frightened him and kept him fearful of going back to sleep. Testing also indicated significant learning disabilities associated with neurological deficits.

VII. Possibly Significant Stabilizing Environmental Factors
Despite Eric's early exposure to inter-generational familial disruption, poverty, and pathology, his foster parents did provide him with some "good-enough" (Winnicott, 1975) parenting and opportunities for some viable "transmuting internalizations" (Tolpin, 1971; Kohut, 1977). Eric was very fortunate to have had the Thomases in his life. They were the only stable and reliable people he had ever known. They gave him a home, and they provided him with guidance, discipline, and love. Another significant stabilizing factor was the therapeutic relationship with the author, which provided the child with a sense of safety and the experience of security from intrapsychic and extra-psychic threats to his self-esteem and sense of well-being.

VIII. Assessment of Development
A. Drive Development
1. Libido
   a. Phase Development
   In traumatized children, excessive levels of excitement pour in through the breach in the young ego's stimulus barrier, thus "putting the pleasure principle out of action" (Furman, 1986, p. 193). Psychosexually, Eric was developmentally arrested at the oral phase, though he manifested a veneer of "phallic" dynamics, interests, and behavior. For example, despite his oral dependency, in one posttraumatic play therapy session, Eric spontaneously wrote "p——" on the blackboard. He said, "If you were not married and you took a girl into bed... What is the thing you take a pee out of?" In this instance, he tried hard to avoid the use of street vulgarity; after a year in therapy he had gained knowledge of what was appropriate in the presence of an adult.

b. Libidinal Distribution
   i. Cathexis of Self
      Clinical and scientific studies have revealed that children with traumatic stress demonstrate deficits in taking the perspective of others. For example, Fish-Murray, Koby, and van der Kolk (1986) report that children like Eric use pre-operational cognitive schemas (a basic narcissistic tendency referred to by Piaget [1970] as "egocentrism"). Narcissistic investment in the bodily self was very evident in Eric's behavior. He found pleasure in physical performance: it seemed to increase his sense of competence. Eric focused on his physical self and tended to use his body as a defensive armament against intrusive ideas, emotions, and people and environmental situations of danger. Like many deprived, traumatized children, when it came to investing libidinal nurturance in self Eric appeared to show a kind of libidinal bankruptcy. For example, though he dressed himself very well, basic hygienic practices had to be consistently monitored. Eric's avoidance of body management appears to be rooted in his lack of self-caring skills and in a feeling that he does not deserve to be cared for—either by himself or by others.

   In addition to psychic trauma, Eric had experienced the uneven emotional investments of his parents and a pattern of shifting investments in self- and object-representations. Eric's early lack of mirroring experiences may have resulted in a sense of narcissistic vulnerability. To counter this, he used "grandiose-self" defenses: in one of his spontaneous fantasies during a session, for instance, he visualized himself orbiting in space around the Earth, far above the banalities to which ordinary mortals are subjected.

   ii. Cathexis of Significant Figures
      Eric was very attached to his oldest brother, Norman, who lived in a residential home for disturbed, violent boys. He also had cathexed Natasha, his second oldest sibling, whom he experienced as a surrogate mother, especially after his mother's death. Later, Eric was able to become emotionally attached to his aged foster parents, who provided him with healthy models of caring and control.

   iii. Cathexis of Self-Representations and Object-Representations
Eric's self-representations were inferred from psycho-diagnostic testing results and from therapeutic observation over the span of several months. One aspect of his self-representation was that of a boy playing a guitar with a crippled, broken leg, which shows the fragility of fleeting moments of inner peace, creativity, and freedom for the child. Another aspect of his general self-image was noted on a TAT story, reflecting a depressogenic character of this child's experience—of sadness, object loss, profound oral deprivation, and abject squalor and physical and emotional hunger. He stated, "This boy is sad. He has no food nor nothin'. He lives in a shack-up house. He has to eat dirt and wood for food. He takes a big bucket of mud to drink water. Then he makes mud pies for supper, then he eats them."

For Eric, images of self and others ranged from magical to reality-congruent. His developmental image of others is one of rejection, abandonment, and tremendous threat of annihilating him. Though Eric's restless, jittery physical movements and expressions were in part associated with CNS deregulation aggravated by the trauma, these movements were also determined by unconscious relational reenactments. For Eric, hyperaroused physical movements were unconsciously motivated to serve several functions. First, they warded off "toxic objects"—people whom he feared would overwhelm, harm, or even kill him. Second, they served counterphobic ends to keep potentially retraumatizing "agents of aggression" from overwhelming him by himself becoming a threat to would-be aggressors. Thus, his "violent motor discharge" is undergirded by primitive paranoid and splitting ego defenses. For example, during the fourth diagnostic-evaluative session, he was unable to put into words his anxiety-laden thoughts and fears about being attacked by "people inside the house." Instead, he got up from his seat and in a furious, speedy, agitated manner, he ran across the therapy room, as a projectile. He returned to his seat and said, "Whew! I feel safer now."

There were times Eric was able to cathartic the world of people, but this was usually done in a sporadic, random fashion that spans the entire dynamic gamut from "total objectual avoidance" to "total object addiction." Stability in perception and in relating to others was a later therapeutic achievement for the child. For the most part, people were experienced as needs-satisfiers and as "stimuli buffers" (protecting him against a profound sense of vulnerability, against intrapsychic overstimulation and environmental dangers).

2. Aggression
Eric was an aggressive boy who got into fights frequently, even though he was reprimanded or punished for these behaviors. He was put off the bus several times for starting fights: his fantasy life was characterized by violent and aggressive preoccupations. After several months of treatment with the author on a two-times-per-week basis, Eric reported the following aggressive fantasy: "A man came up to me and my girlfriend and kissed her. I was beating up this man for kissing my girl: I knocked him into the water, beat him in the water, dragged him out, and beat him some more." The fantasy was delivered with excited affect and violent gesticulations and jerky body movements in demonstrating how he discomfited a man—an adult, someone bigger than he. This fantasy illustrates Eric's basic aggressive tendency toward adults who betrayed him and would potentially retraumatize him by separating him from love. These issues formed aspects of complex transference configurations in the therapeutic enterprise.

After the sixth month in therapy, on two occasions after speaking about very painful interactions with adults, Eric raised his voice loudly (as if to block out intrusive ideas, affects, and memories), and suddenly went off on a tangential subject. On both occasions he became increasingly agitated and hyperactive as he got out of his seat and launched himself into the surrounding space like a projectile, his entire body becoming a symbolic representation of "the deadly knife" (the fatal weapon).

During the course of the analytic therapy Eric expressed hostility toward his age-peers from whom he felt estranged and isolated: he didn't understand them; they didn't understand him. He experienced them as threatening (in terms of their ability to inflict upon him self-esteem-destroying humiliation and ridicule). On many occasions during the treatment Eric discussed this and described a number of preemptive counter-
phobic attacks against “the enemies”: he hit them first, while using a hyperaggressive street demeanor replete with expletives.

It often seemed that Eric did not give in to depressive feelings, that little or no aggression was directed toward his self. This appeared to be due to manic motoric defense against depression, which complicated the process of bereavement over the many significant losses in his life. There were times, however, when Eric did show depressive feelings in therapy. For example, at age twelve, one year after beginning therapy, he said, “I don’t want to talk about my feelings; I can’t. They hurt me too much.” On a previous occasion in therapy, Eric had promised the wrier, “I’ll give you only one feeling.” He then lowered his head and spoke of his depression and suicidal ideation, and his deeply felt sense of rejection by members of his family and his peers. After ten months of therapy, he expressed at length his concerns about one of his sister’s criminal activities in an all-girls gang. Psychodiagnostic testing had revealed strong depressogenic feelings associated with suicidal thoughts and wishes as a way of being reunited with his dead parents. Thus, on an Incomplete Sentences item, beginning with the stem, “If I had a gun,” Eric completed the sentence by stating, “I would kill myself!” As he spoke his voice fell, and a somber spirit captured his countenance, and he hung his head in depressed, almost lifeless silence.

The quality of Eric’s aggressive impulses reflects the relative absence of the modulating effect of libidinal self- and object-investments. In this regard, Furman (1986) notes that “the damaging effect of trauma on drive fusion and integration is . . . particularly severe. The clinical manifestations of defusion and impaired integration are especially prominent in the personality functioning of traumatized children” (p. 197).

B. Ego and Superego Development

1. Ego Development
   a. Basic Apparatus
   Eric’s biogenic endowment appeared to be relatively intact, except for some neurological difficulties in visual-motor coordination reported in psychoneurological test reports. Organic and language problems reportedly were associated with lead poisoning from the projects where Eric’s family lived. He suffered from learning disabilities as well. Neurological soft signs were also associated with biopsychic disruption and alterations in the aftermath of psychological trauma (Parson, 1994b; van der Kolk, 1987). As Fish-Murray, Koby, and van der Kolk (1986) pointed out, “The memory of the trauma is registered in the CNS, but not as yet digestible by the existing structures of logic . . . [and] adaptive thinking processes” (p. 101). Eric’s level of intellectual functioning was in the low-average range on the WISC-R, an instrument that measures verbal and nonverbal intelligence. On a test measuring ego functions involved in perceptual organization and planning he performed at the level expected of a younger child.

b. Ego Functions
The causative link between psychic trauma and severe ego regression is well documented (e.g., Furman, 1986; Parson, 1994b; Waxler, 1972). Children with traumatic stress often show significant deficits in the executive functions of the ego (Parson, 1994a). Schaer’s (1991) observation of traumatized inner-city children led him to the conclusion that “the occurrence of the actual (traumatic) event . . . fundamentally skews ego formation, and distorts affective growth while casting a pall over object relations development” (p. 13). Formal assessment with psychological instruments ( Bender-Gestalt Test, House-Tree-Person, the Peabody, the WAIS-R, WAT-R, the Rorschach, TAT, Incomplete Sentences, and a structured clinical interview) was conducted prior to the therapy to assess Eric’s psychological functioning. As noted before, results revealed that the child’s intellectual capacity was in the low-average range of measured intellectual abilities, while specific deficits in Eric’s ego were noted in realistic perception, regulation of affects, impulses, and drives; language and communication; thought organization; control over motor behavior; frustration tolerance; and defensive organization. He showed problems in reading, spelling, handwriting, composition, arithmetic, small motor coordination, and grapho-motor competence.

Eric, like most children of violence, showed the phenomenon of developmentally advanced ego functions juxtaposed with regressed ones. Because the ego is “the central victim in the traumatic event” [A. Freud, 1967, p. 236], its functions may become arrested or regressively enfeeled. As a result of the trauma, Eric’s ego was “knocked out by a flood of excita-
tion" (Yorke, 1986), which was, as Freud put it, "too powerful to be worked off [i.e., mastered] in a normal way" (p. 75).

This "knocking out of the ego" is associated with a traumatic shattering and developmental incapacity of the synthetic-integrative functions of the ego. The deficit in this function was implied in the ego's poor binding of the drives. The traumatic splitting asunder of the drives (libidinal from aggressive) after the inciting violent event exerted a primitizing effect on Eric's integrative ego functions, resulting in ego weakness that made the portent of encountering potentially disintegrative stimuli symbolic of the trauma very problematic. Other ego-psychological consequences of trauma included severe difficulties in keeping track of time (which Terr [1981] called "time skew") and incapacity to shift sets and employ cognitive flexibility. Ego functions associated with symbol-using were also adversely affected in this child (Hoffman-Plotkin and Towne, 1984; Parson, 1994a). Eric also showed problems in the area of conflict-free information processing, as in the ability to contrast, compare, and find causal connections. Thus, ego functions involved in post-traumatic mastery show anomalous vulnerability; but also noteworthy are the child's adaptive ego operations.

From a culture psychoanalytic perspective, Meer's (1970) research studies that explored the dynamics of African American culture led him to conclude that inner-city children showed much less neurotic symptomatology than middle-class white children with the same degree of familial pathology. He found, however, that the inner-city children he studied had more problems than the middle-class children in intellectual ego functions. Borrowing from the works of Fenichel, Mahler, and other psychoanalytic writers on pseudomobility, pseudodependency, and pseudodeficit, Meer theorized that the high incidence of intellectual deficits among African American children may be understood as symptomatic.

c. Ego Reaction to Danger Situations:
Post-Traumatic Defensive Organization
Child victims of trauma have been overwhelmed by threats to their lives or threats in their presence to the lives of others. After the trauma the emotional climate of danger persists internally, and an "enduring vigilance" (Kardiner, 1941) per-
ment through immersion in constant play, daydreaming, and “reorganizing fantasies” in which he reconstructed or remade a more benevolent world for himself and those whom he loved. Thus, his world of loss and pain was often magically transformed from the situation of parental deaths, family dissolution, isolation, and abandonment to a happier time and place. According to his foster mother, Eric was able to accomplish various chores around the house. However, these chores would turn into “reenactment play” motivated by defensive and adaptive fantasies involving feats of extraordinary strength and prowess, courageous exploits, great wealth, and being “super cool.” He often used this capacity adaptively and it has served him well in therapy.

In an ego defense paradox, Eric demonstrated both traumatophobic-avoidance and traumatophilic-reexposure tendencies. Freud (1920) himself was fascinated by the tendency of trauma patients to reexpose themselves to traumatic stimuli. An example of Eric’s “voluntary” reexposure to trauma is his tendency to get into hostile exchanges with older girls. Prior to the beginning of a therapy session during the first six months of treatment, Eric’s foster mother informed the author that the child had told her that an older girl in his neighborhood had threatened him the day before. Eric had run back to the apartment, entered the kitchen, opened the drawer, pulled out a large kitchen knife (the weapon his mother had used to kill his father), clenched it tightly in his left hand with a fierce, determined, murderously rageful look on his face, and rushed through the door. When confronted by his foster mother, he said, “She’s not going to mess me up; I am going to protect myself from her!” Confronting a girl much older and stronger than himself was an unconscious “invitation” to her to stab him with a knife, thus an identification of himself as victim with his slain father and as victimizer with his deceased mother.

d. Secondary Interference of Defense Activity
Eric’s developmental arrest in ego defensive organization interfered with successful age-appropriate play, adaptation to school, and self-control. The child’s reactive hyperaggressivized motor behaviors also undercut opportunities for vital internalization. As Alpert, Neubauer, and Weil (1956) pointed out, “Surplus discharge in motility makes neutralization difficult since it does not lend itself to modification through object relations” (p. 45).

As is true in traumatized children in general, Eric’s hyper-vigilant and traumatophobic-avoidant defenses prevented the exposure to increasingly complex environmental stimuli so essential for the evolution of psychological complexity, defense integration, and personality cohesion. Avoiding persons, places, things, and situations because of fear of the return of the dissociated (Parson, 1984) is a real threat to the child’s future maturation and well-being. Eric’s affective constriction also robbed him of experiencing a full range of human emotions.

e. Affective States and Regulation
Post-Traumatic Affective Stress Response
Failure in posttraumatic mastery also was seen in the ego’s relative incapacity to use signal anxiety and to produce neutralized energy for its use. Eric’s traumatized ego structures were unable to modulate strong affective tensions, making him vulnerable to a complex state of posttraumatic affective syndrome, consisting of inner tension states, anxieties, fears, sadness, shame, guilt, rage, and violent feelings (Parson, 1994a), poor impulse control, physiological arousal, and persistent catastrophic expectations that either he or someone close to him would be killed again.

Numbing is a dose of “anesthesia” injected into the child’s affective response repertoire to control revivifications of traumatic imagery and associated affective responses. An example of this response was observed during the sixth month of therapy when he would state, “I have no feeling” or “I can’t have a feeling now: it hurts too much.” Eric’s difficulties in processing feelings were also manifested in his use of denial and negation, as noted during the testing and in therapy. During a psychological testing session, for example, Eric gave a typical “affect-disavowing” response to every Rorschach chromat Card (color), and to TAT Cards with affect-laden contents. He said, “This is not a feeling: I don’t feel anything!” The general problem of affect intolerance made mourning for his many losses difficult to achieve.

Eric also utilized projection to handle feelings of sadness, guilt, and rage. For example, in his response to the Incomplete Sentence stem, “MY MOTHER IS,” he stated, “Sad in
Heaven; she's sad because she died." During the same session, with significant transference implications, he insisted, "I don't want to kill him; he wants to kill me!" Anna Freud, in *The Ego and the Mechanisms of Defense* (1936), described the ego defense mechanism of reversal, by which the child inverts from a passive, acquiescent victim to an active participant to control the sense of inner danger. In reversal, Eric turned vulnerability into brutal force, dependency into self-sufficiency, while his helplessness was transformed into feats of magical rescue.

Identification with the aggressor protected the child from experiencing persecutory feelings associated with his basic traumatophbic orientation. This defense was noted in Eric's behavior when, after producing a projective drawing of a female figure in the shape of a large knife (identification with his mother as aggressor), he explained, "This is me; I am a boxer. I am boxing." When confronted by powerful trauma-related imagery (here, a knife), Eric may identify not only with the aggressor but also with the victim. For a tar story he stated, "She stabbed herself with a pair of scissors like this" (demonstrating).

2. Superego Development and Characteristics
Eric's superego functions are varied and are at differing levels of maturity and integration. His superego operations are based upon fear of losing people who are close to him and upon whom he depends for survival and fear of immediate retaliatory measures from adults or peers in authority. Children and adolescents who have witnessed violence and are traumatized by it suffer conflicts between the id—in the form of split-off, dissociated impulses—and external reality and, to a lesser degree, between id and superego. This is in part because the ego of the child who has been an eyewitness to violence is unable to master intrusive traumatic imagery and affects.

Eric's superego operations were assessed by analysis of his dreams and nightmares, spontaneous verbal and nonverbal behavior, and transference and countertransference materials and of the results of psychological testing. The superego's relationship to the ego was marked by harsh criticism, and his ego ideal was exemplified in a fragmented, incongruous image of a narcissistically wounded and profoundly deprived figure—a "tough, fierce, wealthy dude who spends all his money in feeding himself, so he don't starve." Diagnostic-evaluative procedures and psychotherapy notes, comparing the situation before and after a year of therapy, showed that Eric's superego, which initially lacked the positive elements of the "loving and beloved superego" (Schafer, 1960), later acquired a sense of internalized benevolence and increased self-esteem.

IX. Assessment of Fixation Points and Regressions
This section of the Profile deals with the persistence of earlier modes of psychic organization and expression in instinctual and object relations domains. As noted earlier, Eric's pathology was related to developmental arrest and ego disorganization (Lachmann and Stoirow, 1980; Kardiner, 1941). Thus, at age four certain maturational mechanisms were "frozen in time," reducing Eric's later capacity for empathy (oral), generosity (anal), healthy assertiveness (phallic stage), and ambition and values (genitality). Eric was constantly reminded of his painful past through "traumatic reminders" (Pynoos and Eth, 1986) when he interacts with certain people, under certain environmental conditions, and in traumatic dreaming or nightmares.

X. Assessment of Conflicts
Post-Traumatic Character Traits
Anna Freud's (1965) concept of "internalized conflict" refers to the taking into the child's self of drive-conflict experiences that originally occurred in relationships with people in the external world. Eric's internalized conflicts were maintained independently of environmental influences until the effects of therapy provided sufficient structuralization and ego autonomy. Character is the supraproductive structure and organization of the psyche that coordinates and consolidates the simultaneous influences of id, ego, and superego operations. It is "an organizational principle applied to psychic functions" (Steingart, 1969, p. 282). Eric's style of relating or character pathology represented a convergence of internalized conflicts and traumatic experiences. His post-traumatic defensive organization was based on turning passive acquiescence as victim into active-oppositional demeanor as victimizer, on identification with the aggressor, and on ego-syntonic intrusive-repetitive dynamics in relating to others, numbing of feelings, avoidance of stimuli that trigger traumatic reminiscences, and hypermotor movements to ward off depressive affect, grief, and internalized images of terror.
From a very young age, Eric internalized adult models of violence and sadistic impulse expressions in human relationships. His distrust of adults was based upon a deeply internalized principle: “Adults kill, they murder; they cannot be trusted to offer me safety. They may kill me, too. Sometimes I feel I have to kill them first before they kill me.” Internalized violence-organized models of this kind offered Eric no protection against inner persecutory “presences,” and made him fearful of his own potential for violence and murder.

Eric’s traumatic experiences were within the context of relationships between people. He had witnessed intense conflict between his parents and had learned that people kill each other when they disagree, that people close to him could harm and kill each other, and that losses are apt to occur from any human encounter. Though a part of him was fearful of violent consequences from being with people, his anticipation was that other people will “do me in”—that is, harm or even kill him.

As a consequence of violent expectations, Eric maintains a “strike-first” personal policy: he feels he cannot take a chance. He seeks this strike-first advantage after any threat. In Eric’s mind, a threat is the same as an actual violent assault. He also has learned that when violent impulses are unleashed they cannot be retrieved. People disappear, never to return, and if they do return, they are dramatically changed, and return only to disappear again. He was aware of two kinds of objects, both to be found in the context of violent conflict: the aggressor and the victim. He avoided becoming a victim and eschewed passivity in the face of violence and threat. If given a choice, he preferred to be the (defensive but protected) aggressor, one who defends himself from violence by becoming violent. Generally, Eric’s personality was organized around the dynamic themes of horror, danger, paranoid anxieties and distrust, and profound vulnerabilities, and it featured primitive anxiolytic defenses and protection against dysphoric feelings.

XI. Assessment of Some General Characteristics
Implications for Post-Traumatic Child Psychotherapy
This section of the Profile creates forecasting scenarios “to assist the diagnostician to predict the chances for spontaneous recovery and reaction to treatment” (Lauffer, 1965, p. 119) and “long-term prognosis” (Nagera, 1963, p. 531). In predicting Eric’s possible response to posttraumatic play therapy, the clinician evaluated (1) the child’s bicultural self-organization (which Erikson [(1950) 1993], Halpern [1964], and Parson [1985] believed to be important in clinical work with African American and other minority and lower SES children); (2) his psy-

chotic trauma and associated ego distortions and problematic object relations; (3) the nature of his developmental arrests, regressions, and points of fixations; (4) his bonding capabilities; and (5) the course of initial contacts with the child and his foster parent (Mrs. Thomas), which included psychological and socioecological explorations.

After the assessment, an interdisciplinary team agreed that Eric’s prognosis both for therapy and for spontaneous recovery were poor to guarded. Despite this bleak early picture, therapy ultimately proved to be very beneficial for the child.

Culture and coping
Culture in the psychotherapeutic process is important. Its importance, however, may vary from child to child, from a patient in one socioeconomic group to one in another, and from one therapist to another; it may even vary in importance from one session to next. If therapists working with inner-city children, youths, and families experience undue fear over the child’s potential for violence due to personal conflicts or to media portrayals of inner-city people as violent, the therapist takes responsibility and explores any potential impediment to the therapy.

Coping refers to a highly individualized strategy employed during states of crisis. During these states, people are typically unable to fall back on ordinary skills they have found of value in the past. Highlighting the coping capabilities of inner-city children who live in a non-average, precarious, and catastrophe-generating environment, Schaer (1991) writes that “despite the existence of overwhelming, frightening events in the lives of inner-city children, they do not become marasmic, literally withering on the vine due to their submission to hostile environments” (p. 14). The concepts of “psychological hardiness” and post-violence adaptivity (Parson, 1993) are relevant here. They serve as moderating variables (or “stress buffers”) between traumatic stress and illness.

Meers’ (1970, 1972, 1973a) work in the area of culture and coping also is germane to the current discussion. He reported on the unique characteristics of inner-city-reared children and held that psychoanalytic research offered a rich source of data unobtainable through any other method of observation. He believed that longitudinal research explorations would provide valuable documentation of black children’s adaptive as well as dysfunctional ego processes and that professional ignorance and social indifference were responsible for the virtual absence of psychoanalytic data on inner-city children. The current posttraumatic child profile could make a contribution here.
Several writers have highlighted the coping capabilities of black children in crisis (Coles, 1967; David, 1975; Meers, 1972, 1973a, 1973b; Parson, 1985). These strengths need to be identified and then incorporated into diagnostic and psychotherapeutic processes used with these children. Meers (1970) found that the unique ego strengths of black inner-city children made it possible for some of them to tolerate noise, confusion, and isolation but, as mentioned earlier, at the high price of impeding learning, curiosity, and other essential capacities.

The Nonaverage, Catastrophe-Generating, and Precarious Environment
As a general theory of human behavior and of therapy, psychoanalysis extends its methods and healing processes to accommodate the psychological and biological responses to catastrophe-making hyperaggressive environs. Unlike the hypothesized "average expectable environment" advanced by Heinz Hartmann (1939, 1958), in which order and regularity are key variables, the inner city is a place of patterned unpredictability and catastrophe for many children and their families.

Myers and King (1983) propound the idea that the stress-coping processes of inner-city children should be analyzed as an aspect of the assessment. They point out that "very little work has been done in this area." These writers advance an "urban stress model," which consists of five basic elements: (1) the antecedent stress state, the basal level of stress for a person or group; (2) the eliciting stressor, the objective external stressful stimuli that force the individual into states of disequilibrium and adaptational struggles to regain the usual level of functioning; (3) the mediating factors, intrapsychic ego capacities, and persons, structures, and situations that alleviate or exacerbate the effects of the stressful situation; (4) the adaptation process, the physiological, cognitive, affective, and behavioral elements of coping; and (5) the health outcome, the positive product of the coping effort.

Eric's world was one of high basal rates of stress, with an eliciting stressor that did not produce merely an ordinary stress response but a catastrophically stressful one, witnessing the homicide of a parent (Eth & Pynoos, 1994). The mediating factors—both intrapsychic and environmental—were overwhelmed by the deprivations and traumatic experiences Eric had endured, and the adaptational and health-outcome processes were assisted by the psychotherapeutic process, and the benevolent and caring integrity of Eric's foster parents.

XII. Diagnosis
A. Categorical-Descriptive Diagnosis
Eric's level of ego disturbance described in the Profile combines Anna Freud's (1965) third, fourth, and fifth diagnostic categories.

Thus, the child showed pervasive developmental damage due to both early deprivations and neglect and exposure to traumatic violence. Eric's fixations and regressions and his acquired destructive psychic processes had interfered markedly with his overall development and structuralization of personality.

B. Diagnostic Statement and Formulation
Many clinicians may find assessing posttraumatic stress disorder (PTSD) in inner-city children as unnecessary and so avoid differentiating posttraumatic stress from other psychological disorders. In a thematic issue on trauma that appeared in the Psychoanalytic Study of the Child, Erna Furman (1986) advanced the view that assessing for PTSD was essential even though "professionals find it hard to differentiate post-traumatic stress from other disturbances" (p. 193).

As noted before, Freud (1920) was intrigued by the problems posed by the traumatic neuroses and wrote that in these conditions "there really does exist in the mind a compulsion to repeat [as in traumatic neurosis] which overrides the pleasure principle [as implied to be operative in the hysterical neurosis]" (Freud, 1920, p. 340). He saw recollections experienced by the victim as "factually disturbing" and with an "intensity of stubborn persistence." This involuntary tendency to persistently repeat aspects of the original trauma in life and in therapy was clearly demonstrated in Eric's personality operations. Structurally, compulsion to repeat (trauma) represents an archaic functional organization that "gives the appearance of some 'demonic' force at work" (Freud, 1920, p. 340). In order to understand Eric's traumatodynamics, and the process by which an external event (such as murder) is transduced into ego psychological conflicts and physical symptoms, it was necessary to integrate psychoanalytic theory of trauma (Freud, 1918, 1920; Freud, Ferenczi, Abraham et al., 1921; A. Freud and Burlingham, 1943) and the descriptive criteria for the diagnosis of posttraumatic stress disorder (PTSD; DSM-IV) which reflect recent clinical and scientific developments in the assessment of psychological responses to trauma in children (e.g., DSM-IV; Frederick, 1985; Nader, Pynoos, Fairbanks et al., 1990; Parson, 1994a; Pynoos and Eth, 1986; Terr, 1979, 1981).

Posttraumatic stress disorder is a psychiatric disorder characterized by significant biopsychological disturbances that are reflected in problematic cognitive, affective, physiological, and social functioning. Its descriptive criteria involve a history of trauma (for example, episodes of rape, incest, car accidents, aggravated criminal assaults, or, as in Eric's case, eyewitnessing unspeakable violence by a parent to another parent). It is a history in which (1) "the person
experienced, witnessed, or was confronted with an event ... that involved actual or threatened death or serious injury”; and (2) “the person's response involved intense fear, helplessness, or horror. In children, this may be expressed instead by disorganized or agitated behavior” (DSM-IV, p. 428). Moreover, the diagnosis constitutes reexperiencing the trauma (in Eric's case, he experienced intrusive ideas, memories, and feelings associated to the original event in the form of nightmares, spontaneous feelings and thoughts, and traumatic play rituals); persistent avoidance of stimuli, resulting in reduced responsiveness to and interaction with the external world (Eric's numbing and avoidance, denial, and negations, noted earlier, were observed in direct verbal contents and in the symptomatic hypermotility and traumatic hyperplay); and (4) psychophysiological arousal (Eric showed irritability, hypervigilance, startle reactions, and difficulty going to sleep and remaining asleep). Eric's symptomatology reached DSM-IV criteria for posttraumatic stress disorder.

XIII. Recommendations and Disposition of the Case

A. Posttraumatic Child Psychotherapy

For Freud (1900) the latent contents of dreams constituted the royal road to the unconscious in adults. He found that dream-analysis tended to increase understanding of unconscious communication. For the child, however, play-analysis is a royal road to understanding the child's unconscious, while “trauma-analysis” is a path to understanding the patient's dissociated traumatic repetitions—in memory and in frightening and painful affects and nightmares, as well as in human relationships.

Posttraumatic child therapy in this case utilized biopsychosocial data derived from formal assessment, verbal and nonverbal behavior, transference behavior, countertransference responses, affective expressions, associations, play-analysis, traumatic-dream-associations, disturbed sleep patterns, general physiological reactivity, startle reaction, disturbed capacity to modulate alarm and hyperarousal, irritability, aggressive explosiveness, separation and annihilation anxiety, guilt, shame, hypochondriasis, somatization, panic, flashback “twilight” phenomena, affect constriction, numbing, and fixation on trauma themes and repetitive-compulsive phenomena.

During the initial phase of the treatment, attachment to and trust in the therapist were tenuously organized and very fragile. The child found play to be un gratifying, conflicted, dysphoric, anxiety-provoking, and affectively turbulent. For him, play was not a plea-
surable or even neutral event: it was charged with potential dangers that threatened the reactivation of dissociated affects and memories around loss, murder, and death.

The goals of the treatment were (1) to establish the therapeutic alliance and basic trust; (2) to increase the child's sense of control over inner turmoil and chaos and over the unpredictability of the environment; (3) to create a climate of safety and predictability in the therapeutic setting; (4) to assist the child in making connections between feelings and behavior; (5) to reconstruct traumatic childhood events (to integrate trauma elements, losses, and actual and symbolic forms of violence within the self and in relation to others) and to increase capacity to organize events and experiences into stable inner representations; (6) to work through the child's pathologic defenses and character distortions; and (7) to facilitate the recovery of a progressive development.

In order to achieve these goals, techniques and procedures governing the building of the therapeutic alliance, treatment climate control, and phase-specific operations were employed. The emphasis in the early phase of the treatment was on communicating safety and providing the child with reassurance in a here-and-now process that emphasized holding rather than transference interpretative activity. This is in part because this kind of interpretation would have required a higher level of ego integration than the child yet possessed, due to his developmental ego anomalies. By the holding function of the therapist is meant active fostering of a child-sensitive therapeutic attitude accepting the child as he is; it means that the therapist actively supported the child's feelings, thoughts, and behaviors and affirmed his sense of self.

The therapist's functions also included monitoring countertransference feelings while listening with third-car acuity to derivatives from the child's trauma story-telling rituals as they unfolded over time. The power of listening to horror, tragedy, and experiencing the child's internalized affective terror may induce images, cognitions, and psychophysiological changes in the therapist, countertransference management through increased awareness is imperative. As Eric's posttrauma needs-satisfying object, the therapist provided an essential “affect-buffering function”—an auxiliary stimulus barrier, providing posttraumatic guardianship that protected him while respecting "the child as a person in his own right" (A. Freud, 1972). Protecting Eric from overstimulation in therapy and outside the physical setting of the treatment was a constant challenge.
The therapist's technical stance modeled nonviolence in a relationship that could be experienced as empathic, predictable, reliable, nonimpinging, and facilitatingly maturational. This stance made it possible for the therapeutic relationship to be experienced by the child as a model of the safe, nonviolent world (Parson, 1994a).

Early interpretations were geared primarily to assist Eric gain insight into how split-off, terror-driven affects, drives, and impulses were being kept in check by behaviors that constantly got him into trouble with other people—at home, on the school bus, and during the school day. Later phases utilized transference interpretative activity to foster integration of the child's traumatopsychic fragments.

The physical setting selected to treat Eric had its own "holding features," which promoted an essential emotional holding environment. Physical holding included a room that was warm, inviting, and nonintrusive (or nonimpinging, in Winnicott's [1975] sense). Thus, stimuli such as lights, sounds, and color of the walls and carpet were subdued. Stability and predictability were integral factors in site planning. That is, it was important that each session be conducted in the same room, same location, and during the same time of the day, as much as possible.

In the mid phase of the treatment, explorations were geared to help Eric face "the unrememberable and unforgettable" (Frank, 1969), through periodic systematic reconstruction of trauma elements and analysis of transference feelings. Frank maintained that regaining memories lost after traumatic situations required "understanding and communicating the nature of the experience, reconstructing the nature of the trauma, and supplying the missing events" and that when this was done "crucial change soon occurred" (p. 103).

Freud (1914) believed that remembering and repeating in therapy were not enough. In his essay, "Remembering, Repeating, and Working Through," he spoke about the difficulty patients have in remembering. He felt that in order to ensure integration and long-term resolution, working through was essential. Working through with Eric empowered him to alter rigid, defensive psychological armaments against feelings generated by intrusive thinking and memories, grief states, and dissociative ego defenses, such as numbing. This was facilitated by the therapist, who provided the child with object constancy, "an illusion through which children maintain a delicate balance between a past that offered safety and a future yet to be discovered" (Kaplan in Cohen and Sherwood, 1991, p. 13). The therapeutic setting is "a kind of emotional home base from which children venture forth to confront the larger world and "an emotional bridge for children" (ibid.).

In terms of changes in Eric's behavior and attitude, his internalizations had matured beyond vendetta rage, narcissistic rage, and other narcissistic vulnerabilities. No longer was violence an instrument for conflict resolution, self-esteem-building, and hyperarousal management. He had gained a sense of greater autonomy and a strategy for mastery. He also achieved some capacity to be alone and made important strides toward an ethics of caring and concern for others. Moreover, he was able to grieve his losses and began to construct a new nonviolence paradigm within himself.

B. Clinical Learning Laboratory
Eric also was referred for a specialized training program to address his learning disabilities, one that integrated didactic with experiential learning, like the programs outlined in Children with Special Needs: Case Studies in the Clinical Teaching Process (Sapir and Cott, 1982) and in "I Ain't Nobody": A Study of Black Male Identity Formation (Beiser, 1988). In "Cognitive Ego Psychology and the Psychotherapy of Learning Disorders," Herman and Lane (In press) present a contemporary psychoanalytic view of cognitive functioning and learning which has tremendous relevance to the theoretical integration of organic, sensory, ego, drive, and superego maturational factors in children with learning disorders. The authors note that despite the need to understand the child's internal world, positive parental attitudes and behavior are essential to move the child toward ego psychological maturation. Thus, they mention that "on the parental side, the presence of positive responses to every forward step" (A. Freud in Herman and Lane, in press, p. 3) offers the child opportunities for integrative inspiration. These programs recognize the child's unique personality dynamics, cultural, and academic remedial needs.

C. Family Support and Conferencing
The tragedy to which Eric's family was subjected is categorized as "catastrophic" (McCubbin and Figley, 1983), as opposed to a normative, expectable occurrence. Meeting with Eric's foster parents and siblings and his extended family members for mutual information sharing proved helpful to the child and the treatment experience.

D. Follow-up and Aftercare
After eighteen months of intensive analytic psychotherapy with Eric, the author terminated the treatment in order to fulfill time-commitments elsewhere. At follow-up with his new therapist, the child was still progressing toward psychological integration, while
achieving freedom from internal psychotraumatic conflicts and symptoms.

**Value of the Profile in Clinical Work with Multiply Violence-Traumatized Inner-City Children**

Assessment with the Profile and posttraumatic analytic child psychotherapy may be useful forms of intervention for many inner-city children. This Profile-therapy combination works for the child and is therefore recommended to clinicians. For while the Profile structures the details of in-depth information about every significant dimension of the child's personality and functioning, the therapy uses this information to structure the most meaningful intervention possible for a specific child.

This author's experience and the experience of others (e.g., Thompson and Kennevy, 1987) indicate that integration of general psychoanalytic principles of treatment with the special characteristics of inner-city children is very important if meaningful change is to occur. For clinicians who desire to help these children, introspective surveys into countertransference feelings about specific traumatic experiences (e.g., rape, mugging, incest), class, ethnicity, and race are imperative (Nader, 1994; Parson, 1994; Schaefer, 1991; Schwalter, 1985).

Many practitioners seem reluctant to apply psychoanalytic principles and methods in treating these children. This reluctance is often rooted in countertransference-based feelings and distortions of the true nature of the child's self and its conflicts (Parson, 1988, 1994a). These feelings then lead to a consciously formulated set of "reasons" why dynamic formulations and approaches should not be applied to these children. For example, a therapist may "fear" that analytic approaches may harm the child, may "create" acting-out of violent impulses, or may be ineffectual because the child's intellectual functioning may be "too low." The child may be perceived as "too damaged," or as "unmotivated, unanalyzable, or untreatable." Others may view this approach as too time-consuming and "not cost-effective enough" for such a child.

Of course, it is clear by now that the consequences of not finding effective preventive methods will also continue to prove very costly to children, families, communities, and society in general. Not only does the Profile provide a structured, systematic means of studying the child's traumatodynamics and culture, but it offers the clinician, the child, the family, and the school the opportunity for both intervention and prevention (including primary, but especially secondary and tertiary).

The specific findings derived from profiling the inner-city child in this article are that: (1) inner-city children do benefit from and change as a result of psychoanalytic psychotherapy; (2) even a child with less than average measured intelligence may benefit from this kind of intervention; (3) management of internalized violence is possible with careful assessment and "good-enough therapeutic holding"; and (4) therapists' management of feelings about violence and about media-formulated images of inner-city children and youths is imperative.

The psychoanalytic study of the inner-city child, because of its profound commitment to a true discovery of the child's internal models of conflicts, desires, internalized terror, and defenses, can play an important role in creating the possibility of a new paradigm of a nonviolent world.

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