The Effect of Severe Trauma on Maternal Functioning

A clinical case study

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Abstract

This paper describes the effect of severe familial disruption, violence and abuse in her own life on an indigenous woman’s capacity to mother her infant daughter. The difficulty of providing support and treatment is demonstrated and some reasons for this are discussed.

Introduction

Kevin Rudd’s recent apology on behalf of the government to the indigenous people of Australia was a necessary and significant step in improving the relationship
between indigenous and non-indigenous Australians. However, the well-publicised problems with addictions, violence and child abuse in the indigenous community, as well as the appalling statistics on infant mortality and general life expectancy in the indigenous population, indicate that the effects of two centuries of persecution and neglect will not easily be undone.

Many workers have noted that the development of the mind, of the capacity to think about experience, depends on the presence, from earliest infancy, of a caregiver with a functioning mind; a mind which can contain and process the infant’s experience and return it to the infant in a manageable form. Bion has called this capacity alpha function; Fonagy refers to it as the capacity to mentalise. Winnicott speaks of the need for a good-enough mother, who can allow the infant the experience of ‘going-on-being’ without impingements. It is clear that many indigenous Australians have not had the experience of mindful care, and that the problems which result continue to be passed on to future generations.

This paper gives a detailed account of a brief therapy with a young indigenous woman subjected to repeated experiences of trauma, abuse and loss from her earliest life. The paper describes the effects of these experiences on the patient’s capacity to process her own and her infant daughter’s emotional experiences. The problems encountered in maintaining the therapeutic relationship are discussed. Such problems are likely to occur in any attempt to assist extremely traumatised individuals.

For some years I have worked sessionally at a private psychoanalytic clinic, set up specifically to assist parents who are having difficulties with their infants or young children. The clinic is staffed by a number of clinicians and there are regular meetings where difficult cases are presented and discussed.

One of my first referrals was a young woman whom I shall call Sally Anne. The mode of referral was unusual. The contact was made not by the patient herself, but by a friend, Y, who acted as an agent for Sally Anne. Y, a middle-aged Caucasian woman, explained that Sally Anne was Aboriginal, and had had very traumatic life experiences which included being removed from her family and spending time in various abusive foster placements and institutions. She had a baby girl aged 3 months, and wanted help to understand her feelings and actions towards this child. She had had a son ten years before, and had chosen to give him up to her extended family because she had begun to abuse him physically. Sally Anne did not want this to happen again.

The realities of committing to treatment at a private, psychoanalytically-oriented facility were explained to Y—no bulk billing, commitment to attending
consistently, payment for missed sessions; it was suggested that a public agency would be more appropriate. However Y explained that Sally Anne was adamant that she would not approach a public agency after her experiences with ‘the welfare’. She, Y, would bring Sally Anne to the sessions and would make sure she attended regularly and on time, and would also guarantee payment for the sessions in cash.

Although there was some doubt as to whether we could offer anything helpful, an appointment time was eventually offered and accepted. The referral was discussed at some length by the clinicians; we hypothesised that Sally Anne herself might be much like a baby who needed adult support and supervision.

Sally-Anne arrived at the session on time, beautifully presented, and with the baby equally well dressed and groomed. I saw a very tall, slim, striking young woman, long hair in tiny African-style braids, colourfully and attractively dressed, with the poise and movements of an athlete. I found out she had been a dancer in one of the Aboriginal dance companies since her mid-teens. The baby, a little girl then just three months, seemed extremely tiny and vulnerable in her mother’s arms.

Though Sally Anne presented warmly and was immediately engaging, as she tried to tell me why she had come she became quite agitated and it was difficult for her to give her story coherently. Each time she began to tell me of difficulties in the present her thoughts were disrupted by a torrent of memories of previous painful experiences, and her rage and resentment about them. She fitted the description of the ‘unresolved’ category of mothers of insecurely attached infants, described in attachment studies (Fonagy, 2001, pp. 23–4). She cried throughout the session, memories and tears about past abuses welling up and gushing out no matter where the conversation had started. She also became quite angry and tense from time to time; angry about the events she was describing, including her painful states of mind, and angry with me too—I was like all the other helpers, saying nice things but doing nothing about the problems, just sitting there and talking. If all I offered was talk, she could get that from her friends, she said. And I was white, and not to be trusted. However, she did not trust the Aboriginal helping agencies either.

When in tears, she would smile through them at the baby, explaining to me that she didn’t want to upset the baby, that she always pretended to the baby that she was happy. When she was tense and angry, she would cuddle the baby tightly, hold the baby in the air, tell her, and me, how cute she was—trying desperately to cover up the hostile feelings she was experiencing. The baby was settle to begin with, and there was some gazing and smiling at her mother; but as Sally Anne told her story, the baby too became restless and miserable, throwing out her arms and legs in an alarmed way, and shaking; when the baby looked at me, it was with an
expression of utter despair that I found heart-rending. I felt great concern for this infant. However I was slightly comforted to note that she seemed in good physical shape, showed no evidence of injury, and was neatly and appropriately dressed.

Sally Anne said that since the birth of her baby she had been having vivid flashbacks of her experiences of violent physical and sexual abuse; these flashbacks could be triggered by anything at all, sometimes nothing at all. She would feel very angry, and start to shout at the baby, to ‘push her around’, ‘rough her up’. Sometimes she would blank out, and although it was only for a few seconds or a minute, she was afraid of what she could do to the baby. She had some warning of these blanks, and had managed to run from the flat in order to protect the baby from possible harm. On one occasion the door had slammed shut behind her and she’d had to climb back in through a window—a dangerous manoeuvre, as the flat is on an upper floor. She said that so far she had only hit the baby once, on her legs; she was less afraid of harming the baby physically than she was of ‘getting right into her head’ and causing mental, emotional damage. She would sometimes call the baby horrible names, yell abuse at her for no reason, refuse to feed her—torture the baby, as she herself called it. When she shouted, the baby would become very quiet, and curl up very small—to protect herself, it seemed; Sally Anne was amazed at this.

She did not understand why she behaved like this towards the baby; she knew that as she looked at the baby she would remember that she herself had been small and defenceless, and terrible things had been done to her; she would be enraged at the people who had done these things, and the rage would be directed at the baby—who had nothing to do with it.

The flashbacks had begun after she had the baby, and they were especially bad at night, which was when much of the abuse to which she had been subjected had occurred. She could not sleep, and when she did she had terrible nightmares, though she could not remember any details. She was not living with the father of the baby, but had a great deal of contact with him; she felt safe only in his presence, he would take the baby from her if he saw she was agitated. She did not trust relationships, did not want to live with the father; she was however sharing her flat with a woman friend who ‘kept an eye’ on her. She had told no-one of the flashbacks, until recently when she felt she had to tell Y; she was ashamed to tell anyone about her early experiences, especially the baby’s father, who was a Muslim and would leave her in disgust, she was sure, if he knew what she had been through.

She had had a child 10 years ago, when she was 19. She had found herself being violent with him, hitting him and throwing him around. She noted that she had
not begun to feel violent towards her son till he was older, over a year old; she wondered whether the earlier onset of problems had to do with this baby being a girl. She had taken her son up to her grandmother and extended family at the remote indigenous community in North Queensland from which her mother had come; she wanted him to have a better life, had felt afraid of what she would do to him if she kept him. She said bitterly that he did have a better life on the reservation, but he didn’t have his mother, and when he remembered her it was memory of being hit, hurt. She understood that her violent behaviour had to do with the experiences she herself had endured as a child, and was angry and resentful that these events which were not her fault had deprived her, and her children, of the chance of a normal life.

She did not want to have to give this baby up as well; she said to me that if she lost this baby she would go on a killing spree—or at least kill herself. She would also kill anyone from the welfare who tried to take the baby from her; she did not trust them, they had always said nice things and seemed concerned, but afterwards terrible things had happened.

Her actual early history was hard to piece together, and emerged over several sessions; there seemed to be many inconsistencies, which seemed to me to be due to Sally Anne’s confusion, her difficulties in conceptualising terrible experiences and connecting them to make a coherent story.

She is the second of three daughters of a full-blood Aboriginal mother and a Celtic father. The mother divorced the father when she discovered him sexually abusing the older girl, who would then have been about six years old. Nevertheless, custody of the children was awarded to the father, because he was white. (Later, when she was able to question her grandmother about what had happened, which she had never done till she began to be able to process events with me, she was told that actually the father had run off with the children illegally, and the family had been unable to trace the children). Father took them to Tasmania, where his mother was; Sally Anne’s own mother died some years later of cancer, and she never saw her again.

Things were relatively stable for a while, but then the grandmother died, and the father began to abuse the girls physically and sexually again. She said father would disappear to the pub, sometimes for days on end, and lock the girls under the house, in the dark without food, till he returned. Eventually the welfare had been notified by the (white) neighbours, with whose little girl the children played; this child had been talking to her parents about what she observed next door, and though they did not believe her at first they eventually broke in under the house to investigate during one of father’s absences, and found the girls imprisoned in the
dark. Sally Anne had broken into the office of the local welfare agency, and stolen her file; she had seen documented the details of what had happened to her—cigarette burns, bruises, hospital admissions with injuries. Father was jailed for three years, and the girls put into foster care.

Here, however, things were no better. The men in the house, the foster-mother’s son and her father, would drink at night and then come upstairs and molest the girls—‘just help themselves to us’. She would lie awake at night listening to their conversation, often climbing out of the window and running away to avoid the abuse. She was a good long-distance runner, but would then be in trouble for this. One night the foster-mother heard her crying, and came upstairs and caught her son in the act of abusing Sally Anne; he was sent out of the room, then she was questioned and blamed for the events. There was never any further mention by the foster-mother of this incident.

She tried to tell people what was happening, but was not believed. She told me how and why she began drinking. This happened when, at the age of 11, she took to school a bottle into which she had put a little out of each of the bottles in the drink cabinet at home; she wanted to tell the headmaster what had been going on at home, and to give him evidence that the men at home really did drink and then get abusive. The headmaster however did not believe her, and attempted to cane her for bringing alcohol to school, accusing her of bringing it to drink herself. Sally Anne became enraged, grabbed the cane from him and hit him with it, saying she was sick of being hit for nothing, then ran away and drank the lot. After that she drank every day, often excessively—but had stopped altogether when the baby was born. She thought that stopping drinking made things harder—she was less violent and angry when she drank.

After this foster-home, there were other institutions, all of them violent and with very severe punishments for misdemeanours. There were few kind people, though there were some, whom she remembered warmly; but the good relationships were always short-lived and could not be relied upon.

At 16, she ran away for good, and was taken in by an Aboriginal dance group, who became her family, and with whom she maintains strong ties. Y, her support, works in the dance company’s administration, and, being also a midwife, delivered both her children.

Two years prior to her presentation, Sally Anne’s older sister had died, supposedly suffocating during a convulsion, the sequel to head injuries sustained during the abuse she had suffered. Sally Anne did not believe the death was natural. However her grandmother was now looking after her sister’s several children too. At the
time her sister died, Sally Anne herself had been raped and stabbed by an Aboriginal man who had broken in to the house where she and the other members of the dance group were staying during a tour; Sally Anne had almost died, had taken several months to recover; she showed me one of the scars. The man had been sentenced to only two months’ jail, as the judge noted that violence was a normal part of life for Aboriginal people. Bitterly, Sally Anne wondered whether he would have got a longer sentence if he was white—or if she was. A few months after she got out of hospital and returned to NSW, a white man had pulled a knife on her when she refused to strip for him. She had grabbed a cleaver and beaten him with it till he lost consciousness; she wasn’t going to let it happen again. He was in a coma for some time, and she was charged with the assault, in her mind narrowly escaping a sentence for manslaughter when the assailant regained consciousness. The case was still unresolved, she said. She had not had much space to mourn her sister.

The younger sister, still a teenager, is the outcome of an attempted reconciliation between mother and father when he was released from jail and was trying to trace the two older girls. She too has been assaulted and raped, and has permanent brain damage as a result of abuse; Sally Anne was not sure whether father was responsible but assumed so. She too lives with the grandmother.

Sally Anne told me she had been a little girl who cried all the time, because of all the awful things that were happening. But in high school she got tough, became a fighter; she could fight, and she could run. These defences had stood her in good stead; she seemed to be the only one in the family who had survived intact, at least physically. Over the time she saw me, it became clear that she still used fighting and running to deal with painful situations; alcohol too had been a way of running. However when things became difficult with the baby, these defences became problematic.

The first interview left me feeling overwhelmed, bearing the weight of the terrible story I had heard. I had had shoved into me the force of Sally Anne’s own fears of her violence, as well as the fear, sadness and outrage at the events of her life. I was left feeling terribly distressed, helpless in the face of insurmountable odds, and unsure I had anything worthwhile to offer in the face of the crushing burden of these feelings and experiences. Though it seems obvious now, it took some time then for me to understand that these were the feelings Sally Anne must have felt during all the terrible experiences she had had.

Treating a traumatised borderline patient is a challenging experience in any circumstances; the presence of a tiny, helpless infant adds an urgent and very frightening dimension to the situation. Though Sally Anne agreed that she needed to see me and talk, to try and disentangle these intrusive, powerful feelings and urges from her baby, I was not sure that I could protect them both. The level of
trauma and disturbance was very great, and the baby very small and vulnerable. I could offer only one session a week—and she was very ambivalent about coming. Getting her to accept the idea of help from ‘the welfare’ seemed impossible for the time being at least.

I was encouraged by the fact that she was deeply concerned for the baby and motivated to seek help, and by the fact that she had a strong support in Y, in whom she was able to confide to some extent. I was also encouraged by her ability to express her feelings and to grapple with thinking about them, in spite of her confusion and distress. I kept reminding myself, too, of Selma Fraiberg and her team, who found that the presence of the baby in the therapy session results in very remarkable changes within a short time, in the relationship of the mother to the baby, and in the baby’s capacity to develop (Fraiberg, 1980, p. 53). She and her team repeatedly found that, even though a mother’s severe depression had not lifted, the baby’s interactions with mother changed rapidly and dramatically if mother and baby were seen together. She attributes this to a force for development in the baby, coupled with the very real wish of any parent to give her child a better experience than that she herself may have had.

I was much helped and supported by the team of colleagues at the clinic, with whom I discussed this case at length, whenever the opportunity arose, both formally and informally. Fraiberg emphasises the need for support and discussion when working with very disturbed mothers and babies (Fraiberg, 1980, pp. 14–15); Caroline Garland spoke in much the same way about the need for support and discussion when working with patients suffering the after-effects of severe trauma.

My thoughts after this first session were that Sally Anne had been unable to symbolise her traumatic experiences as a young child; they had lodged inside her as terrifying ‘objects’, beta-elements which could not be thought about. The presence of a small, vulnerable and distressed infant brought back to her some of her own early terrifying experiences, which she could not process; she was compelled to defend herself by pushing these intolerable feelings into the baby. She had certainly pushed them into me in this first session—but better me than the baby! She had demonstrated some capacity to think and symbolise; if she could tolerate psychoanalytic therapy, it might give her a space to make a connection between her affect and her actual experiences, leaving her free of the need to locate her terror and rage in the baby.

Although I wasn’t sure whether I would ever see Sally Anne again—and wondered what I would do if she didn’t come back (should I report her baby as at risk?) She did in fact return, albeit half an hour late, for the next session. To my relief, both
she and the baby seemed much more settled; Sally Anne remarked that the baby loved this room. Sally Anne was less flooded with the events of the past, and was able to tell me more about how her life had changed since the baby was born. The stresses included major strains on the relationship with the baby’s father, as well as major changes in her own lifestyle—she could not work, could not train or exercise, previously an important outlet for her. She had no space for herself. On the other hand she was reluctant to leave the baby with anyone else. She agreed when I suggested that the restrictions brought about by having to care for the baby left her feeling frustrated and helpless, as she had often felt as a child, and that this was contributing to her angry feelings.

She also told me something of one of the institutions where she and her sister had been placed, and how they had assaulted two of the ‘screws’ who were harassing them—and ended up in solitary confinement for two months as a punishment. Several times she compared the clinic building favourably with the institution she was describing—both the building, and my room, were a great improvement on that place, she was at pains to assure me. It seemed clear that she was less afraid of me than before, though still very wary of trusting me—would I punish her if she let me know more about what she was really like? I think she wanted to warn me that she was dangerous, wouldn’t put up with harassment.

The next session was taken up with her overwhelming needs for support, and her fears that her needs could not be met; she felt no-one could be trusted to cope. It was clear that these feelings related to me in the transference; indeed, I felt very strongly that one session a week wasn’t enough, that she would benefit from practical help at home; but she was still absolutely opposed to the idea of any help from ‘the welfare’. She told me how much the baby liked to come to see me, and could acknowledge that she liked to come too—because the baby did. In this session she was able to talk of her ambitions for the future—it seemed that the idea of a future had become possible again.

Though she was very late again for the next session, and complained that she didn’t know how this therapy worked, as she seemed to be angrier since she had been coming than she was before, there were marked changes in the way she and the baby related to each other. Both mother and baby looked well and relaxed; the baby seemed plumper, more alert, and much happier and more content than she had previously. There was much more mutual gazing between mother and baby, and smiling; the baby also gazed intently at me, and smiled. The baby vocalised a lot, and Sally Anne remarked that she didn’t do that anywhere else but in my room. She also said that the baby always seemed to do a pooh when she came to see me, and that if she hadn’t done one for a while Sally Anne didn’t worry be-
cause she knew that it would be all right when she came to see me. She agreed that both she and the baby felt able to let go, get rid of unwanted and uncomfortable feelings, here.

Sally Anne was now much more grounded in the present, and talked mainly about problems with her flatmate and the baby’s father, both of whom she felt were exploiting her; she was however very frightened of standing up to them for fear of losing what little support she did have. She was able to wonder whether she would feel less angry with the baby if she could sort out her conflicts with the adults in her life, and take control of her own situation more. She was also able to think about allowing help from a suitable agency.

Although I was still afraid for the baby, Sally Anne now reported that she hardly growled at the baby at all on some days. I felt that we had made a connection, and that Sally Anne was using the sessions. I felt a little more hopeful for Sally Anne and her child. However this brighter state of affairs was unfortunately interrupted by the prospect of my taking a long break of five weeks.

News of this was devastating to Sally Anne, plunged her back into negative thoughts about the helpers who seemed so nice and helpful but let the bad things happen anyway; she also reported that she had become obsessed with the fear that someone might break in and harm her or the baby. I said I thought it was perhaps her own violently angry feelings that she was afraid of, including very angry feelings with me for deserting her. She became very quiet at this suggestion, but did not respond.

The next session was a very disturbed and disturbing one. She had been feeling very angry again, and the baby seemed reluctant once more to look at her mother, though Sally Anne kept trying to engage her. Sally Anne was able to admit that she did hit the baby sometimes, and had horrible thoughts too. She told me that she had had a terrible dream about the baby being burned with a cigarette; I was extremely anxious, wondering if the mark I could see on the baby’s blanket was a cigarette burn. However the baby seemed intact when Sally Anne changed her.

She had been giving some thought to my suggestions of help from an external agency while I was away, as well as sessions with someone else from the clinic; but she was afraid the agency people would report her if she told them about the violent thoughts, and sometimes violent actions. I explained that I too was bound to report if I thought the baby was in danger, and that so far I hadn’t felt that this was the case. I tried to explain that the purpose of intervention by the child protection agency, if that were to become necessary, would be to help and support her so that
she could look after the baby without risk; babies were only removed if support and help were not successful. I doubted whether she believed me.

She was able to report two dreams, the first she had been able to remember in detail; one in which her father was beating her mother, who was holding her as a little baby; the baby was getting accidentally hit. She could relate to the idea of the father and mother as being parts of herself, and the baby getting hurt in her position between the violent father-feelings and the terrified, abused mother feelings. She was also able for the first time to wonder in a coherent way about the baby’s feelings and experiences, and how exactly her own feelings affected the baby. She said that the baby gets angry and aggressive sometimes, is it because of her own feelings?

In the other dream a white girl was trying to steal her boyfriend; I wondered whether she felt that I was both the robber, and one being stolen; whether my leaving her provoked the dilemma Caroline Garland speaks of in her paper about children in care who are abused, when the object you turn to is also the persecutor who has caused the traumatic event.

She also told me of plans to visit her family in the remote community, and that she had booked a flight a week before my scheduled break. We discussed this issue in terms of whether she would miss more sessions, and I reminded her of the commitment to pay for missed sessions. She flew into a rage at this and left mid-session throwing the fee at me on her way out. I had the feeling she ran away to protect me from her violent rage—much as she did with the baby.

I wrote a letter encouraging her to return to talk about what had upset her so much, and to my relief she did return, and thanked me for my letter to her. She said she thought that she was upset with me for leaving her—she had run out of the session and told Y that I was running out on her. It surprised her to discover that she was upset by my leaving her. I felt encouraged by her increasing ability to connect feelings and actions, her increasing understanding of herself; however this understanding was as yet extremely fragile and I did not think it could survive a long break.

Sally Anne had re-booked her flight to a time that would not interfere with our remaining sessions, and said she would be willing to see one of the other therapists between her return and mine. She also agreed to my contacting an early intervention agency to try and arrange home visits. I had the feeling she wanted to make up for her ’bad’ behaviour the previous session. However the baby seemed very restless and irritable, and would not look at her mother; she did a large pooh while her nappy was being changed, and it leaked onto the rug covering the couch. I thought that Sally Anne had the shits with me in a big way, but was being compliant.
towards me and taking her angry feelings out on the baby. Sally Anne confirmed that she did get very angry with the baby at times, even seemed to enjoy upsetting her—though she made herself snap out of it. She admitted that she was sometimes frightened by her feelings towards the baby, and on one occasion had taken the baby in a panic to Y for safe-keeping.

By the next session the angry feelings had spilled out elsewhere too. Sally Anne had finally given the flatmate marching orders, something she had wanted to do for many months but been too afraid to attempt. When she had finally negotiated a date for the flatmate to leave, the nightmares and flashbacks had ceased, and she had felt much better. However, when the day came, the flatmate had retaliated by accusing her of all kinds of things; she had reported her to the local police, and also reported her to DOCS as an abusive mother. She told Sally Anne that if she was in therapy she must be too crazy to look after a baby properly. All hell had broken loose, Sally Anne in a panic had run away from her home and spent some hours in hiding, with only her mobile phone as a link to the outside world. She had had murderous thoughts of revenge against the flatmate, who had lied about her and had stolen some of her property; but she had resisted the temptation to beat the flatmate up.

In spite of the chaos that Sally Anne reported, the baby was much more settled than for the previous two sessions, and was able to sleep in the session for the first time. In contrast to the previous session where the baby wouldn't look at her mother at all, this time there were periods of mutual gaze, with the baby smiling broadly at her mother. It seemed that all the rage was being directed elsewhere—away from both the baby, and me, the one who was putting her out of her secure place with me.

Sally Anne was also able to talk about her fears of visiting her relatives in the remote community, her fears of taking the baby there. She spoke of ‘the brothers’ drunken rampages through the settlement, when no-one was safe, especially no female. There were also more complaints about the baby’s father, his lack of attention to Sally Anne, and refusal to take responsibility for the baby—he gets all the benefit of time with the baby but doesn’t provide any financial or practical support. I was sending her away to a very dangerous world, with no supports.

Our last session was somewhat fraught—Sally Anne had had a visit from a worker for one of the home help agencies, but the director of the service felt, probably rightly, that Sally Anne was too great a risk for her volunteers to attend to. Sally Anne had confronted the baby’s father and was refusing to have anything more to do with him—though he did ring and leave a message on her mobile, which pleased her. She could acknowledge that she felt I was sending her packing, deserting her. I repeated our arrangements for someone else to see her while I was away,
and again she agreed with them. However I was most doubtful about her capacity to keep the idea of our relationship alive over such a long absence. She expressed fears that she would not be able to leave the community once she was back there—Y could not accompany her because of family commitments. I wondered if I would ever see her again, whether she would be pulled back into her old ways of managing when I left her.

I spoke again to my contact at the early intervention agency, and tried to arrange for follow-up while I was away. However, when I returned I found that Sally Anne had not made contact with the clinic nor with the helping agencies while I was away. She did not arrive for her first session, and when I rang her expressed surprise that she was expected. She said she had just got back, and was ill with flu—this certainly sounded true. She promised to return next week, but again did not arrive. I spoke to Y and discovered that she had tried to come to her session but had arrived over an hour late and given up.

Despite numerous attempts, phone calls to Y and messages, I was unable to re-establish contact. I understood that the separation had indeed been too long for her to tolerate.

I did have one further message from her, some four months later—she rang to say she desperately needed to see me as she wasn’t coping. Unfortunately she left it on the private telephone line at the clinic, and the message did not reach me for two days. By the time it did, she was again uncontactable. Both telephone and mobile phone had been cut off. I was the one left desperate to make contact, and having no success—again the experience was pushed into me. I made contact with Y, who revealed that Sally Anne had started drinking again, had come over and left the baby with Y one evening, saying she couldn’t look after her any more; but had returned late that night, drunk, and taken off into the night with the baby. Y had tried to reason with Sally Anne, but eventually, in her concern for the baby, had reported her to DOCS herself. The end result of this was that DOCS refused to give her any further information about what was happening with Sally Anne and the baby. And I have no further information about them.

**Discussion**

This patient shows many of the features described by Caroline Garland in the two papers she gave in Sydney in 2000. Sally Anne seems to fit the profile of the group of institutionalised children who had received enough good input in their early lives to make a clear distinction between right and wrong, and to protest about the treatment they were subjected to (Garland, 2000, ii, p. 3). Like the people in this...
group, she was treated as a trouble maker and repeatedly punished for her protests. Like them, she became increasingly violent and unmanageable in her behaviour. Like them, she was and is compelled to enact her states of mind because they can’t be thought about. Like them, she finds conflict, and separations, unbearable. Like them, when she wants help it has to be available immediately; she cannot wait, as she could not wait for two days for me to get back to her.

While Sally Anne could partly process some of the things that had happened to her, the reality of her small baby daughter’s frailty, helplessness, vulnerability, had too great an emotional impact to be able to be thought about—she felt compelled to fight aggressively, or run, rather than risk feeling like the small helpless terrified infant she had been (GARLAND, 2000, i, pp. 18–19). The baby had to have all these feeling put into her—as did I, again and again, in the sessions.

As she became able to put some of her thoughts, feelings, fears into words, she did however begin to be able to gain some distance from unbearable emotions, and to be able to think rather than to act. Both she and the baby benefited from this. Also, as she became less overwhelmed by intrusive thoughts and feelings about her past, she was able to start to deal with situations in the present where she felt she was being exploited and controlled.

In her paper on institutionalisation in childhood (GARLAND, 2000, i), Garland speaks of the abused person’s ‘inability to trust others, particularly those in any position of authority’, and how this is often expressed in its reversal, that is, as chronic untrustworthiness. Effectively this reversal obliges the ‘other’ to be the one who is disappointed, abandoned, let down, betrayed; the one who is in a state of chronic apprehensiveness. Broken appointments, promises, hearts, unmet debts may all be frequent. Alcohol or other addictive substances may seem a more reliable and controllable object than another person. This makes treatment of patients like this very difficult (GARLAND, 2000, ii, p 12). Yet, like the man Garland described in her paper, Sally Anne was quick to respond to interpretations and, again like her patient, her states of tension seemed to be relieved by having her feelings understood.

Caroline Garland ends her paper by emphasising how important it is to keep offering help to people like this, and to try to understand and manage the repeated breakdowns of such help. Attempts to improve the situation of indigenous Australians will involve trying to assist many whose stories are similar to Sally Anne’s. Understanding the problems which are likely to arise may help workers to keep alive in themselves a feeling of the possibility of hope, of progress, of goodness, in the face of repeated rejections; how else can we expect to keep such hope live in these very traumatised individuals?
References


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