

The Signal



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Infants Born of Rape

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INTRODUCTION - FRANCES THOMSON SALO

These papers begin to explore a painful subject that at times may feel almost unthinkable, that of infants who are born as the result of a rape. These papers were part of a symposium on 'Infants and rape' presented at the World Association of Infant Mental Health 2006 Congress in Paris. Campbell Paul in the context of work with sick babies discusses questions about self representation and identity when there has been rape, and the defences used. Amanda Jones describes how a young, deeply traumatized asylum-seeking mother used a psychodynamic, systemically sensitive, parent-infant intervention, to find a way to accept, and gradually love, her seventeen month old first-born son born as a consequence of

her suffering multiple rapes. Juliet Hopkins concludes with a discussion of the two papers.

The papers explore the ways that a baby conceived as a result of rape might be affected by the psychic work the mother needs to do to enable the baby to come alive in her mind as a person in his or her own right. With these babies, we need to consider the autonomy of the fragile self. It is crucial to be aware of the effects on infants and their families, and to refine and extend therapeutic approaches. Such work is increasing relevant given the conditions in which some infants and their families currently live. It is, for example, estimated that in Rwanda 10,000 babies were born as a result of genocidal rape. Perhaps it is only when clinicians can allow themselves to hear the pain in such shocking cases that these babies and their mothers can fully get the help they need.

When babies are born of rape their mothers frequently wish that they and their babies would die. Some mothers are not able to mother their babies and some give them away or try to kill them. The whole subject of these infants may be under a taboo of silence in their communities. Some resilient babies, however, help ease their mothers' pain and suffering. How a mother tells her child about his or her conception depends on how she has been able to find a place for an internal representation of a good father alongside the representation of the rapist biological father. The context is always important (Emde, R, personal communication, 18.5.06).

One Rwandan mother was reported as saying that she would tell her son about his conception and add that God is not angry with either of them, that it happened because of war, and that God loves them (Wax, 2004).

WORKING WITH A SICK BABY BORN OF A RAPE - CAMPBELL PAUL

While no expert on the tragedy of rape I offer some of my thoughts from a clinical perspective. As it is 150 years since Sigmund Freud was born, it is timely to reflect on the question of where we have come to in our understanding of human sexuality and related issues since then.

Sexual violence is an issue both overwhelming in its enormity and yet in many ways hidden. The World Health Organisation (Krug, 2002) special publication on violence details that women in a range of countries, from 10% in Brazil to 46% in Peru¹, report incidents (often repeated) of attempted or completed forced sex by intimate partners during their lifetime. Up to fifty percent of women have therefore experienced something like rape or a similar assault within their own intimate relationships. As infant mental health workers, I suspect it is an issue we rarely ask about. What does it mean that so many women, presumably so many mothers of the infants referred to us, have been so violated? Do they make a complete disjunction between these assaults and the acts of sexual union that led to the conception of their babies? Or maybe they make a range of accommodations.

1. Other examples are 23% in UK, 15% in Canada.

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Rape occurs in a range of settings – what meaning does it have for the woman? What effect does it have upon the human integrity of the man? I shall, however, leave aside this question, one that is riven with controversy, to concentrate on mothers and infants. The consequences for women are many: gynaecological trauma, infections, STDs, HIV/AIDS, as well as a range of psychiatric and psychological disturbances (depression, PTSD, suicidal ideation) – and of course the likelihood of an unwanted pregnancy. Other social consequences can be profound: women may be blamed, shamed and excluded from their own families, indeed in some communities expelled from the entire community. (In Kenya, women raped by soldiers were, on joining the settlement, rejected by their husbands, and set up their own community with their children.) Women may be blamed for bringing shame upon their families or partners, and justice seems so often a totally remote concept. Rape is at least to some extent a product of social mores, rules and behaviour, whether these are acknowledged or not. In some communities the woman and the baby are seen as the evil, guilty partners and are sometimes killed. Rape has for centuries been used as a weapon of war as part of a more conscious, systematic process but can also occur in the midst of severe social chaos or poverty where law has broken down – for example currently in Liberia at least 40% of women have been raped and fear this would happen to their daughters. The president, Ellen Johnson Sirleaf, is leading a fightback and courageously declared her experience of attempted rape when in prison earlier on.

Even in the 20th and 21st centuries, in the former Yugoslavia and Rwanda, women were held captive for the purpose of demoralising and destroying a community – a form of genocide – through alienating and shaming women, their husbands, their sons, their fathers as well as the children themselves. The trauma of the capture and sexual assault itself is then perpetuated on a daily basis as the family is *faced* with the offspring of their tormentors in their midst.

How these infants themselves have fared in this context is not clear – we can only imagine how disruptive it must be.

In statements that victims of rape made to the Medical Foundation for the Care of Victims of Torture in the UK, many women said that they did not blame the child, whom they saw as ‘an ‘innocent victim of war (Papineni, 2003, p 362)’. While it is not known how many infants have been abandoned, clearly many still live with their mothers, who may identify with the child and also fear the infant being described as ‘filth’ by the whole community. In Rwanda, such children are often known as ‘les enfants de mauvais souvenir’, that is, children of bad memories or ‘*children of hate*’ (Papineni, 2003).

How difficult it must be to seek help in such circumstances: the mother is doubly aware of her shame in that she knows that she was forced to gratify her oppressor’s desire and she knows that everyone in her community knows this as well. What does she believe her infant will know? What does she glean from his eyes to her?

Correspondents Report (Australian Broadcasting Corporation 10.2.06) addressed some of these questions in a program in which two Bosnian women discussed their dilemmas. Safeda wondered when to tell her adopted son that his Muslim mother was raped by a Serbian soldier. Safeda was ill and about to die and was in great conflict about whether to tell her son about his conception. His biological mother had abandoned him so that he had not been breastfed; he was adopted by a Muslim couple. One question was whether he should try to find his mother – ‘Not really, he has parents, there’s love from the adoptive parents, his mother especially’. Another question was whether to tell him that he was Muslim – ‘He is more Muslim than Christian... We will see this happen again. ... Their children live with us.’ The second woman, who was single, was raped by soldiers and became pregnant. She poignantly said of her son, ‘He’s my whole life. When I go, he’ll be all on his own. But my son

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will be a good man.' Even though her son had a very divergent parenthood and traumatic conception, his mother was able to detach him from wrongdoing done to her by his father. Can she talk of his father? Can she even think of his father? As clinicians we see some mothers whose babies present with problems, who say, 'His father is not around' or 'I don't know who her father is'. Should we explore this with mothers or leave things unsaid?

Also of interest was the process of making the television documentary, of daring to talk about a topic of which so many were ashamed. For these mothers, despite the inevitable traumatic memories experienced by the mother or adoptive mother, the child was *a person in his own right* – detached, as it were, from the 'father', if I can use that term,. Somehow they made this *dissociation* possible.

For families whom I see at the Royal Children's Hospital, Melbourne, this disjunction is not always possible, as with Helen², 28 years old, and her 5-month-old daughter, Sarah. Helen had been sexually assaulted and anally penetrated by a stranger when she was alone in the street one night. She has suffered considerable anxiety symptoms and severe gynaecological and bowel symptoms with intermittent pain and rectal bleeding. She subsequently became pregnant to her husband, unrelated to the sexual assault. She found the whole process of intercourse, pregnancy and childbirth very traumatising, but managed it in a private, self-contained way. Her daughter, Sarah, had become embroiled in Helen's sexual trauma as she reminded her of the assailant of some years before. The baby presented with distress and feeding difficulties, refusing bottles and Helen had 'lost all confidence in her'. For Helen, as it unfolded in therapy, it was hard to provide any sense of containing limits for her. She felt guilty for connecting her daughter to the violence done to her. But as she became aware of this unconscious connection: men – violence – rape

² Names have been changed to protect confidentiality.

– her memory – sexuality – her daughter, there seemed to be some degree of freeing that enabled her to provide more appropriate limits and containment and to help her regain better self-regulation and homeostasis.

Helen and Sarah are doing well at present but there remain tensions and lacunae in the relationship between Sarah's father and mother – many things had never been said between them. They have recently commenced marital counselling which Helen seems to find confronting and helpful, but there has been some freeing of Sarah from this sexual trauma.

What of those babies conceived in communities which are not in the grip of war or equivalent chaos? There are many babies conceived in rape in our communities whom we do not know about. In a 3-year longitudinal telephone survey in USA about trauma and health, 4,000 women were followed up three times a year and 6% reported rape-related pregnancies (Holmes et al, 1996). The context is that in USA an estimated 680,000 of women more than 18 years old are assaulted each year but 60% of all rape cases are females less than 18 years old, so that the figure may be much higher. Only 15% report the crime to the police. The researchers asked about non-consensual assault, with force or threat of force (with some sexual penetration of vagina/rectum/mouth). 80% agreed to interview. The results suggested a 13.6% *lifetime* prevalence rate of rape. In USA there are estimated to be about 32,000 rape-related pregnancies per year. For many this means having to experience the difficulties of being a very young teen mother. These figures are in the context of an estimated 3 million unintended pregnancies in USA per year. Often the offender was known – even well known - to the baby's mother, which suggests links to ongoing family violence. There is a high prevalence (more than 45%) of multiple assaults. Many were never disclosed to law enforcement or health workers. (There are different contexts: date rape, marital rape,

incest and random sexual assault.) Or were they disclosed to the child? It is a complex problem: 30% for example did not discover they were pregnant until the second trimester, so that termination of the pregnancy becomes problematic. 30% opted to keep their baby, 50% had an abortion, 6% placed the child for adoption and 12% had a spontaneous termination.

CHANTELLE

Here I shall describe Chantelle, who was born early – too early in many ways. Her mother, Kerry had a complicated pregnancy, with high blood pressure and pre-eclampsia leading to a semi-urgent Caesarean section at 34 weeks. Chantelle had severe respiratory distress syndrome and needed five days of ventilation; she also had a mass in her abdomen and possible pre-birth brain damage, so that her start was very problematic. Kerry, aged 35 years, had also had a very traumatic life, with many presentations to mental health facilities and multiple diagnoses, mainly of Borderline Personality Disorder but including bipolar disorder. She had certainly been very sad and anxious about Chantelle's birth, fearful that she might not be able to bond with her or able to care for her. She feared losing her baby, but was nonetheless very honest about this experience and her feelings. She talked of her concerns that she had poor control of her own anger. 'I sometimes think of hitting her – but I would never do it.' She had found herself losing most of her relationships over the course of her early adulthood, including those of her long term foster parents who felt they could no longer bear the hurtful disappointments that resulted from their attempts to keep in touch with Kerry. She was unpredictable – one minute she was sad and needing their love, at other times angry, distancing and rejecting, and on rare occasions violently threatening.

Kerry revealed that she had been a child born of rape. She never knew her father – her birth mother found it impossible to talk about it, only that Kerry was conceived by force, by a man she had never known. Kerry found this out in her

early teens. There remained big gaps in her memory which seemed to make things worse for her – she was a person who could never know herself. She had begun self harming at 14 years but was, however, able to sustain her studies and get a job.

Her partner relationships had been many, complicated and disrupted, but in recent years she had settled with Sam, her current partner; there had been consistency, albeit with dependency. She hated him - he had raped her. She had refused sexual relations with him, but he insisted and forced her – she felt violated and dirty. Chantelle was a result of this intra-marital rape. It was as if Kerry existed without any sense of *self and boundary*, just as she fantasised it had happened to her mother – a repetition. Chantelle had medical problems: she had small brain haemorrhages and she looked ‘odd’ but no specific diagnosis was made. Kerry said how hard it was to care for her baby – she wanted so desperately to do this but felt incompetent and unable; she felt she needed help with basic aspects of child care. Indeed the ward nursing staff were very concerned at the way Kerry bathed Chantelle, whom she let slip into the water. Chantelle was very stiff and mechanical and it was a joyless and unsmiling procedure. Kerry seemed very detached from Chantelle who herself had persistent avoidance of direct gaze with her mother as well as others. It was as if Kerry, although a bright woman, had *no idea about her baby’s body*, no idea how to hold, mould, contain it.

She said that Chantelle being sick made her very confused and she wondered whether Chantelle’s illness was a *punishment* for Kerry’s problems or whether Chantelle was being punished. For what? For being her daughter? Kerry said that when she looked into her daughter’s face she saw herself - but as a shell of a person, as somehow ‘*bad, damaged goods*’. Her past was projected into her daughter – or was it *her daughter herself, she found it difficult to distinguish*. She thought that maybe Chantelle was really just her husband’s daughter and there was none of herself in her daughter at

all. Somehow there was a mockery of herself. Projections seemed to fly about like missiles and in the midst of this Kerry saw herself reflected in her daughter’s face as bad, unwanted, abandoned and somehow evil.

With the huge gaps in her personal narrative she fitted the fantasy of her own father violating her mother and herself into her self concept, that she must be bad and unlovable, like him. She also fitted this into her view of her daughter.

Donald Winnicott, (1971) paediatrician and psychoanalyst, wrote about the importance of the mirror role of the mother (and it could be the father), whose task is to enliven the baby through face-to-face engagement (and holding of the baby). In this context, ‘the baby, looking at the mother ... sees herself reflected in the mother’s face’ For Kerry, as she looks into her baby’s face, she sees a shameful, damaged image of herself reflected and this is the image of emptiness that Chantelle may then see reflected back to her through what she sees in her mother’s face; she then avoids the gaze of her mother and others.

Kerry was admitted to a mother-baby psychiatric unit with Chantelle for a couple of weeks, but still felt unsafe to look after Chantelle, despite improved self regulation, feeding, sleeping and containment of her medical problems. Chantelle went home with her parents, but Kerry was not allowed to be alone with her on a Protective Services’ order, as she was unable to say that she felt completely safe caring for her daughter. Chantelle remains an infant of concern, although developing a relationship with the family support worker who visits regularly and has a vital role with Chantelle and her mother.

Chantelle *was* able to play, but usually began an interaction with a tense, hypervigilant gaze, her eyes reaching to the back of the eyes of whoever met her, so that there was a shift in the way she related to people. Her penetrating gaze seemed to be one of self defence. As Chantelle and her parents have moved out of

the Children’s Hospital geographical area we are not directly involved in her ongoing treatment. Her parents are her primary carers, she is now one year old and her physical and social development seem satisfactory. We remain concerned about her emotional development. Will she be able to be helped out of this chain of intergenerational traumatic projections? Kerry has been honest about her baby, in a protective way, even though the risk is high that she may harm her. The workers have strong feelings about Chantelle and have been able to work with them. Kerry was welcoming of our interventions (the mental health service), as well as those of her own therapist, the infant-focused family worker and Protective Services. So there is some cautious optimism.

To summarise, when pregnancy results from rape the family, the community, everyone has views about the woman – if they know - and about the potential baby. But what does the mother feel about herself and her baby, who is often seen as a ‘bastard’ infant, as evil and a punishment? Can she love her baby? I think that a critical role for health professionals is to gently engage with parents and the baby in an attempt to identify the powerful projections that lodge on the baby, and hopefully attempt to detach some of these. In the two cases here, the mothers volunteered their history of sexual assault. What of the many women whose babies have symptoms of a range of common infant mental health paediatric problems but who are unable to tell us about their assault? How can we establish trust in such women in a way that is facilitating? So much depends on the context. These two women presented their babies through a non-stigmatising child health system, which may have made it easier for them to trust. For others it may be that a longer term relationship-based home visiting early intervention program (Zeanah, 2006; Lyons-Ruth, 2006) can provide the necessary sense of safe containment to share feelings of shame and anger. Agencies such as sexual assault units can play a vital role in supporting

communities if they provide a safe, supportive setting in which terrible events can be disclosed to someone who will sensitively listen. Perhaps through these means we can help the mother see that her baby's own story must develop, separate from the narrative of the rape that resulted in the conception – that her baby becomes an independent person.

For clinicians seeing mothers before they have made disclosure of sexual abuse, when we ask a mother if her pregnancy was 'planned', we are asking a lot. It is not an easy question. For a woman who has been sexually assaulted, especially within her partner relationship, it can be a crucial question. She would be wise to assess us well before answering this question – if she does divulge the fact of rape leading to conception and the baby she is consulting us about. She needs to know that we – and the system we work in – can support her in a containing, non-judgemental way. But if she feels safe to tell us, I believe that there is a remarkable opportunity to help enliven the baby. By speaking of it, the mother may be able to begin to consciously disconnect any poisonous projections there may be onto her baby. She may feel better able to see her son, her daughter - as a separate person.

The baby whose very existence means violence can be seen by his mother as always a reminder of the violence – he is the embodiment, literally, of the perpetrator and at the same time the embodiment of herself as a victim. To look at him can be painfully distressing. But WE can look – we can meet and greet him as a *new* person, we can engage him, and help his mother more by possibly seeing him NOT as a representative of hate but *one of hope*. It seems a unique opportunity since it may prove impossible for a mother to talk of this again until in the midst of the intensity of her baby's *adolescence*, it having been a dark secret for so many years. If the mother can talk of it, this can prevent some of the build up of sadness, self loathing, hatred and detachment that can occur. At other times a shallow defence of denial of the rape and its impact can

lead to parents avoiding an intimate relationship with their child. So I believe it is important to be receptive to such stories and secrets – the time of the new baby's life is one of great change, flux and of promise.

In summing up communication between infant and mother, Winnicott wrote, speaking for the baby:

I find you

You survive what I do to you as I recognize you as not-me;

I use you;

I forget you;

But you remember me;

I keep forgetting you;

I lose you;

I am sad.

So I hope that we are all able in our different contexts to help babies and their parents find – lose – and find again – each other, be sad – and then happy all over again. The baby can become a person.

RAPED IN UTERO - AMANDA JONES³

I met Fatima and Daniel when Daniel was seventeen months old. The memory of my first sight of them is vivid. As I was walking towards the clinic early in the morning I noticed a young African mother sitting on a wall with a screaming toddler positioned across her lap whilst she changed his nappy. It was a cold morning. The mother's face was very still; she was also painfully thin. I did not realise this couple was the new referral I was due to meet an hour later. A support worker had made the referral and had described a depressed mother who was finding her son's behaviour hard to manage. The support worker asked if she and an interpreter who knew the mother could accompany Fatima to the first appointment. I agreed.

When I went to the waiting room

3. A modified version of this paper was subsequently published in the Journal of Child Psychotherapy as Levels of change in parent-infant psychotherapy, 2006 Vol 32 pp 295-311, publishers: Taylor and Francis, <http://www.tandf.co.uk>.

there was the couple I had seen on the wall. The room was a tip. Daniel was throwing toys around in a mindless way. When I greeted them Fatima did not look up at me, nor did Daniel. I started to lead them towards the room. Daniel ran ahead, unsteadily, as if he knew where he was going. On this brief journey down the corridor, he fell over three times. Not once did he look backwards to his mother for help. He literally fell into the room. Although I did not know it at the time, in those few moments, Daniel revealed his internal object relationship with his mother: she was not there in his mind as a mother he sought help from; he split off and denied any awareness of wanting a response from her or indeed of wanting contact or help from any adult. Yet, in the tripping, he demonstrated how he was continually *falling to pieces* and then having to gather himself together.

Fatima sat down. She did not remove her coat, or Daniel's. As the family support worker tried to take Daniel's coat off, he hit her face. Within minutes the room was trashed. Daniel tipped over all the boxes, pushed everything off the table, and threw a box of crayons at me. I felt as if something unstoppable was going on. I felt besieged. My emotional response suggested that powerful projective identificatory processes were in play between this mother and son.

It was hard to know how to start. I did not know how to talk about parent-infant therapy to a woman who had clearly come from a situation where therapy would be an alien concept. I fumbled and said that the support worker had told me that Fatima seemed very low, and that I knew it was hard to care for a small child when a mother was unhappy and lacked support. Fatima still did not look at me, but I could see tears rolling down her cheeks. Daniel registered his mother's tears. A few seconds later he picked up a wooden object. Quick as a flash he went over to his mother and, with a blank expression, hit her across the head. Her bodily response was

startling: she brought both arms up to shield her face, and turned away from Daniel. He froze, hand in the air, as if poised to hit again, and she remained frozen. She made no attempt to limit Daniel, nor did she make any sound throughout the interaction.

This brief sequence captured a repeating behavioural pattern, a pattern which enacted in actions a mix of memories and feelings that could not be 'remembered' and put into words. Contact between them seemed catastrophic. Somewhat disorientated, I said to Fatima that I imagined she had gone through quite a journey to get to the UK: what would it be important for me to know? It was incredibly hard to follow her story. I realized there had been a civil war in her African country of origin and she had been imprisoned for seven months. Fatima managed to convey how during this time she was interrogated, beaten and gang raped, sometimes on a daily basis. I could see scars on her neck. Like many of the other women, she expected to die from her injuries, or be killed. This was not a fantasy: many of her fellow captives did not survive. Fatima's affect was flat, as if she had felt forced to recount details of her rape ordeals on many occasions.

As Fatima spoke of being raped, I started to realise that Daniel's father was likely to have been one of the military men. As I conceived this terrible thought, Daniel was banging an object noisily on the table. The sound frightened his mother; she covered her ears. Daniel came up to me and screamed, lashing at my face. Fatima made no move to touch him, but she managed to push a bottle of milk towards him. Daniel tried to hit her head with it, creating yet another startle response. He then ran and sat in a corner and sucked on the bottle. As his mother continued to talk, Daniel slowly came nearer to me. I hung my hand down from the chair and, to my surprise, felt his head start to push rhythmically against my hand, as if stroking himself. He stayed there, facing the wall, but he had made contact. I talked to

him; his mother seemed surprised. Through the interpreter, I put into words what it might feel like to feel so full of terrifying feelings.

Fatima continued and described in a monotone voice how she escaped from the prison and after her arrival in the UK, having had no antenatal care, gave birth to Daniel. She had tried to leave the hospital without him. Somehow – and it is not clear how – she ended up taking him back to her bed and breakfast accommodation. She said she had wanted him aborted or removed from her.

For the first nine months of Daniel's life he spent most of his time in a room with a deeply depressed and traumatized mother who described feeling terrorized by his cries. She felt unable to touch Daniel, let alone hold him, when he showed distress. Then a woman took pity on them and offered to let them sleep on her floor in our service area. This woman encouraged Fatima to go to the local health clinic with Daniel where the family support worker had noticed signs of attachment disturbance and referred to our service.

Towards the end of this first two hour session I asked Fatima about life before her imprisonment. She looked at me in a confused way. She did not know what I meant. Again I felt disorientated, but persisted, saying I wondered about her parents, her early life. She said she had no memories. Then she mumbled that her parents had died when she was a child, in an accident. I asked how old she had been; she could not remember. I said that the horrifying circumstances she had recently been through might have also opened up the wound of that loss which, for a child, would have felt incomprehensible and cruel. She nodded. I describe this because of how, amidst the violence and trauma, tiny seeds of information were being offered that gave me reason to think this young woman might be able to use therapy, and make an attachment to me.

As I was so alarmed by Daniel's behaviour and his mother's state of mind, I offered to see them twice a

week. I described this to Fatima, and how I would be available over a sustained period of time. I suggested that the family support worker join us for the first few sessions, as she was clearly important to Fatima. The interpreter said she would be able to work with us on a regular basis. As far as was possible, we made a regular therapy space. Fatima agreed. I could not get them out of my mind.

The next few sessions were suffused with Fatima's prison experiences, horrifying material that affected us all profoundly. I could see how it was impossible for her to think of Daniel as a small child in need of help. I learnt quickly the ways Daniel managed distress, mostly by banging his head on the floor. It was not easy, but whenever this happened, I would interrupt his mother and find ways to ensure we attended to Daniel's state. Fatima could feel angered by this.

Daniel was hyperactive and a poor sleeper and eater. I can only describe him as *pushing himself into or onto objects* in a mindless way. He was incredibly clumsy, always falling down and hurting himself, and then hitting his head hard on the floor to soothe his hurt, whilst his mother remained still. Fatima could admit that she did not want to help Daniel, or touch him. Again and again she spoke of how she would have given him up for adoption at birth had she been given the choice. It was hard to hear such hostility but I think it paved the way for other feelings to emerge. Fatima knew she could tell me if she no longer felt able to parent Daniel. In the context of her hatred being taken seriously, more benign feelings started to grow.

As the full horror of Fatima's imprisonment emerged, as well as her neglect of Daniel's emotional needs, I became more and more preoccupied with how Daniel too had been imprisoned in two situations. Firstly, when in utero during his mother's assaults and secondly, in the first months of his life, Daniel had been trapped with his mother's state of mind. In the present, we had to endure repeated experiences of feeling trapped in an enclosed

space which quickly became filled with terrifying anger and pain. I was continually worried as to how the therapy room could be felt as imprisoning for him. Daniel's stress response system was primed to perceive all of us as potential attackers to be fought off. His early neglect rendered him vulnerable to feeling assailed by any intense feeling coming from within or without. He coped with this by trying, particularly through his hitting, to get rid of such feelings. Over and over again I witnessed him mindlessly approaching his mother's head and hitting it. But his mother contributed to the pattern and it was my task to help her consider this dimension: to add new perspectives to her experience of being a helpless victim.

During this early period of the work, Fatima remembered my question about her parents. She often spoke of how she wished her father could have protected her from what happened to her. We moved in and out of talking about the imprisonment and how, as a child, she had also felt imprisoned by feelings she did not understand. The wish for her father's protection was, I think, critical in terms of some affection slowly starting to come alive for Daniel. It implied that there was, as Serge Lebovici described, a *fantasmatic baby* in her unconscious: the *want* to give her father a baby. Thus her want for maternity was already present as a small child. In her core internal world there was a creative parental couple. The fact that she had managed to care for Daniel's basic needs implies a strong, previously unconscious, commitment to care for a baby, predicated probably on the fact that she had been loved as a baby.

In the transference with me, I occupied many positions, but often I felt Fatima experienced me as if I was a father-figure, a paternal presence. I offered hope and protection and yet also, continually, the reality of absence and what felt like harsh limitations. I was aware of the depth of Fatima and Daniel's growing attachments to me.

In the first phase of the work with Fatima and Daniel I did not mention the use of video. It was hard to imagine using it with an interpreter, and with Daniel who could become so hard to handle. I also thought Fatima might feel intruded upon, raped again, if I filmed her. But I felt I was observing a behavioural pattern that it might help Fatima to see for herself: namely, her profound startle response when Daniel hit or approached her face, and then – swiftly – I observed her move into become taunting or aggressive with him. The movement between aggressed and aggressor flipped incredibly quickly between them.

When I explained to Fatima that it could help sometimes to watch together what happened between parent and child she cried, saying she would not know how to play with Daniel. I said I realized that finding ways to reach one another was painful, and that the video might give clues as to what works and what goes askew. Fatima agreed, but I think she did so out of a sense of obligation to me, not because she wanted to see herself.

So in the sixth session I filmed a three-minute interaction. In it, Daniel picked up a plastic phone and spoke into it. His mother responded, as if answering him. I think Daniel was thrilled at the potential play between them. His body was tense with anticipation. Then Fatima broke contact, she looked to the floor. Daniel froze. Then he lunged at his mother's head, hitting her with the telephone. She pulled back, as if she had been beaten by a grown man. Within a few moments, Fatima recovered and – under the duress of the film – attempted to continue some form of play with Daniel. But her play was impregnated with anger. She taunted and humiliated him by holding a small toy just out of his reach. Daniel tried to grasp it as she brought it nearer to him, then just as he was about to grab it, she lifted it high again. After several thwarted attempts, Daniel cried out in frustration. At this point Fatima smiled, as if unconsciously triumphing at having the power

to cause him to cry out. She was relieved, I think, no longer in the position of terrorized victim. Fatima then proceeded to pile up bricks in Daniel's lap, which covered his genitals.

SOME THOUGHTS ABOUT THE INTERACTION

At first, there was contact in the play and the play was about telephone communication. When Fatima broke it, cutting the line so to speak, perhaps she needed Daniel to be in touch with the theme of something unwanted. She had not wanted to be filmed. I think Daniel felt a primitive experience of catastrophic loss: in this instance initiated by me, enacted by his mother, and experienced by him. He felt the disconnection and mood, he felt unwanted - his deepest trauma - and threatened, and he hit out at her. He induced in her, fleetingly, a feeling of pain and terror which she seemed to experience as an assault by a grown up, not a small child. Then Fatima adopted the aggressive position, creating in Daniel a diluted version of the humiliation and helplessness, the kind of feelings she possibly felt when raped or tortured. Daniel then ended up in the vulnerable position with his penis under bricks.

At a deeper level still, Fatima seemed to repeat the experience of loss: loss of a potentially responsive, loving figure. Her feelings about the traumatic loss of her parents were, at this stage, heavily defended against. Daniel too experienced loss of a responsive parent in these moments of daily abandonment. I helped Fatima talk about her feelings towards me filming her, and how my power and the power of the military men became confused. I think she felt she lost me as a helpful figure during the filming and this contributed to the enacted rupture of contact.

When Fatima watched this interaction in the following session, she physically flinched again when she saw Daniel hit her. Fatima asked to watch it twice. She said how she

seemed so scared. She asked: how could such a little child frighten her so much? Then she was able to notice how she became angry. This was a critical moment. Fatima's noticed how she retaliated. I am not sure this could have been thought about, with the same speed, and in the same way, without the visual aid.

Throughout the rest of the session, after Fatima had seen and felt the visual interaction, she was able to put into words more clearly how Daniel terrified her, how she felt him to be a huge military man, and how his needs felt like the soldiers' needs: she hated having to attend to them, she felt she was submitting. It was hard to listen to yet somehow she managed to hold Daniel on her lap both whilst she watched the tape, and whilst she free associated to it. Although what she was saying was distressing, Daniel rested against her. He was calm.

The next week, after these connections, something surprising happened. In the midst of all of the previous, very entrenched, fight-flight-freeze responses, a new intimacy was allowed to develop. I filmed, without knowing it, the first time Daniel was ever allowed to kiss his mother's face and mouth. During the interaction Daniel was on her lap.

THE KISS

At one point their eyes met. Fatima pulled back but Daniel persisted in reaching with his hand to touch her cheek. She could let him. Then, with both hands, he pulled their faces closer and opened his mouth wide. Fatima closed her eyes. Daniel's mouth touched her jaw line. Fatima flinched but somehow managed to stay still. A small smile started to emerge; her face softened. Daniel registered this non-verbal invitation and grabbed her shirt. He kissed the side of her face clumsily, beautifully, and she moved her mouth towards him. He then, very gently, made lip-to-lip contact with his mother. Her face broke into a full smile; so did his. Then, as if the intensity needed diluting, he slipped off her lap and started to play on the floor.

A moment of intimacy happened and the video was able to capture a new movement. The next week, when we watched it, Fatima told me how it was the first kiss, and she wept as she felt sorrow for Daniel. This was the first expression of feeling *for* him. She also noticed how bewildered Daniel was when she had pulled back from him. She saw how his eyes looked painfully bewildered when she had stilled in response to his hesitant, and yet determined, attempt to make contact. She could *see* his confusion and distress. She was in a different, observer position and could see Daniel's experience from a different perspective (Britton, 1989).

This helped Fatima to describe how her head and face had been traumatized during the beatings when in prison. She could see how Daniel reaching for her triggered a startle reaction, and then how this confused him. At this point I said how it was as if she was starting to feel that they had both been brutalized and raped. This contributed a new narrative: Fatima and Daniel as a mother and baby who had both suffered.

The kiss, held on film and in our minds, provided a transforming moment. Thereafter, Daniel was not automatically equated with a raping penis; he started to become a little baby, traumatized too. In a way, this was a new moment of conception for Daniel. It helped Fatima build up a sense that she was his mother, who had chosen to try and help him, and she could be effective in protecting him.

From my perspective, Fatima's tendency to use automatic defensive processes – especially projective identification – started to change. By owning her own wish to retaliate and hurt, and putting such feelings into words, how she behaved changed. It would take longer for Daniel.

In the next phase Fatima and I worked together like a parental couple to help Daniel with his tendency to violently eject distressing states of mind. Fatima began to understand Daniel's bodily violence as a way of getting us, and particularly his mother, to experience

his as-yet unrepresented feelings of terror and rage in the context of feeling abandoned. As Daniel started to find his mother, he became more vulnerable. He started to use me, as a relatively robust third figure, to help him express a particularly desolate experience. In one session, when his mother was unwell, he hid under the desk for some minutes, as if trying to find a safe space. Her physical fragility frightened him. As I was speaking to Fatima, Daniel suddenly came up beside me and grabbed my hair. He hung off it; it was painful. When I managed to look in his eyes, they were blank. I did not have a sense of Daniel trying to hurt me. I felt he had disappeared into a dissociated space in which he felt nothing but I felt, and experienced, his need to cling, as if for his life. This pattern manifested again and again over the ensuing weeks. I lost handfuls of hair because Daniel *could not* let go. The interactions were hard to handle. But over the months we worked on understanding Daniel's need to cling and Fatima and I spoke of it as his *capacity to cling*. The trigger his mother and I realized was always when he felt dropped or abandoned.

This case has left me wondering about the transmission of unconscious forces between the generations. Out of such circumstances, how can we explain Daniel's determined capacity to cling, shown both when in utero, and then vividly through the scenes with my hair? Perhaps the unconscious force of his maternal grandparents was, at some level, *always* being transmitted. That force has now found a way into consciousness and words, and it shows now in the close physical and emotional contact he and his mother can now enjoy.

I think Daniel's first kiss was a transformative moment. Fatima and I became the new parental couple who could love him and want him as he was. The men who brutalized Fatima were propelled by complex and tragic unconscious forces. In the present therapy something of Fatima's parents came alive again and allowed the two of us, although both female,

to have a deep enough therapeutic relationship such that Daniel could in a way be conceived and born again.

DISCUSSION - JULIET HOPKINS

What these papers convey is truly shocking. The therapists have protected us from the full impact of their patients' horrifying experiences by the containment of their understanding and the hopeful outcome of their cases but horror must remain with us at the sadistic act of rape and its most tragic and lasting consequences.

Campbell Paul has referred to the condemning attitude to rape in many different countries but as therapists we are caught up in our own emotions and cultural values in this subject, too. What challenging issues therapists deal with and what decisions would we have made? Campbell Paul reminded us of the significance of the mother in the child's mind. In view of the shock and horror surrounding rape, it is not surprising that there is a dearth of research on any outcomes for babies of rape. The anecdotal evidence shows that many are aborted or abandoned at birth by mothers who refuse to look at them, and among those who are kept by their mothers, girls vastly outnumber boys.

Amanda Jones has shown how Daniel's approach was a trauma trigger for Fatima but the evidence, particularly from Bosnia, suggests that girls cannot escape being trauma triggers either – she has described a refugee mother who kept her daughter of a war rape but remained obsessed by her child's vulnerability and the continuous challenge of protecting her. Babies of rape inevitably grow up unable to understand the fear that they arouse in their mothers; a disorganised attachment must develop with its underlying expectation of catastrophe. In order to achieve coherence the infant may develop irrational fears or become aggressive as Daniel did, projecting his own fear while trying to make sense of his mother's fear of him. And as these children grow up the

representations of their fathers in their mothers' minds will create enormous difficulties in forming an identity, as Campbell Paul has described. Amanda Jones has brought us the detail of her therapy work, a deeply psychoanalytic approach. She did not offer this depressed mother a prescription or tackle her symptoms of PTSD, or give her a behavioral program for her tyrannical toddler as might have been done but by most sensitively working with the couple's unconscious projections she was able to help them to begin a positive relationship.

I think the two points that Amanda Jones illustrates particularly well are

1. The value of enabling the patient to reach back behind the recent trauma and to reopen emotional contact with loving figures in the patient's past, in this case Fatima's parents, tragically lost in her childhood. Jones could do this because she recognised from Fatima's developing positive transference to herself that she must have had a good enough beginning.

2. The value of thinking in terms of the third position, the position that Jones took as the third party, able to accept both mother's and son's projections and to mediate in the space that she had created between them, a position that enabled Fatima to see Daniel increasingly from a new and much less threatening perspective.

I would like to end by paying tribute to the magnitude of the therapists' work. The emotional burden that has to be carried in cases like these is enormous. I think it is crucial to have colleagues to help to bear the pain and anxiety – and in addition to the support of colleagues, the necessity to balance each therapist's caseload to protect us from insensitivity and burnout. It can also help to have had a psychoanalytic training which supports the therapist in the value of containing intolerable emotions, so that they can be thought about as possible communications and so can be used to further the therapy.

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