

## The Concept of Cumulative Trauma

EVERY phase of theory-making in psycho-analysis has influenced the current concept of trauma and its clinical evaluation (Fenichel, 1937). I shall, somewhat arbitrarily, divide the total span of analytic researches into five stages. This is an artificial division to show what new ideas emerge at which stage. One stage does not cancel out the other. They run parallel, reinforcing and partially correcting each other, and each time a new strand is added to the growing complexity of psycho-analytic metapsychology.

In the first phase, 1885 to 1905, while Freud was postulating the basic concepts for the understanding of the unconscious—dream work, primary and secondary processes, the psychic apparatus, symptom formation, and the aetiology of hysteria and obsessional neurosis—the concept of trauma played a very vital and significant role (Freud, 1893a, 1895b). Trauma was conceived of essentially as (a) an environmental factor that intrudes upon the ego and which the ego cannot deal with through abreaction or associative elaboration: ‘hysterical patients suffer from incompletely abreacted psychical trauma’ (Freud, 1893a); and (b) as a state of strangulated libidinal energy which the ego cannot discharge. The paradigm of this traumatic situation is sexual seduction. We have a vivid account by Freud himself (1950a, letter 69; also 1914d) and by Jones describing (1953) how frustrated and demoralized Freud felt when he discovered that these traumatic events of seduction had never actually happened. During this phase the corresponding theory of anxiety is: ‘Neurotic anxiety is transformed sexual libido’ (Freud, 1897b). The chief defence mechanism discussed is repression.

The second phase, 1905 to 1917, is characterized by systematic attempts at working out infantile sexual development (Freud, 1905d)

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and psycho-analytic metapsychology (Freud, 1914c, 1915c, 1915d, 1915e, 1917e). In terms of infantile sexual development and libido theory the paradigmatic traumatic situations are (a) castration anxiety, (b) separation anxiety, (c) primal scene, and (d) oedipus complex. Trauma pertains to the strength and urgency of sexual instincts and the ego’s fight against them. It is in terms of unconscious fantasy and inner psychic reality that all conflicts and hence traumatic situations are envisaged. During the latter half of this phase Freud worked out his first systematic statement of metapsychology, and we have the concept of ego-libido, primary narcissism, and ego-ideal on the one hand, and a detailed examination of the mechanisms of introjection, identification, and projection on the other. The paper on ‘Mourning and Melancholia’ (1917e) marks the end of this phase, and by opening up the discussion of aggression and guilt starts the next.

The period of 1917 to 1926, the third phase, gives us the ‘final phase’ of Freud’s metapsychological thinking. In *Beyond the Pleasure Principle* (1920g) we have the first statement of the repetition compulsion as a principle of psychic functioning and its relation to the death instinct (principle of inertia in organic life). Here, Freud arrived at his dualistic theory of instincts, and from his earlier distinction between sexual instincts and ego instincts moved on to the duality of life versus death instincts. With the hypothesis of dual instincts and repetition compulsion, and the definition of psychic structures in terms of ego, id, and superego (Freud, 1923b), the concept of trauma took on an exclusively intersystemic and instinctual frame of reference. The vast literature on guilt, masochism, melancholia, depression, and internal anxiety situations documents at great length such traumata and the ego’s mode of handling them. The extreme and most detailed discussion of such intersystemic and instinctual traumata is perhaps by Melanie Klein (1932) in her description of paranoid and depressive positions. This phase in Freud’s own researches achieves its culmination in his revision of the concept of anxiety in *Inhibitions, Symptoms and Anxiety* (1926d).

The fourth phase, 1926 to 1939, is launched by the revision of the concept of anxiety and inaugurates the beginnings of ego-psychology proper. Strachey (1959, pp. 77-86) has given us a masterly summary of the evolution of Freud’s concept of anxiety. I shall single out for comment only the fact that in *Inhibitions, Symptoms and Anxiety* Freud clearly distinguished between traumatic situations

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and situations of danger, corresponding to which are the two types of anxiety: automatic anxiety and anxiety as a signal of the approach of such a trauma. 'The fundamental determinant of automatic anxiety is the occurrence of a traumatic situation; and the essence of this is an experience of helplessness on the part of the ego in the face of an accumulation of excitation . . . the various specific dangers which are liable to precipitate a traumatic situation at different times of life. These are briefly: birth, loss of the mother as an object, loss of the penis, loss of the object's love, loss of the super-ego's love' (Strachey, 1959, pp. 81-82).

With the revised concept of anxiety and traumatic situations the role of environment (mother) and the need for 'extraneous help' in situations of helplessness comes into the very centre of the concept of trauma. Thus the intra-psychic, intersystemic, and environmental sources of trauma are integrated into a unitary frame of reference. Toward the end of this phase in his two papers 'Analysis Terminable and Interminable' (1937c) and 'Splitting of the Ego in the Process of Defence' (1940c) Freud focused his attention on the ego in terms of the modifications acquired during the defensive conflicts of early childhood, as well as through primary congenital variations and the disturbances of the synthetic function of the ego. This is why I have characterized this phase as inaugurating ego-psychology proper. These new formulations have far-reaching implications for the evaluation of the source and function of trauma.

The last phase is from 1939 to today. In this the developments of ego-psychology through the researches of Anna Freud (1936 onwards), Hartmann (1939, 1950, 1952) and others, and the whole new emphasis on infant-mother relationship, have changed our very frame of reference for the discussion of the nature and role of trauma.

### Function of Mother as Protective Shield

In *Beyond the Pleasure Principle* (1920g) Freud set up a conceptual model to discuss the fate of a living organism in an open environment. 'Let us picture (he said) a living organism in its most simplified possible form as an undifferentiated vesicle of a substance that is susceptible to stimulation.' Freud next proceeds to point out that the two sources of stimuli possible are the external and the internal ones. He continues: 'Then the surface turned towards the external world will from its very situation be differentiated and will serve as an organ for receiving stimuli' (p. 26). This gradually develops into a 'crust' and eventually into a 'protective shield'. Freud

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postulated that '*Protection against stimuli is an almost more important function for the living organism than reception of stimuli. The protective shield is supplied with its own store of energy and must above all endeavour to preserve the special modes of transformation of energy operating in it against the effects threatened by the enormous energies at work in the external world*' (p. 27). Continuing his argument Freud postulated that this sensitive cortex, which later becomes the system Cs., also receives excitations from within. It is however, less effective against inner stimuli, and one way the organism protects itself against the unpleasure from inner stimuli is to project them to the outer environment and treat them as 'though they were acting, not from the inside, but from the outside, so that it may be possible to bring the shield against stimuli into operation as a means of defence against them'. In this context Freud described as 'traumatic' any

. . . excitations from outside which are powerful enough to break through the protective shield. It seems to me that the concept of trauma necessarily implies a connection of this kind with a breach in an otherwise efficacious barrier against stimuli. Such an event as an external trauma is bound to provoke a disturbance on a large scale in the functioning of the organism's energy and to set in motion every possible defensive measure. At the same time, the pleasure principle is for the moment put out of action. There is no longer any possibility of preventing the mental apparatus from being flooded with large amounts of stimulus, and another problem arises instead—the problem of mastering the amounts of stimulus which have broken in and of binding them, in the psychical sense, so that they can then be disposed of [p. 29f.]. [Developing his argument further, Freud concluded:] what we seek to understand are the effects produced on the organ of the mind by the breach in the shield against stimuli and by the problems that follow in its train. And we still attribute importance to the element of fright. It is caused by lack of any preparedness for anxiety, including lack of hypercathexis of the systems that would be the first to receive the stimulus. Owing to their low cathexis those systems are not in a good position for binding the inflowing amounts of excitation and the consequences of the breach in the protective shield follow all the more easily. It will be seen, then, that preparedness for anxiety and the hypercathexis of the receptive systems constitute the last

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line of defence of the shield against stimuli. In the case of quite a number of traumas, the difference between systems that are unprepared and systems that are well prepared through being hypercathected may be a decisive factor in determining the outcome; though where the strength of a trauma exceeds a certain limit this factor will no doubt cease to carry weight [p. 31f.].

The total context of Freud's discussion is the observation of an infant's play with a reel that related to 'disappearance and return' (of the mother) and the traumatic dreams in general. If we replace in Freud's model 'the undifferentiated vesicle of a substance that is susceptible to stimulation' by a live human infant, then we get what Winnicott (1960a) has described as 'an infant in care.' The infant in care has for his protective shield the caretaking mother. This is the uniquely human situation, in so far as this dependency in the infant lasts much longer than in any other species that we know of (Hartmann, 1939); and from this prolonged period of dependency the human infant emerges as a more highly differentiated and independent organism *vis-à-vis* his environment.

My aim here is to discuss the function of the mother in her role as a protective shield. This role as a protective shield constitutes 'the average expectable environment' (Hartmann, 1939) for the anaclitic needs of the infant. My argument is that cumulative trauma is the result of the breaches in the mother's role as a protective shield over the whole course of the child's development, from infancy to adolescence—that is to say, in all those areas of experience where the child continues to need the mother as an auxiliary ego to support his immature and unstable ego-functions. It is important to distinguish this ego-dependency of the child on the mother from his cathexis of her as an object. (Ramzy and Wallerstein [1958] have discussed this aspect in terms of *environmental reinforcement*.) Cumulative trauma thus derives from the strains and stresses that an infant-child experiences in the context of his ego-dependence on the mother as his protective shield and auxiliary ego (cf. Khan, 1963; and pp. 168-202 below).

I want to stress the point that what I am describing as breaches in the mother's role as protective shield are qualitatively and quantitatively different from those gross intrusions by the mother's acute psychopathology which have been often discussed in our literature

in relation to schizophrenic children or overtly hostile and destructive patterns of behaviour in delinquent children (e.g. Beres, 1956; Lidz and Fleck, 1950; Mahler, 1952; Searles, 1959, 1962; Shields, 1962; etc.). The breaches I have in mind are in the nature of maladaptation to the infant's anaclitic needs (Winnicott, 1956a).

The mother's role as a protective shield is a theoretical construct. It should include the mother's personal role *vis-à-vis* the infant as well as her management of the non-human environment (the nursery, the cot, etc.) on which the infant is dependent for his total well-being (cf. Searles, 1960). I should emphasize also that the breaches in this protective-shield role, as I envisage them, are not traumatic singly. To borrow the apt phrase from Kris (1956c), they have the quality of a 'strain', and do not so much distort ego-development or psychosexual evolution as *bias* it. In this context it would be more accurate to say that these breaches over the course of time and through the developmental process cumulate silently and invisibly. Hence the difficulty in detecting them clinically in childhood. They gradually get embedded in the specific traits of a given character structure (cf. Greenacre, 1958). I would like to restrict myself merely to stating that the use of the word trauma in the concept of cumulative trauma should not mislead us into considering such breaches in the mother's role as protective shield as traumatic at the time or in the context in which they happen. They achieve the value of trauma only cumulatively and in retrospect. If the concept of cumulative trauma has value and validity, then it should help us to identify more accurately what sort of ego distortion and disturbance of psychosexual development can be related to what type of failure of environmental provisions, in relation to anaclitic needs in the infant and the child. It should help in replacing such incriminating reconstructions as bad, rejecting, or seducing mothers, as well as such anthropomorphic part-object constructs as 'good' and 'bad' breast. Its place could be taken by a more meaningful examination of the pathogenic interplay of specific variables in the total relationship of an infant-child's psychic and physical equipment and how the environment meets it. This in turn would sponsor the clinical search for effective therapeutic measures rather than merely prescriptive ones. I have given a detailed account elsewhere, from the treatment of a female patient, to show how an early disturbed relation between mother and daughter led to homosexual episodes in her adult life (Khan, 1963).

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In the past two decades, research in ego-psychology and infant-care techniques have gained in complexity and depth.\* From these researches it is possible to distinguish theoretically between four aspects of a human infant's total experience:

1. The role of the caretaking environment and its contribution toward the release and stabilization of the intra-psychic potentialities and functions (cf. Freud, 1911*b*, p. 220).

2. The special sensitivity of an infant making demands on the primary environment, which I am designating here as a mother's role of protective shield (cf. Escalona, 1953).

3. The unfolding of the maturational processes, autonomous ego-functions, and libido development.

4. The gradual emergence of the inner world and psychic reality, with all the complexity of instinctual needs and tensions, and their interplay with inner psychic structures and object-relationships.

In our literature, perhaps, one of the most sensitive and elaborate description of the caretaking role of the mother is in Winnicott's writings. According to Winnicott (1956*b*), what motivates the mother for her role as a protective shield for the infant is her 'primary maternal preoccupation.' The incentive for the mother's role is her libidinal investment in the infant and the infant's dependence on it for survival (cf. Benedek, 1952). From the infant's subjective point of view there is at the beginning little perception of this dependence or of the need for survival.

What the mother's caretaking role achieves in optimal circumstances is:

1. Through making herself available as a protective shield the mother enables the growth of the maturational processes—both of autonomous ego-functions and instinctual processes. The mother's role as a protective shield defends the infant against the mother's subjective and unconscious love and hate, and thus allows her empathy to be maximally receptive to the infant's needs (cf. Spitz, 1959).

\* It is not possible to review this work here. Brody (1956) has surveyed this literature exhaustively. I shall point out a few of these contributions which have been especially valuable to me in arriving at my concept of cumulative trauma. These are by: Benedek (1952), Beres (1956), Bowlby (1958, 1960*a*), Erikson (1950*b*, 1956), Escalona (1953), Anna Freud (1951, 1958*b*), Fries (1946), Greenacre (1954*b*, 1958, 1959, 1960*c*), Hartmann (1939, 1952), Hoffer (1949, 1950, 1955), Kris (1950*b*, 1951*b*, 1956*c*, 1962), Lichtenstein (1961), Mahler (1952, 1961), Ramzy and Wallerstein (1958), Spitz (1945, 1959, 1962), Winnicott (1945*a*, 1948*b*, 1949*b*, 1956*b*, 1960*a*).

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2. If her adaptation is good enough, then the infant does not become precociously aware of his dependence on the mother—hence does not have to exploit whatever mental functions are emergent and available toward self-defence (cf. Freud, 1920*g*; James, 1960).

3. The protective-shield of the mother enables the infant to project all the unpleasurable inner stimuli on to her, so that she can deal with them and thus sustain the illusion of omnipotence of well-being in the infant. Erikson (1950*b*) has defined this sense of well-being as 'trust', Benedek (1952) as 'confidence', and Kris (1962) as 'comfort' (see also Searles, 1962).

4. Through functioning as a protective shield, and so providing a model, the mother enables the infant's psyche to integrate what J. Sandler (1960) has called a 'qualitative organizing component'. In later ego-development and functioning we can identify this as guiding the synthetic function of the ego in its discriminating role, both in relation to inner instinctual reality and to the demands of the external environment.

5. By providing the right dosage of life experience (Fries, 1946) and need satisfactions through her body care, she enables the infant's inner world to differentiate into id and ego as well as gradually to demarcate inner from outer reality (cf. Hoffer, 1952; Ramzy and Wallerstein, 1958).

6. By lending her own ego-functions as well as her libidinal and aggressive cathexes (through her role as a protective shield) she helps the infant to build up supplies of primary narcissism, neutralized energy, and the beginnings of the capacity and wish for object cathexes (cf. Hoffer, 1952; Kris, 1951*b*). Both what she provides and what emerges through the infant's maturation interact and supplement each other (Erikson, 1946; Freud, 1911*b*; Hoffer, 1949; Winnicott, 1951).

7. If these tasks are accomplished successfully, then the shift from primary dependence to relative dependence can take place (Winnicott, 1960*a*). In this stage the function of her role as a protective shield becomes more complex; it takes on an essentially psychological aspect. She has now to help the infant with his first experiences of inner instinctual conflicts on the one hand, and yet sustain for him that flux from primary identification to realization of separateness which is the essence of disillusionment (Winnicott, 1948*b*) and a precondition for a true capacity for object cathexes (cf. Milner, 1952; Anna Freud, 1958*b*).

8. If she is successful in these achievements, then the infant

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gradually becomes aware of the mother as a love object and of his need for her love. This is now an object cathexis which employs instinctual (id) cathexes that have become available in the meantime (Anna Freud, 1951).

9. By providing phase-adequate frustrations she sponsors the capacity for toleration of tension and unpleasure, thus promoting structural development (cf. Kris, 1962). Rubinfine (1962) in his valuable discussion of this aspect of maternal care concludes:

... where need satisfaction is always and immediately available (i.e., deanimated), there should be a relative absence of tension. Without appropriately timed experiences of frustration and delay, there may result retardation in the development of various ego functions, among them the capacity to distinguish between self and nonself. Such failure of differentiation of self from object, and the consequent failure of defusion of self- and object-representations, leads to interference with the development of the capacity to discharge aggressive drives toward an external object, and results in the turning of aggression against the self.

Winnicott (1952a) has stressed the point that a mother should and indeed must fail the id, but never the ego of the infant.

The vehicle of all these transactions between mother and infant is dependency. This dependency is to a large extent not sensed by the infant. Similarly, it is important to keep in mind that the mother's role as a protective shield is a limited function in her total life experience. In the beginning it is an all-engrossing one for her. Still, theoretically it is significant for us to be able to see it as a special instance of her personality and emotional functioning. Spitz's (1962) distinction between the totality of the infant's anaclitic needs and the implementation of the mother's diatrophic attitude in response to these needs is pertinent to remember in this context. Unless we can do this we cannot identify how this role as a protective shield can be and does become invaded by her personal needs and conflicts. It is the intrusion of her personal needs and conflicts that I characterize as her failure in respect of her role as a protective shield. The mother's role as protective shield is not a passive one but an alert, adaptive, and organizing one. The protective-shield role is the result of conflict-free autonomous ego-functions in the mother. If personal conflicts intrude here, the result is a shift from the protective-shield role to that of symbiosis or rejective

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withdrawal. How an infant will react to these failures depends upon the nature, intensity, duration, and repetitiveness of the trauma.

In our literature three typical instances of this type of failure of the mother as a protective shield have been thoroughly discussed:

1. The most extreme and pathogenic is through the excessive intrusion of the mother's psychopathology. Winnicott (1949b, 1952a) has discussed it as failure of the good-enough holding environment leading to psychosis or mental defect. Mahler (1952, 1961) has coined the phrase of symbiotic relationship between mother and child that leads to schizophrenic illnesses. In this context I would like also to mention, among others, the researches of Beres (1956), Geleerd (1956, 1958), Lidz and Fleck (1959) and Searles (1959).

2. The breakdown of mother's role of protective shield has also been discussed in terms of loss of or separation from her. Here again the pioneer researches of Anna Freud and Burlingham (1944, 1944) and Winnicott (1940, 1945b), and the later exhaustive investigations of Bowlby (1960a), Spitz (1945, 1951), and Provence and Lipton (1962) stand out as particularly important (also cf. Hellman, 1962).

3. The third instance of breakdown of mother's role as protective shield occurs when either some constitutional sensitivity (Escalona, 1953) or physical handicap (Burlingham, 1961; Anne Marie Sandler, 1963) impose an impossible task on the mother, or when a severe physical illness in the infant or child creates a special demand which no human adult could possibly meet (cf. Anna Freud, 1952b; Frankl, 1961).

### Aetiology of Cumulative Trauma

I am here tentatively trying to conceptualize a fourth type of partial breakdown of the mother's role as a protective shield, which becomes visible only in retrospect as a disturbance and can be designated as cumulative trauma. I have been specifically guided and helped in arriving at this hypothesis through the researches of Winnicott, Kris, and Greenacre.

Over the past twenty years Winnicott has been persistently drawing our attention to the importance of the mother's caretaking function, the vital role of dependence for the infant's emergence into self-status, etc. James (1962) has recently given us a valuable critique of Winnicott's researches. What is pertinent for my purposes in Winnicott's hypotheses is his elucidation of the role of

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regression to dependency needs in the therapeutic process (1949c), his researches into the antisocial tendency (1956a), and his careful delineation of the early psychic and affective processes of integration in the child (1945a).

It is Winnicott's basic hypothesis (1952a) that all relative failures in infancy of the good-enough holding environment (mother's role as a protective shield) set up a compulsion in the relatively matured child and the grown adult to correct the imbalances and dissociations in ego-integration. This is achieved through regression to dependency needs. In Winnicott's idiom, establishment of 'the false self' is one result of such caretaking environment's failure to adapt through good-enough holding (1949b). What Winnicott calls 'the false self' is a characterological consequence of the disruption and distortion of ego-autonomy. What Winnicott calls 'impingements' are the failure of the mother in infancy to dose and regulate stimuli—both external and internal. Winnicott believes that these impingements are disruptive of true ego-integration, and lead to premature defensive organization and functioning (1948b). What Kris (1962) has described as 'a specific kind of provocative overstimulation which was bound to produce mounting tension in the child without offering appropriate avenues of discharge' and also as 'tantalizing', Winnicott designates as 'impingements'. I am here considering these as some of the most pathogenic genetic elements in cumulative trauma (cf. Erikson, 1950b).

Kris in his paper 'The Recovery of Childhood Memories in Psychoanalysis' (1956c) has distinguished between 'shock trauma' and 'the strain trauma'. The latter he has defined as the 'effect of long-lasting situations, which may cause traumatic effects by accumulation of frustrating tensions'. The clinical examples that Kris offers here and in his contemporary paper on 'The Personal Myth' (1956b) leave me in no doubt that 'the strain trauma' and the screen memories or precocious early memories that the patients recount are derivatives of the partial breakdown of the protective-shield function of the mother and an attempt to symbolize its effects (cf. Anna Freud, 1958b). Kris's sensitive and consummate account of the predicament of the infant Anne in his paper 'Decline and Recovery in a Three-Year-Old' (1962) is the most apposite material in relation to my concept of cumulative trauma. It is interesting to note in Kris's account that even though the mother and infant were observed from the start, it was only later, i.e. in relative retrospect at thirty-four weeks, that the fact of disturbed maternal handling

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constituting a 'tantalizing' situation for the infant Anne could be definitely established.

Greenacre's studies (1954b, 1960a, 1960c) have been largely concerned with the vicissitudes of the maturational factor in infancy and its effect on ego and instinctual development. In 1959 she introduced the concept of *focal symbiosis* to identify a specific variant of what Mahler has described as symbiotic relationships. Greenacre defines focal symbiosis as 'an intensely strong interdependence (usually between mother and child, but sometimes, as in my cases, with people other than the mother) which is limited to a special and rather circumscribed relationship rather than a nearly total enveloping one. . . . In limited or focal symbiotic relationships, there is often a peculiar union of the child's special need with the parent's special sensitivity, and . . . the total personality of either parent or child may not be as much involved as in the severe case of symbiotic psychoses described by Mahler' (pp. 244, 245). Greenacre (1959, 1960a, 1960b) furthermore relates a great deal of the psychopathology of perversions, borderline cases, and body-ego development to focal symbiosis. In her concept of focal symbiosis she has fruitfully extended the range in time and developmental process through which the child and his human environment can involve each other in terms of the archaic dependency relationship.

In the context of these formulations I shall now examine the nature and function of the cumulative trauma. Cumulative trauma has its beginnings in the period of development when the infant needs and uses the mother as his protective shield. The inevitable temporary failures of the mother as protective shield are corrected and recovered from the evolving complexity and rhythm of the maturational processes. Where these failures of the mother in her role as protective shield are significantly frequent and lead to impingement on the infant's psyche-soma, impingements which he has no means of eliminating, they set up a nucleus of pathogenic reaction. These in turn start a process of interplay with the mother which is distinct from her adaptation to the infant's needs. This interplay between mother and infant can have any or all of the effects described below.

1. It leads to premature and selective ego-development. Some of the emergent autonomous functions are accelerated in growth and used in defensive action to deal with the impingements that are unpleasurable (James, 1960; Winnicott, 1949c).
2. It can begin to organize a special responsiveness to the

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mother's mood that creates an imbalance in the integration of aggressive drives (cf. Winnicott, 1948a; Sperling, 1950).

3. The involvement of precocious functions with the mother's collusive response militates against developmentally arriving at a differentiated separate 'coherent ego' (Freud, 1920g) and self. This in turn leads to a dissociation through which an archaic dependency bond is exploited on the one hand and a precipitate independence is asserted on the other. A specific result is that what should have been a silent, unregistered dependency state now becomes an engineered exploitation of instinctual and ego-dependence, with a precocious narcissistic cathexis of the mother.

4. As a further consequence the disillusionment that belongs to maturational separating off from mother is side-tracked and a false identificatory oneness is manipulated (cf. Searles, 1962). This way, instead of disillusionment and mourning, an ego-attitude of concern for the mother and excessive craving for concern from the mother become established. This concern is quite different from the concern that belongs to sadistic instinctual attack on the mother and the ensuing feelings of guilt (cf. Klein, 1932). This concern is an ego-interest that substitutes for a true object cathexis (cf. Winnicott, 1948a).

5. Through the impingements that derive from failure of mother's role as protective shield, a precocious cathexis of external and internal reality takes place. This organization of inner and outer reality leaves out a very important function of the ego's subjective awareness and experience of itself as a coherent entity. Its synthetic function is also disrupted (cf. James, 1960).

6. The strain and impingements from the failure of mother's role as protective shield, which I am designating here as cumulative trauma, have their most specific effect on the vicissitudes of body-ego development in the infant and the child. The researches of Coleman, Kris, and Provence (1953), Greenacre (1958, 1960b), Hoffer (1950, 1952), Kris (1951b), Milner (1952), Spitz (1951, 1962), and Winnicott (1949b, 1949c, 1951) have stressed the importance of the maternal caretaking procedures (protective-shield role) for the development of the body ego in the context of the earliest stages of the ego-id differentiation and the gradual integration of a sense of self. Here I want to refer, only very briefly, to my inference from clinical material that the breaches in the mother's role as protective shield leave their precipitates most sentiently and effectively in the body-ego development of the child. These residues over the course

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of maturation and development gather into a specific type of body-ego organization and form the substratum of the psychological personality. Pertinent here are the observational data offered by Coleman, Kris, and Provence (1953), Kris (1951b), and Ritvo and Solnit (1958). In the adult patient it is through the clinical observation of the idiosyncrasies of the body-ego behaviour in the transference-neurosis and the total analytic setting that we can hope to reconstruct what are the particular genetic patterns of the cumulative trauma in a given case (Khan, 1963). The concept of cumulative trauma tentatively offers, in terms of early ego-development and in the context of infant-mother relationship, a complementary hypothesis to the concept of fixation points in libido development. In this sense it tries to map out what were the significant points of stress and strain in the evolving mother-infant (child) relationship that gradually gather into a dynamic substratum in the morphology of a particular character or personality.

Once this interplay between infant and mother starts, it brings into its sphere of action all new developmental experiences and object relations. In many significant aspects this later pathogenic interplay between mother and child aims to correct the earlier distortions through impingements. This is what I think Greenacre (1959) refers to as the drive behind 'the union of the child's special need with the parent's special sensitivity'. That these attempts at recovery only complicate the pathology is an irony of human experience. This is perhaps at the root of many attempts at cure through love and passionate involvement in our adult patients. I have tried to discuss this aspect in my paper (1962) 'The Role of Polymorph-Perverse Body-Experiences and Object-Relations in Ego-Integration' (see also Alpert, 1959; Khan, 1963; Lichtenstein, 1961).

I have so far stressed only the pathogenic effects on infant development from breaches in the mother's role as protective shield. It would, however, be a gross misrepresentation of the total complexity of the interplay between mother and infant if we fail to state that although the infant ego is weak, vulnerable, and extremely dependent on the mother's role as protective shield, the infant has also a great inherent resilience and potentiality (strength). It not only can and does recover from breaches in the protective shield, but it can use such impingements and strains as 'nutriment' (Rapaport, 1958) toward further growth and structuration (cf. Rubinfine, 1962; Kris, 1951b). It is important to remember that though the ego can survive and overcome such strains, exploit them to good

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purpose, manage to mute the cumulative trauma into abeyance, and arrive at a fairly healthy and effective normal functioning, it nevertheless can in later life break down as a result of acute stress and crisis. When it does so—and this is of great clinical importance—we cannot diagnostically evaluate the genetics and economics of the total processes involved if we do not have a concept like cumulative trauma to guide our attention and expectancy. It has often been remarked in our literature during the past three decades that the character disorders of a schizoid type, which have become the more frequent type of patient in our practice, present a clinical picture whose aetiology needs constructs that include disturbances of infant-mother relationship that were at the time neither gross nor acute (Kris, 1951*b*; Khan, pp. 13-26 above). I am suggesting that the concept of cumulative trauma can help us a great deal here. The human infant is well endowed to struggle with the vicissitudes of his internal and environmental stresses. What is important for us is to be able to identify in the clinical process what effects this struggle has left and how it has shaped the adult character (cf. Greenacre, 1954*b*, 1960*b*; Lichtenstein, 1961; Khan, pp. 181-202 below).

One treacherous aspect of cumulative trauma is that it operates and builds up silently throughout childhood right up to adolescence. It is only in recent years that we have learned to evaluate as pathogenic a certain precocious development in children. Such precocity had previously been celebrated as giftedness or strong ego-emergence or a happy independence in the child. We are also inclined to view with much more caution and reserve, if not suspicion, a mother's boasts of a specially close rapport and understanding between herself and her child.

Clinical experience shows that the phases of maturational development where these impingements from mother's failure in her role as protective shield tend to get organized into an active collusive relationship between mother and child are the late oral, early anal, and phallic phases—the phases where the emergent instinctual process and maturational ego-process test the mother with their full need and demand. It is also these stages where the stimulus hunger asks for maximal psychological adaptation, response, and restraint from the mother in her role as protective shield. The chief psychic process involved in such collusive relationships is identification, as Kris (1951*b*) and Ritvo and Solnit (1958) have stressed. This identification remains essentially of an incorporative and projective type, interfering with internalization and assimilation of new object

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representations, and thus confuses a proper differentiation and growth of internal psychic structures. This holds true also of the distortion of the libidinal strivings and object relations of the oedipal phase (cf. Schmale, 1962).

The phase at which the child himself acutely becomes aware of the distorting and disruptive effects of this collusive bond with the mother is at adolescence. Then the reaction is dramatically rejective of the mother and all the past cathexes of her (Khan, pp. 168-180 below). This, of course, makes the adolescent process of integration at once tortuous and impossible. At this point attempts at integration which wilfully negate past libidinal investments, ego-interests, and object ties are instituted. This leads either to collapse of personality development into inertia and futility, or a short, magical recovery into omnipotent isolation, or a passionate craving for new ideals, new objects, and new ego-interests (Beres and Obers, 1950; Erikson, 1956; Geleerd, 1958; Khan, pp. 181-202 below; Spiegel, 1951).

### Conclusion

The concept of cumulative trauma takes into consideration psychophysical events that happen at the preverbal stage of relationship between mother and infant. It correlates their effects on what later becomes operative as a disturbed relationship between mother and child or as a *bias* in ego and psychosexual development (Khan, 1962, 1963). Once an infant-emerges out of the pre-verbal stage we can never see directly the first impingements and failures in the mother's role as the protective shield. What we see in direct observation or clinically are derivatives of these mental processes and capacities. What I am conceptualizing here as cumulative trauma has been described by Anna Freud (1958*b*) in another context. She states 'that subtle harm is being inflicted on this child, and that the consequences of it will become manifest at some future date'.

Even though we have now available many sensitive accounts of direct observations of the feeding situations and the total relationship between infant and mother (J. Robertson, 1962), there is still doubt as to whether we can identify at the point of its actuality the breakdown of the mother's role as protective shield in relation to the infant's anaclitic needs. As Kris's (1962) account of the infant Anne makes abundantly clear, even though an infant was observed by a team of highly skilled professionals, it was only in retrospect that the effects of such breakdown of a good-enough provision of maternal

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care began to be visible. In the case of Anne we see how the impingements from the mother's handling already began to gather into the structure and function of the cumulative trauma. It is important for us to be able to chart out clearly the earliest nature and role of these failures, because only thus can we organize our clinical expectancy and arrive at true diagnosis. As Anna Freud (1962) expressed it:

... if our present direction of interest is no more than a turning of our glance from the effects of dependence on to the contents and processes in the period of dependence, it is still a turning-point of decisive importance. By taking this line we change the direction of our interest from the illnesses themselves—neurotic or psychotic—to their pre-conditions, to the matrix from which they arise, i.e. to the era where such important matters are decided as the selection of neurosis and the selection of the types of defence.