

PARENTAL ABANDONMENT: A UNIQUE FORM OF LOSS AND NARCISSISTIC INJURY

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ABSTRACT: This paper presents an overview of the effects of parent loss, looking initially at the voluminous and significant research regarding institutionalized children, and children who have lost a parent by death. In contrast to the considerable literature and information about these child populations, less has been written regarding the abandoned child. Otto Kernberg's and Heinz Kohut's newer theories of the psychology of the self, and narcissistic personality disturbances are viewed as providing useful new insights about the abandoned child population. Two cases are presented, followed by application of Kohut's and Kernberg's treatment approaches. These newer treatment interventions offer more optimism for work with abandoned children, who are an ever increasing population.

The population of young people under the age of seventeen losing one or both parents, temporarily or permanently, through the many and varied separating vicissitudes of divorce, hospitalization, residential mobility, military service, diverse life-styles and death, is reaching horrendous proportions so fast that it is becoming statistically normal to undergo loss during the period of childhood (Anthony, 1976). The literature on the subject is rich and gives us considerable information about the effects of institutionalization on children, as well as the trauma experienced by a child of any age when a parent dies. However, death has a finality about it which abandonment does not, and this fact complicates a child's surrender of the cathexis of the image of the parent, be the parent a real object or a never-known romanticized shadow. It appears that there has been meager examination, clinically and theoretically, of the phenomena of abandonment and its specific traumatic features. Given the sizable and increasing abandoned child population, it seems in order for those doing clinical work with children to examine the effects of death and abandonment—and compare and contrast these two loss phenomena.

Children in Institutions

The classic studies of René Spitz (1945, 1946), present direct observation of infants in two kinds of institutions: a foundling home and a penal

institution where the mother continued to care for her child. He described two kinds of pediatric psychiatric conditions: "hospitalism," by which he meant a diseased condition of mind and body, as shown by physical and mental retardation and a lack of responsiveness which he felt resulted from prolonged institutional care, and "anaclitic depression," by which he meant a specific reaction to separation which tended to occur when a good relationship between mother and infant had been interrupted. Some infants, after they have lost their mother, develop weapiness, then withdrawal, then rigid behavior, and ultimately become insomniac, ill, and emaciated. Anna Freud and Dorothy Burlingham (1944) observed retarded verbal development in one- to two-year-olds, without families, and this was confirmed by Provence and Lipton (1962), who found that language development was the first area to be depressed in early infancy and remained the sector of greatest retardation, as measured by tests during the period of institutional living. They further found that play was impoverished and repetitive, and that consistent mothering care was essential for the baby's awareness of his own body. The impairment in object ties resulted in impaired body image and sense of self. The overall implications are that infants in institutions are impaired in their relationship to people because of a deficiency in the weakness of emotional attachment and because there is no discrimination, trust, or ties. There is a poor capacity to anticipate and defer immediate gratification. Speech is retarded and communication in all forms is meager. There is a low investment in toys, people, and self. Few autoerotic activities, such as touching and exploring their own bodies, less thumb sucking and less genital play is observed. The only self-stimulating activity is excessive rocking. For this group only a long period of family living resulted in significant improvement. Foster home placements resulted in seeming dramatic gains, but nevertheless some permanent impairments, e.g., concrete thought, impoverished imagination, and indiscriminate friendliness remained.

The Provence and Lipton findings substantiate similar ones by Goldfarb (1965) who compared infants in institutions, who were placed in foster homes at approximately age four, with infants who lived in foster care since infancy. In summary, the group beginning life in an institution was more retarded intellectually, demonstrated an absence of a normal capacity for inhibition, hyperactivity, restlessness, no genuine attachments, and indiscriminate and insatiable demands for affection.

Death of a Parent

Shifting to consideration of a less damaged child population, much has been written about the death of a parent, and the question of mourning and working through the loss. There is specific controversy about the issue of mourning, and when this complex psychological process can be accomplished. Furman (1964) presents case material about his work with

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a six-year-old whose mother died during the child's analysis, and concludes that the young child could successfully mourn. Furman characterizes "mourning" as a process based on the acquisition of a concept of death and the attainment of object constancy, both of which are possible by the age of four.

In contrast, Wolfenstein (1973) differs and states that the mental constructs of object constancy, and the concept of death, may be far from sufficient to insure the immature individual's ability to tolerate the work of mourning. Children who have lost a parent at an early age tend to retain their intense cathexis of the image of the parent. At the same time, they acknowledge only superficially the fact of the parent's death. Thus, they maintain a dual and contradictory attitude toward a major reality of their life. There is a splitting of the ego, insofar as the two opposing views of the lost parent are not mutually confronted. Freud (1957) describes the work of mourning as the gradual, painful decathexis of the lost object. Wolfenstein (1973) is most specific in stating that mourning becomes possible only after adolescence has been passed through. Adolescence serves as a trial mourning, an initiation into the way of decathecting a major love object.

Wolfenstein (1969) describes the protest in reaction to loss and the warding off of sad affects. Denial of the finality of the loss was overtly or covertly maintained. In therapy, latency age children will skirt the mention of the lost parent, engross themselves in a play and suggest "let's change the subject." The avoidance of the finality of the loss is supported by fantasies of the parent's return. While such expectation persists, there is also an acknowledgment of the fact that the parent has died. These two trends of acknowledgment and denial coexist without being mutually confronted, constituting what Freud called a splitting of the ego. Instead of grief, the most common reaction to the loss of a parent which we find in children and adolescents is rage. However, instead of the rage being directed at the departed parent, for the abandonment, this parent is perpetuated in an idealized fashion, which aids in denial of loss. What results is that the rage and negative feelings are directed to the surviving parent and others in the immediate familial environment. Not being able to turn to substitute objects, the bereaved child often feels more at odds with those around them and alienates them by his angry behavior. The denial of the loss is not purely on an intrapsychic level, or expressed in object terms toward the surviving parent, but is expressed in the wider environment of school and peers. The parent is felt to be a part of the child or an inalienable possession, without which he is incomplete, which accounts for repeated findings that children are deeply ashamed of having lost a parent. They often try to conceal this fact or feel chagrined when it is revealed. The bereaved child feels a painful inferiority to children who have an intact family (Wolfenstein, 1966).

Nagera (1970) discusses children's reaction to the death of important

objects and concludes that the loss of an important object represents a developmental interference. He details what he calls the characteristic responses: the short sadness span, the incapacity to sustain mourning, the massive use of denial and reversal of affect, the inability to grasp the reality of death, the search for substitutes (before the event if the child was aware of the oncoming death, and after if he was not), the simultaneous overt and insidious symptom formation and character distortions, the fear of contamination causing their own death which is often side by side with fantasies of reunion. Nagera describes his view as closest to that of Wolfenstein, that is, that mourning as defined by Freud (1917) and as observed in the adult is not possible until the detachment from parental figures has taken place in adolescence. Some aspects of mourning can be observed in children but there are important differences in the mourning of children and of adults. Nagera describes latency children as those who strongly cathect a fantasy life where the lost object may be seen as alive and, at times, as an ideal. Adolescents are still tied to their infantile imagos and tend to recathect the image of the lost object.

Separation from the Parent

We are familiar in our work with the idealization of parents by children who are separated from them, e.g., in residential settings, by adopted children who romanticize the never known original objects, and by the abused child who fights for return to the abusing mother. In these groups, however, surrogate or adoptive parents are available to the child. When there has been an abandonment and not a death, we can easily postulate that this reality feeds the fantasy of eventual return and reunion. The lack of finality of the loss is a fact where a parent exists and occasionally presents themselves at Christmas or the child's birthday. We are familiar with the story of the child in foster care who longs for his own parents, cannot respond to the foster family's expectations of closeness and trust, and, due to the depth of pathology and aggressive behavior, is shifted from one foster home to the next, and the next. Wolfenstein (1966) describes a similar response following death, a persistent quest for the lost parent, rage rather than grief, the repetition of disappointment and the vindictive determination to prove that no one can help.

The reaction of children of varying ages who have been separated from their parents has been studied and described in an attempt to ascertain mourning responses. Bowlby (1960) considers the reactions of infants separated from their mothers as identical with the adult mourning response. His views have been questioned by Anna Freud (1960), Schur (1960), and others who see the process of mourning in children as different from that which we see in adults. Neubauer's (1960) account of the one-parent child and his oedipal development describes the distortions of

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the object. Fantasy objects, immensely idealized or endowed with terribly sadistic attributes, replace the absent parent. He presented the case of a 3½-year-old girl whose father had left one week after her birth, and had visited only twice. His influence proved to be more pathological to her than that of the remaining parent. He also presented a review of the literature emphasizing the pathogenic potential which an absent parent may exert on sexual identification and superego formation. Neubauer emphasized resultant pathologies of homosexuality, and superego disturbances; i.e., too severe a superego with harsh preoedipal qualities, or a deficient superego which allowed incestuous acting out. Neubauer's findings are substantiated by more recent conceptions regarding narcissistic pathologies, as shown by sexual perversions (Kohut, 1971) and poorly integrated superegos, which mainly contain derivatives of premature, aggressive, distorted parental imagos without the normal integration of aggressive forerunners of ideal self and ideal object images (Kernberg, 1975).

Abandonment, a Narcissistic Injury

Neubauer's findings, cited above, foreshadow the recent study and conception regarding pathological narcissism, and the etiology of this disturbance. One has ample room to speculate on the overriding character disturbance of the parent who literally or emotionally abandons his or her child, and we can postulate a spectrum of severe disturbances that include psychosis, borderline syndrome and pathological narcissism. Kernberg (1975) describes chronically cold parental figures with covert but intense aggression as a very frequent feature of the background of these patients. Despite superficial functioning, the interaction with the child has a high degree of callousness, indifference, and nonverbalized spiteful aggression which results in intense oral frustration, resentment and aggression developing in the child, who needs to defend against extreme envy and hatred (Kernberg, 1975). Kohut (1971) includes the absence or unavailability of the parent or parents in the early life of the child as creating narcissistic injury and fixation. Events in the early life of a child, such as the absence of a parent, or loss of a parent through death, divorce, hospitalization, or withdrawal because of emotional illness, contribute to the narcissistic fixation in a negative sense. The decisive repression of the archaic, idealized parent imago (or other modes of its inaccessibility, e.g., through a vertical split in the psyche) may take place after the external disappearance of the parent. A protracted hypercathexis of the idealized parent imago may thus appear in childhood when, during an extended period of separation from a parent, the child is not able to withdraw the idealizing cathexis from him, i.e., when he is not able to see the parent in an increasingly realistic light and to employ this

in the formation of psychic structure. The fantasies about an idealized father spun out by children who were deprived of their fathers during the Second World War belong in this context (A. Freud and Burlingham, 1942). It is the fact that the primarily existing narcissistic idealization has no realistic object which causes a gradual disillusionment to take place. There is a lack of opportunity for the gradual decathexis of the child's preoedipal objects, a dearth of structure-building internalizations in the psyche, and thus the child's capacity to desexualize and otherwise neutralize his impulses and wishes remains incomplete (Kohut, 1971).

Clinical Observations

In my work with abandoned children I have been struck by similar findings as those presented by Neubauer. My observations have been further clarified by the recent writings of Kohut and Kernberg. I have been impressed with the specificity of constant object, as well as self-idealization/de-idealization by the abandoned child, following parents divorce, and/or the pathological illness of the parent, resulting in the complete disappearance of the parent or parents. It has made me speculate on the probability of no genuine mourning or decathexis from the vanished parent, without treatment, even after the adolescent period and decathexis surrender of parental surrogates. I postulate that the inability to mourn the natural parent or parents is due to the resultant severe narcissistic disorders following abandonment. Two such abandoned children, to be described later, manifest inordinate idealization and mirroring of the therapist. This appears different than the transference manifestations of children who have lost their parent through death. Further, there appears to be distinct characterological differences between abandoned children and those who experienced a parent's death. This observation stems from work with both such child populations where both have experienced the loss in the first two to three years of life. The abandoned child seems to demonstrate greater pathology and ego deficits than the child whose parent died.

As the child develops strong feelings for the therapist he becomes curious and wants to know more about this person. Persistent questioning will probably lend itself to interpretations in terms of the transference. For instance, if the child asks many questions about the location of the therapist's home, the age of the children there, etc., he probably would like to be part of the therapist's family (Kessler, 1966). I believe that Kessler's comment also applies for the neurotic child. However, the intensity and incessant quality of the abandoned child's reflections are of a different quality, and interpretations in terms of the transference seem to make little inroad, unless we can uniformly assume that the shadowy therapist represents the vanished object, simultaneously also standing

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for available objects in the child's life. For many of us there is not yet general agreement with respect to which of these attitudes the child displays toward the therapist should be presumed under transference. For example, properly speaking, is the enactment with the therapist of current conflicts and reactions which are being experienced in relation to the original objects, transference? Harley (1971) has described this kind of enactment as an extension from the outside into the therapeutic situation and reserves the term transference for the repetitions of past experiences and conflicts which have emerged in therapy as derivatives of the repressed and which are directed toward the therapist.

The descriptions which follow depict something different than the aforementioned transference manifestation, specifically an unusual intensity of need for special idealization and admiration by children who experienced abandonment. They want to both be idealized themselves and idealize the therapist. Self and object idealization by the narcissistically disordered patient reflects the projection onto the therapist of the patient's grandiose self. This can be withdrawn at the end of a session showing a complete absence of real dependence on the therapist early in the treatment process. Gradually the idealized features of the therapist, which at first reflect rather conventional ideal attributes, shift into directions which reveal a particular nature of the patient's grandiose self. Throughout the entire process switches occur. Shifts from periods in which the therapist is seen as perfect change into a complete devaluation of the therapist and self idealization of the patient, only to revert later to the apparent idealization of the therapist while the patient experiences himself as part of the therapist (Kernberg, 1975; Kohut, 1971).

I have attempted so far to describe what has proved to be the more meaningful responses to these needs in the treatment situation as these children experienced their apparent self-object search. The incessant questions, preoccupation, interest in the therapist, and the admiration of the therapist had an idealizing quality and perhaps might be best described by Kohut's (1971) description of the idealizing transference, one form being the reactivation of archaic states which hark back to the period when the idealized mother image is still almost completely merged with that of self. Kohut further states that the establishment of the stable narcissistic transference is the best and most reliable diagnostic sign which differentiates these patients from psychotic or borderline cases on the one hand, and from ordinary transference neurosis on the other. The evaluation of a trial period of treatment is of greater diagnostic and prognostic value than are conclusions derived from the scrutiny of behavioral manifestations and symptoms (Kohut, 1971).

The abandoned child, due to pathological divorce proceedings and/or total surrender, i.e., into foster placement, seems far less empathic, more grandiose and self invested than the children who have lost a parent

through death. Anna Freud describes her work with separated but not abandoned children during wartime, and states that displacements of affect from the loser to the lost becomes still more obvious when the lost object is a human one. There were many occasions to observe those who experienced not their own very real separation distress, but the imagined distress, loneliness, and longing of the parents whom they had left behind. "I have to telephone my Mummy, she will feel so lonely," was a frequent wish, expressed especially in the evening (A. Freud, 1969). This empathy with self and/or object appears completely absent in the abandoned child. Further, the remnants of the internalized object representation acquire the characteristics of real but rather lifeless shadowy people (Kernberg, 1970). The shadow of the absent but existent parent appears to stimulate great idealization by children who have experienced being given up, ignored, and emotionally put aside.

Theories of Narcissism

Much has been written about narcissism. Freudian theory and ego psychology present the development in purely object terms, whereby profound self-investment is viewed as the consequence of defensive withdrawal of libidinal cathexis to others, following injury and trauma. Van der Waals (1965) describes pathological narcissism by stating that severe narcissism does not reflect simply a fixation in early narcissistic stages of development and a simple lack of the normal course of development toward object love, but that it is characterized by the simultaneous development of pathological forms of self-love and of pathological forms of object love. He further states that normal narcissism develops simultaneously with normal object relationships and pathological narcissism with pathological object relationships. Kernberg (1970) describes a process of re-fusion of the internal self and object images and that it occurs in the narcissistic personality at a level of development at which ego boundaries have already become stable. Thus this population is not subject to psychotic regression. He postulates a fusion of ideal self, ideal object, and actual self images as a defense against an intolerable reality in the interpersonal realm, with a concomitant devaluation and destruction of object images as well as external objects. In their fantasies these patients identify themselves with their own ideal self images in order to deny normal dependency on external objects and on the internalized representations of the external objects. The normal tension between actual self on the one hand, and ideal self and ideal object on the other, is eliminated by the building of an inflated self-concept within which the actual self and the ideal self and ideal object are confused. Sometimes the cold, hostile mother's narcissistic use of the child made him special, and set him off on a search for compensatory admiration and greatness and fostered

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the characterological defense of devaluation of others. Many of these patients have occupied a pivotal point in their family structure, such as being the only and/or brilliant child, or the one to fulfill the family aspirations.

In contrast to these theorist/clinicians, Kohut (1971) put forth a different view of the etiology of the narcissistic personality disordered patient. He describes two separate lines of development, an object line of development and a narcissistic line of development. The object line of development is the accepted ego psychology view, encompassing stranger anxiety, symbiosis, separation-individuation, object constancy, the oedipal conflict and object love, i.e., attachment to people as separate from the young child. His second line of development of the self, i.e., narcissism, is not a defensive withdrawal, but a normal developmental unfolding that proceeds parallel to the object line of development. When patients evidence disturbances in the realm of self and of those archaic objects connected with narcissistic libido (self-objects) which are still in intimate connection with the archaic self (objects are not experienced as separate and independent from the self), they are arrested in narcissistic development. These patients remained fixated on archaic grandiose self configuration and/or archaic overestimated narcissistically cathected objects. Under optimum developmental conditions the exhibitionism and grandiosity of the archaic grandiose self are gradually tamed, and the whole structure ultimately becomes integrated into the total personality and supplies the instinctual fuel for our ego-syntonic ambitions, the enjoyment of our activities, and for important aspects of our self-esteem. Under similarly favorable circumstances, the idealized parent image too, becomes integrated into the personality. Introjected is our idealized superego and it becomes an important component of our psychic organization by holding up to us the guiding leadership of its ideals. If the child, however, suffers severe narcissistic trauma, then the grandiose self does not merge into the relevant ego content but is retained in its unaltered form and strives for the fulfillment of its archaic aims. And if the child experiences traumatic disappointments in the admired adult, then the idealized parent image, too, is retained in its unaltered form, is not transformed into tension-regulating psychic structure but remains an archaic, transitional object that is required for the maintenance of narcissistic homeostasis (Kohut, 1968).

A full elaboration of the differences of Kohut and Kernberg or my reactions to their theoretical constructs is beyond the scope of this essay. Concisely stated, their differences are as follows. Kohut establishes a continuity of pathological and normal narcissism, with treatment focusing almost exclusively on the vicissitudes of development of libidinal cathexis, so that his analysis of pathological narcissism is essentially unrelated to any examination of the vicissitudes of aggression, and of

internalized object relations. Kernberg differs and likens his view to those of Jacobson, Mahler, and Van der Waals. He states that pathological narcissism can only be understood in terms of the combined analysis of the vicissitudes of libidinal and aggressive drive derivatives. Pathological narcissism does not simply reflect libidinal investment in a pathological self-structure. The pathological self has defensive functions against underlying libidinally invested and aggressively invested primitive self and object images, which reflect intense, predominantly pregenital conflicts around both love and aggression. Kernberg, Mahler, et al., concur that the development of normal and pathological narcissism always involves the relationship of the self to object representations and external objects, as well as instinctual conflicts involving both libido and aggression (Kernberg, 1975).

Case Illustration: Carol

Carol, age five, was referred to the clinic at her mother's initiative. Mother had previously experienced help for herself in the adult clinic, where she was seen for one-and-a-half years. Mother described Carol as having long-standing difficulties, manifested by incessant talking, defiant provocative pseudo-adult behavior toward her, grandiose, bossy interactions with peers and other adults, and night fears, which caused her to sleep in bed with the mother despite her efforts to stop it and the resulting game of musical beds, played most nights. Mother, an attractive, black woman, is an Aid to Dependent Children (ADC) recipient, who works full time for ADC. She was married for seven years and the marriage was characterized by constant fighting, separations and reconciliations, and five miscarriages before the birth of Carol. The marriage ended when Carol was four months old. Shortly after the separation she met her husband on the street and he is said to have threatened to kill her and the baby. Some weeks later, he kidnapped her off the street and kept her a prisoner in his car for six hours at gunpoint. His described state is psychotic, and the mother says he revealed hearing voices telling him to kill her. When he was not threatening to kill her, he gave her the gun and pleaded that she shoot him. Following this harrowing incident she fled to a southern city, taking the infant, and she remained there for a year. She returned north at the urging of her family and because she had no important ties in the south. She has never seen her former husband again and does not know his whereabouts. He has made no attempt to see her or the child. Mother is aware of Carol's preoccupation with her father, her wishes to see him and fantasies regarding him, his return, and their reunion which she is sure she can facilitate, or notions that father has a new family and has completely forgotten her.

With only occasional glimpses of what the child might feel, mother

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described Carol from a narcissistic stance of what it feels like for her to experience Carol's problems. Mother expressed some guilt regarding her own inconsistency and non-empathic handling of Carol because of her own tensions, fears, and feeling overwhelmed by the responsibility of raising a child alone. Mother has always kept Carol with her, although when overwrought she has threatened placement. This lack of emotional balance and equilibrium is in contrast to her idealization of Carol as the most beautiful, brilliant, and precocious of children. She dresses Carol in a most elegant fashion and takes her—though only age five—to every cultural and artistic event. Mother's colleagues at work were so impressed with her endless accounts of her wondrous child, as well as her frequent displaying of the child at the office to demonstrate and perform, that money has been collected for a college scholarship for this five-year-old.

Carol is a black, dainty, small-boned, charmingly attired child, with a distinctly feminine manner. She is very bright and imaginative, and uses creative and rich artwork and stories as vehicles in the sessions. She was seen as suffering from disturbance in the realm of self, i.e., her mother is not experienced as separate and independent from the self. She demonstrated a compelling need for merger with her mother, the powerful object, and thereby reflected a narcissistic personality disorder.

Treatment and Process

Carol manifested acute anxiety at the beginning of therapy and referred to "shots," patients sitting in their beds at the hospital and clear fear that her mother was abandoning her or giving her away to the therapist. In treatment Carol quickly mirrored her behavior at home with her mother, presenting ambivalence, testing, and requiring actual physical controls as she experienced temper tantrums in sessions. She went through months of provocative behavior, wanting to rifle through all the drawers in the office as well as mishandle the phone and the drapes. She tried to get the therapist to chase her, by dancing around the clinic and refusing to come into the office. Simultaneously she expressed to the therapist aggressive and libidinal impulses, e.g., wanting to kiss and/or hit to see whether limits would be imposed on her impulses.

She responded well to being limited with firmness and consistency and was able to abandon temper tantrums and attempts to destroy the office. She manifested handling frustration in a more appropriate way, and mirrored calm, as beginning gains in regulating and self-soothing mechanisms were made. With the giving up of the provocative testing, she used the therapy time to share areas of anxiety via play and endless, imaginative games, stories, and art objects. At times Carol wanted to be a baby and climbed into the therapist's lap, lay in her arms, and became a very young toddler. She seemed to want to both avoid any interpreta-

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tions, as well as recapture a time when she felt safe. She attempted initially to avoid anxiety in treatment via the infant pose or repeated trips to the bathroom.

Carol, in play and actual discussions, reflected her sibling relationship with her mother, their equal status, and her fear of her mother's rageful responses to her defiance. She also showed problems of fusion and control and a fear of losing a part of herself if separated from the therapist and mother. Carol shared many fantasies about intruders and burglars, and this seemed to indicate concerns about the therapist's private life, like her concerns about her mother's private life, when she slept at her grandmother's. Burglaries of the apartment were a reality and it appeared that her reality fit her fantasy and/or that because of her concerns she fashioned her fantasies out of reality.

In the course of treatment, Carol idealized the therapist and demonstrated her wish for her admiration and idealization of her. "If I'm your first customer today, am I your favorite of all the kids you ever see?" Carol demonstrated mirror and merger transference manifestations, preoccupied with imitations of her therapist, obsessed with all details of the therapist, e.g., nail polish, shoes, hair, etc., and would articulate the fantasy regarding the perfection of the therapist and her ensuing perfection from their closeness. The activity of the therapist is best described as empathic, with detailed attention to consistency, firm limits when necessary, and allowance of Carol's idealization. Fantasies about the worker were sparse (that she lived in a hotel with her husband and cat). Relating concerns about the worker to questions and concerns about the lost object, the father, proved to be only minimally fruitful. Carol always denied not knowing her father. She stated she knew him well and only sometimes would modify this statement to references of really knowing his photograph. "Daddy was bad. He didn't pay the rent. They fought all the time like a little boy and girl, the way mommy and I fight, like two kids." Subsequent fantasies and musings were shared: "Mommy and daddy fought all the time and he didn't take care of us, but maybe now he has a new family and other kids that he does take of. One day he'll come to take care of me."

What proved to be more fruitful was not to puncture or question Carol's grandiosity and need for admiration requested via the endless stories and plays she created and produced in therapy hours. Further, the need for idealizing the therapist was accepted. In accord with Goldberg's (1973) discussion regarding psychotherapy of narcissistic injuries, the worker accepted being assigned the role of a narcissistic object because of the patient's needing the therapist to function as a part of herself.

Treatment also included contact with her teachers and regular educative and supportive contact with her mother and this, coupled with Mrs. M's own concurrent psychotherapy aided her in more consistent and

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empathic parenting and understanding of the fluctuating adoration versus hostility, idealization and devaluation of her, the surviving parent.

Termination was planned on the basis of the child's considerable improvement and mother's increased commitment at her job. Many symptoms dissappeared, specifically enuresis, Carol's sleeping with her mother, and the endless temper tantrums. Lessened was her bossy, omnipotent stance with peers and adults. She became more age-appropriate in her interactions at home with mother, and at school with peers and teachers. Still present, however, are specific narcissistic modes of relating, i.e., a paucity of empathy for peers and a preoccupation with her own needs and feelings. She is bright and does well at school, though somewhat under her potential, given the stress she experienced in an overcrowded, ghetto parochial school. A successful referral was made and accepted for Carol to attend an excellent private school on scholarship.

Case Illustration: Karen

Karen, age 13, a white, very attractive, appealing child, with long blond hair, had experienced far more early trauma and deprivation than the previously described child, the details of which are not known, because of the lack of continuity of care and of information in the cross-country child placement records about this child. For the past four-and-a-half years, Karen has lived in an extraordinary and superior foster home, and her foster parents requested treatment for her.

To date, Karen is in her seventh foster home. Her natural mother is described as a prostitute, who abandoned Karen and a seven-year-old half sibling. The police located Karen's natural father and placed both children with him. He could not care for the children and temporary foster homes were arranged. All of this took place when Karen was reported to be four years of age. The current foster mother states that she is convinced that Karen received initial warm care in that the child demonstrated affection and the ability to relate.

Karen was in one foster home from ages four to six, and two subsequent foster homes for periods of several weeks. She was then placed in a fourth foster home for emotionally disturbed children following her conflict with her stepmother. She was described then as explosive and acting out, cutting curtains, smashing lamps, and being locked out of the house by her stepmother.

The father had remarried when she was six, reclaimed her and moved her with his family to the Midwest. Father and stepmother had had a child together and stepmother had several children from her previous marriage. Karen's half sibling has always managed to remain with the father and stepmother. Father and his family are described as lower class, unskilled, white migratory people. Father worked in a gas sta-

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tion. Once settled after the family moved from the west coast, the stepmother attempted to hospitalize Karen in a state hospital and described her as a "sexually perverted child." The hospital refused admission, stating Karen was not psychotic and referred the family to the local child welfare agency, who placed Karen in a special diagnostic home and tried to involve the parents in therapy, but they could not sustain this contact or accept Karen back. Thus Karen was placed in the seventh foster home, and her father surrendered custody at the agency's request. He was to see Karen on a monthly basis but often failed or canceled visits.

The foster parents describe Karen's significant improvement in their home prior to the onset of treatment. She no longer had explosive temper tantrums and poor control only occurred during times of change, e.g., trips abroad. Along with the subsiding of tantrums, Karen was no longer exhibitionistic, running naked in front of the foster father or when male company was in the house. The foster parents were greatly concerned about Karen's social isolation, unsuccessful interactions with peers, accident proneness, losing things incessantly, and long standing learning disability and inability to read.

Karen was a bright and perceptive child. Her ego apparatus was intact and there was no sign or symptoms of organic defects. However, she presented a picture of serious ego defects. She had difficulty in sublimating aggressive impulses, and frustration tolerance was poor. Her memory on a selective basis seemingly was poor, and school related tasks and skills seemed to be present and then get lost.

The following is a summary of work during three years of treatment. Karen was well prepared for therapy, and highly motivated in regard to her wish to preserve her current placement, as well as to improve her academic functioning. Despite her conscious wish for change she was naturally cautious and mistrustful in first establishing a relationship, and in sharing the painful aspects of her life. She showed all her assets and was charming and cooperative, obviously wanting the therapist's acceptance, clearly to please her foster mother. She seemed initially to have put her best foot forward, as though sensing that her foster home and her survival were at stake. She exhibited the too ready affection and lack of testing out that is commonly seen in foster children or institutionalized children. For many months she only presented her most appealing and adequate side and wanted to "play and be happy" in her sessions. Gradually she made considerable strides in forming an alliance and an ever deepening relationship which became increasingly trusting and confident that the worker could tolerate anything from her, especially her hostility, aggressiveness, and infantile demands. Any separation, e.g., around vacation, was stressful for Karen, and yet the work and interpretations about the fact that all separations do not constitute abandonment was helpful. Concurrent with concerns about separations have

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been Karen's displayed concerns about the foster mother's pregnancy and her security in the placement. She has moved, though slowly, to also share her thoughts and feelings about her natural father, his erratic, unpredictable contact, and the futility to romanticize him with her unrealistic hopes.

Many sessions have been devoted to academic and social concerns. Karen has been able to face and share her social isolation and her prior preference for the tomboyish activities with boys. School as a stress situation was more easily talked about. Recognized was her erratic memory that worked on a selective basis, and school related tasks and skills that seemed to be present would then get lost. Karen's loss of her belongings, and loss of words she could read, and loss of multiplication tables she did know, seemed explained by Anna Freud's comments about losing and being lost. A further, even more far-reaching motive comes into view, identification with the lost objects which symbolize themselves, actively with the parents whom they experience to be as neglectful, deficient and unconcerned toward them as they themselves are towards their possessions (A. Freud, 1967).

During the first year of treatment, appointments were increased to three times a week, at Karen's request, because of her expressed anxiety about the foster mother's pregnancy, and her concerns as to whether or not she was still wanted in the foster home. Karen's intense attachment to the therapist was discernable, and at times she articulated a wish for seven appointments a week. Karen had no friends or companionship except for her peripheral, unsatisfactory contacts at a "Y" swimming and gymnastic program, and at art classes. She was clear in preferring to come to therapy, rather than to play after school. This lasted until the last eight months of treatment, when her social relationships improved considerably and she could enjoy invitations from other children and reciprocity, rather than her early hunger, then provocativeness which spoiled things, which was followed by total rejection by peers. Karen seemed often to desire the presence of the worker as a part of her self, who would observe, reflect and participate in her selected activities, i.e., art work, acrobatics, the creation of craft productions, and the knitting of a blanket for the foster mother's new baby. Karen had a need to buy relationships the first two years of treatment, via endless presents to peers and members of the foster family. These gifts she made in treatment and as her security and permanence with her foster family was experienced, she could give this up. She made 57 wool dolls, many as presents, and the creation of these had a re-birth fantasy, the thread or yarn handled by both of us, the umbilical cord between her and the therapist.

Early in treatment, Karen began to read, haltingly but accurately, but only in the presence of the worker. After six months of treatment she read at a 1.9 grade level, moving from complete illiteracy. Math skills

seemed acquired more easily in that Karen understood concepts, but for a year or more she could not retain memorized multiplication tables although she knew how to count. At the conclusion of three years of therapy she was in a regular seventh-grade classroom, thrilled at no longer considering herself a "dummy or a retard" in a special remedial class. Concurrent with the marked academic strides, her improved self-esteem was seen in her improved peer relationships and her responsible management of some jobs such as car washing, baby sitting, and pet walking.

These improvements came slowly, following a social remoteness and preference for the soothing experience of therapy sessions, where she articulated her pleasure at the worker's pleasure—gleam in her mother's eye, if you will—at her expanding capacities and inordinately creative artistic productions and athletic skills. "I just feel good being with you and near you, even when I draw and we don't talk much." Kohut (1971) defines the mirror transference as the therapeutic reinstatement of that normal phase of the development of the grandiose self in which the gleam in the mother's eye mirrors the child's exhibitionist display and other forms of maternal participation in and response to the child's narcissistic-exhibitionist enjoyment which confirms the child's self-esteem and, by a gradually increasing selectivity of these responses, begins to channel it into realistic directions.

Karen's foster parents were committed to keeping her with them permanently, and viewed the four-and-a-half years with this child as most taxing, but gratifying. They were empathic and consistent parent surrogates, psychologically sophisticated, and not ever overwhelmed or ready to give up. Their intuition guided them effectively, though often there was a need to confer and blow off steam over Karen's impulsivity, temper, stealing bouts for several months, power struggles, short frustration tolerance, etc. Because of the vast improvements in these areas they were increasingly confident, comfortable, and have decreased the need for contacts with the agency and the therapist. Foster parents, agency worker, and Karen's therapist all conferred together repeatedly. Karen's therapist had ongoing contact with Karen's teacher until her academics improved. As this case was concluded, Karen felt and had been told that her foster home was a permanent one. She did not want to be adopted, not wanting, "never again," to see her father. She did want foster care with tenure, which had been guaranteed her by the agency and the foster parents.

Clinical Applications

The two cases presented reflect children suffering in the narcissistic realm—with injuries to their self-esteem—seen as a result of parental emotional and/or actual physical abandonment. I have concluded that

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this new focus on the narcissistic issues of this child population is in keeping with the reality principal governing the functioning of nonpsychotic children, i.e., despite rage, denial, and varying states of complete or incomplete mourning, a child does not retain the death of a parent as so totally a narcissistic assault, as does the abandoned child. Wolfenstein (1966) does mention shame and inferiority following a parent's death, but does not elaborate or further consider specific narcissistic trauma. We can only speculate on the narcissistic disorders of the abandoning parents—having insufficient clinical information regarding the parents of children in foster care and the divorced parent population—who narcissistically use and misuse their children as pawns, part objects, or extensions of themselves. However, the newer narcissistic theory makes clear the fact that the parents or objects of those children suffering narcissistic disorders, are archaic, narcissistically cathected, and pre-structural. Kohut (1971) further states that whether the parents threaten punishment or withdrawal of love or confront the patient with their temporary absence or permanent disappearance, the result is always a narcissistic imbalance or defect with resultant symptomatology, encompassing a range such as lack of empathy, sexual perversions, work inhibitions, depressions, feelings of emptiness, delinquency, addictions, uncontrolled rage, pathological lying, and hypochondriac preoccupations.

Despite our increased ability to predict pathological outcomes we cannot prevent narcissistic pathology, but rather can consider more focused modes of interventions as well as more apt clinical skill in direct treatment with this population. Some preventative work may well be done in regard to divorce counseling to more vividly convey to parents possible outcomes for their children without some consistent responsible parenting by both the father and the mother. Foster home placement might be approached with more caution, and only as a last resort, following other interventions and policy considerations, such as "recapitulation" (Kahn, 1973), i.e., giving some families the monies that would otherwise be spent in placement of the child and helping them to utilize it most productively, improved homemaker services, and the like.

In direct practice with children or adults suffering narcissistic disorders, we can no longer rely on ego supportive work and a push for reality and healthy object relations. Nor can short-term therapy with the aim of symptom reduction be the treatment plan. This patient population relies on the therapist as a self object and requires the opportunity and time for a sustained merger to allow for the necessary internalizations and hopeful growth and development. Being responded to as a part object or an idealized object requires a new therapeutic stance by the therapist, as well as a lengthy course of treatment. What appears to be a patient's separation anxiety and dependency problem frequently is secondary to the regulation of self-esteem as separation relates beyond the loss of a

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person, and really must be viewed as the loss of a part of an already fragmented self.

Conclusions

Work with the children who have experienced loss of a parent or parents led to specific questions and hypotheses regarding similarities and differences clinically observed in the child whose parent had died, and the child who has been abandoned. The abandoned child is seen as presenting considerably more narcissistic pathology, a lack of separation of self and object, and an inability to mourn the lost object because of this lack of cohesive self and thereby relationships are experienced as self objects or extensions of their self. Traditional ego supportive treatment with the goal of facilitating mourning and a reinvestment in new objects is not fruitful with this population, but rather what is required is the therapist's understanding of the need and the granting of permission to the patient to use him as a self object. Traditional treatment approaches and ego supportive work aimed toward mourning can prove most successful in the face of a parent loss by death, which has less of a narcissistic assault and a finality about it that abandonment does not. We can hardly measure and compare the pain and grief and rage of children in the face of the devastation of a parent loss. However, raised for consideration is the question of the additional narcissistic trauma inherent in abandonment, specifically, the profound blow to a child's self-esteem and the sense of degradation and narcissistic injury due to having been given up, put aside, left, or lost. When diagnostic assessments reveal this specific narcissistic vulnerability, new treatment approaches are required.

REFERENCES

- Anthony, E. J. The prevention of aftereffects of separation and loss in latency and adolescence. Address to the Association of Child and Adolescent Psychotherapists of Chicago, Illinois, October 1976.
- Bowlby, J. Grief and mourning in infancy and childhood. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1960, 15, 9-52.
- Freud, A. About losing and being lost. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1967, 22, 321-333.
- Freud, A. Discussion of Dr. John Bowlby's paper Grief and mourning in infancy and childhood. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1960, 15, 53-62.
- Freud, A. & Burlingham, D. *War and Children*. New York: International Universities Press, 1943.
- Freud, A. & Burlingham, D. *Young children in wartime*. London: Allen & Unwin, 1942.
- Freud, S. Mourning and melancholia (1917). In *Collected Papers*, Standard Edition. London: Hogarth Press, 1957, 14, 237-262.
- Furman, R. A. Death and the young child. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1964(a), 19, 321-333.

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- Furman, R. A. Death of a six-year-old's mother during his analysis. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1964(b), 19, 377-397.
- Goldberg, A. Psychotherapy of narcissistic injuries. *Archives of General Psychiatry*, 1973, 28, 722-726.
- Goldfarb, W. Emotional and intellectual consequences of psychologic deprivation in infancy: A re-evaluation. In Hock, P. & Zubin, J. *Psychopathology of childhood*. New York: Grune & Stratton, 1955.
- Harley, M. The current status of the transference neurosis in children. *Journal of the American Psychoanalytic Association*, 1971, 19, 31.
- Kernberg, O. F. Factors in the psychoanalytic treatment of narcissistic personalities. *Journal of the American Psychoanalytic Association*, 1970, 18, 51-85.
- Kernberg, O. F. *Borderline conditions and pathological narcissism*. New York: Aronson, 1975.
- Kessler, J. *Psychopathology of childhood*. New Jersey: Prentice Hall, 1966.
- Kohut, H., The psychoanalytic treatment of narcissistic personality disorders. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1968, 23, 86-113.
- Kohut, H. The analysis of the self. *Monograph Series of the Psychoanalytic Study of the Child*. New York: International Universities Press, 1971, 26, 55.
- Mahler, M. *On human symbiosis and the vicissitudes of individuation*. Vol. I: *Infantile Psychosis*. New York: International Universities Press, 1968.
- Nagera, H. Children's reactions to the death of important objects. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1970, 25, 360-400.
- Neubauer, P. The one-parent child and his oedipal development. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1960, 15, 286-309.
- Provence, S. & Lipton, R. C. *Infants in institutions*. New York: International Universities Press, 1962.
- Schur, M. Discussion of Dr. John Bowlby's paper Grief and mourning in infancy and early childhood. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1960, 15, 63-84.
- Spitz, R. A. Anaclitic depression. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1946, 2, 313-342.
- Spitz, R. A. Hospitalism: A follow-up report. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1946, 2, 113-117.
- Spitz, R. A. Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1945, 1, 53-74.
- Van der Waals, H. G. Problems of narcissism. *Bulletin of the Menninger Clinic*, 1965, 29, 293-311.
- Wolfenstein, M. The image of the lost parent. *Psychoanalytic Study of the Child*. New Haven: Yale University Press, 1973, 28, 433.
- Wolfenstein, M. Loss, rage, and repetition. *Psychoanalytic Study of the Child*. New York: International Universities Press, 1969, 24, 432.
- Wolfenstein, M. How is mourning possible? *Psychoanalytic Study of the Child*. New York: International Universities Press, 1966, 21, 107.