Girls and women are disproportionately affected by chronic pain unrelated to medically defined disease. Because the mother-daughter relationship is pivotal in female development, one can speculate that chronic pain could be entangled with and expressive of the mother-daughter relationship. I describe two women who came for treatment with chronic pain and other psychosomatic manifestations as the primary symptoms. Both experienced profound trauma and had deeply conflicted relationships with their mothers, in which reflective function and symbolic capacity were stunted, resulting in a physical language.

Mothers and Daughters are Connected in Many Ways. Their bodies are similar, and they have physical experiences in common. The mother-daughter pair shares early intense attachments and multiple projections, identifications, and internalizations. These attachments and identifications are bidirectional and transgenerational. In the dyad, both partners shape the relationship (see Beebe and Lachman, 1997; Tronick, 2003).

The balance between merger and differentiation in the mother-daughter relationship varies with the dyad, time, context, culture, and development. However, mothers and daughters, no matter how dissimilar and differentiated,
recognize that they are also physically like one another. Sometimes boundaries become so porous that they may feel they are one another. This sort of partial or complete merger could be called “symbiosis,” although the term symbiosis is conceptually imprecise, whether applied to the early infant-mother dyad or later in the lifespan. What we often call symbiosis (see Mahler, 1975) is a state perhaps better characterized by some combination of the terms “boundarylessness,” “undifferentiation,” and “merger” (Pine 2004). Problems arise, however, in verbally describing individual variants of these nonverbal states. Merger, boundarylessness, and undifferentiation are related concepts, but can connote subtly different aspects of these states. Therefore, for ease of communication, I use the term “symbiosis” in this article to describe the gestalt of these concepts.

States of merger and experiences of boundarylessness, first experienced in infancy, emerge in relationships and experiences throughout the lifespan. These states are an essential part of normal development and life experience. One hopes for a developmental evolution during the lifespan in which the potential for states of merger and boundarylessness is balanced with the potential for differentiation, individuation, and autonomy, to the extent helpful for that person, of that age and circumstance, in that culture. One also hopes for flexibility, so, for example, the girl-woman can, when necessary, experience a psychosomatic oneness with the other—for example, during pregnancy, childbirth, breastfeeding, and the sexual act.

The daughter is faced with the task of separating from a mother who is the first love object, a primary source of multiple psychic and somatic identifications and also a rival for the father (Bergman, 1987; Bergman and Fahey, 1996; Holtzman and Kulish, 2003). This is not always easy. Because of the thick and often conflicted constellations of attachments, likenesses, and identifications spanning the generations of women, the boundaries between mother and daughter, although certainly different in every dyad, can be porous, flexible, and ever changing when development is proceeding well (Chodorow, 1978).

As we well know, sometimes development does not proceed so well. The mother, while feeling an intense closeness with her daughter, must simultaneously hold in mind and nurture the psychic and somatic separateness of the daughter (see Coates, 1998). And the daughter, in addition to having the mother's blessing to separate, must have the constitutional and dynamic wherewithal to do so. Otherwise, the potential for symbiosis is perverted, and the relationship becomes a sticky mess, breeding irresolvable
and unworkable conflicts of rage, hatred, rejection, humiliation, and malevolent envy.

Chronic illness in children and adolescents can powerfully affect many spheres of development. The physical dependence and care required in many illnesses complicates the balances of dependence and autonomy, merger and differentiation, intimacy and separation (Seiffge-Krenke, 1997). Because the mother is usually the primary physical caregiver for the ill child, the regression of illness focuses on that relationship. This situation can become further complicated when the child is a daughter, because of the simultaneous intense, mutually reinforcing pulls of attachment and identification and the porous boundaries between mother and daughter.

Deeply conflicted, ambivalent, and poorly differentiated relationships and their intrapsychic representations can feed illness. This process has been described in diabetes, asthma, inflammatory bowel disease, the painful “crises” of sickle cell disease, eczema, rheumatoid arthritis, chronic pain, and a variety of other illnesses and conditions (see Koblenzer, 1987; McDougall, 1989; Wilson and Mintz, 1989; Fonagy and Moran, 1994; Hogan, 1995; Shapiro et. al., 1995; Finell, 1997; Shapiro, 2003). This is not to say that the conflicts or self and object representations cause the illness. Rather, viewed within a biopsychosocial model, the expression of illness is influenced by a complex and unique convergence of biological, psychological, and social/cultural factors (Engel, 1980), with the relative influences of each varying within and among people.

In psychosomatic illness, physical and emotional factors are inextricably woven together. Symptoms become fixed and rigid, taking on a life of their own and taking over the life of the afflicted person. Chronic pain not associated with definable anatomic abnormalities or physical trauma is a common psychosomatic problem (Shapiro, 1995, 2003). In my experience working with people with chronic pain, both in private practice and in a pediatric pain program associated with a major tertiary care pediatric center, girls and women are disproportionately affected. Hypotheses about female vulnerability to chronic pain have included the tendency for girls and women to internalize; psychophysiolgic differences in pain sensitivity, tolerance, and regulation; cultural forces; and the association of chronic pain with psychic trauma, including childhood abuse, with girls and women more likely to have been abused (Morris, 1991; Radomsky, 1995; Shorter, 1994). These hypotheses have, for the most part, been based on epidemiological data, short surveys or instruments, interviews, and sociologic

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observation. There are few reports of psychoanalytic material gathered from girls and women with chronic pain.

The mother-daughter relationship is pivotal in the lives of most women. Most—but not all—girls and women, in their psychoanalytic psychotherapies and analyses, spend considerable time and effort understanding and working through this relationship (Dahl, 1995). Thus it appears reasonable to speculate that debilitating chronic pain could be or become entangled with and expressive of the mother-daughter relationship.

I describe here two women in their relationships with their mothers. Each came to me with chronic pain and other psychosomatic manifestations as the primary symptoms prompting treatment. I present these cases to illustrate just some of the many ways the mother-daughter relationship and psychosomatic illness can be intertwined. For the purposes of discussion, I focus primarily on the mother-daughter relationship. Of course, that means that I have excluded the myriad of other equally significant issues that arose in treatment. In addition, both cases bring up many questions about the understanding and treatment of psychosomatic illness and trauma. The first case has the added complexity of memories of abuse that arose during the treatment and of multiple dissociated self-states. I have chosen not to discuss these and other potentially controversial aspects of the cases to maintain focus on the mother-daughter relationship.

The first patient was an adolescent when she started treatment, and so the real mother enters the discussion. The second patient was an adult. With her, I focus on the maternal aspects of the transferences.

Case #1

The First Session

I first saw Jenn when she was 15 years old. She was brought by her parents for her debilitating chronic pain.

In the very first evaluation session, Jenn's mother described her as having been “sick from the day she was born.” She had been an irritable baby, seemingly “allergic to everything,” and with a predilection for colds and other viral illnesses. The mother went on to describe how Jenn's multiple illnesses had interfered with school attendance starting in kindergarten. With the onset of puberty, Jenn developed diffuse muscle and joint pains, which slowly increased in severity. Over the year or two before I saw her,
she spent most of her waking hours in bed, ate little, and was unable to leave the house for any activities. The mother described consultations with numerous physicians throughout Jenn's lifetime. They had reluctantly agreed to see me after a strong recommendation by a medical specialist they had consulted. No one in their family had ever seen a mental health professional.

I was immediately struck by Jenn's beauty—she had the face of a Botticelli angel. She was neatly dressed, her shirt ironed. Her body was thin, but not too thin, and she sat quietly, moving very little, and looking down at the floor. She made almost no eye contact, answered my questions in a soft, high-pitched, childlike voice, and had little to say except for describing her symptoms—and only when I asked her directly. She showed no emotion except for the tears that ran down her face when she described how terrible her pain was and how it was equally bad all over her body.

As is my usual custom for most adolescents with severe psychosomatic illness, for the initial evaluation I met with Jenn and her parents together. Jenn's mother, who answered most of the questions, was adamant that there were no emotional problems and that all Jenn's restrictions, including her inability to attend school, were because of severe pain and general predilection to illness. The father was withdrawn and noncommittal. When pressed, he stated that he thought his daughter was sick, but if she had more will power she could do more despite her illness. All members of the family were united in their anger at other health care professionals who either had not believed the severity of the pain, or who had offered no possible solutions.

**The Initial Treatment**

I accepted the family's perception that pain was the major problem and pointed out that it was profoundly affecting Jenn's life and development. We began treatment, agreeing that we would explore the pain, other physical symptoms, and related factors in the life of Jenn and her family. Jenn and her mother shared a profound mind-body split (Winnicott, 1964; Shapiro, 2003). Together they focused on the body. Because emotions and inner life were disavowed and inaccessible to me and to them, I had to enter their world speaking their language of the body. We agreed that Jenn would meet individually with me, once weekly, and that a colleague would meet with the family.

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During the first months of treatment, Jenn spoke in a predictably sweet and concrete manner. She showed little insight into her symptoms or life situation. We talked about her pain, how she could not attend school, and how she was having trouble keeping up with her studies at home. I paid special attention to the severity of Jenn's symptoms and the degree of her distress. We tried adjunctive approaches, such as gentle physical therapy with a carefully chosen female physical therapist, and pharmacologic agents. These adjunctive measures helped only a small amount, but Jenn came to feel that I believed her pain and took her distress seriously and that I was not going to challenge her symptoms or experiences.

She described herself as having always been a sweet, obedient child, with neither anger nor anguish, and with no thoughts except those she perceived acceptable to her mother. Gradually, first tentatively and then in a tearful outpouring, Jenn described to me her despondency, the severe conflicts and daily fighting with her mother, her constant and overwhelming anxiety, and, ultimately, her pervasive and imminent suicidal thoughts and intent. It felt to me like a tidal wave of emotions erupting from a deceptively calm sea.

At this point, I discussed with Jenn whether and how she wanted her parents to understand the degree of her emotional anguish. We agreed that I would accompany her to a family the rapy session. During the session, she described her anguish to her parents. Jenn's mother was initially shocked at the extent of her daughter's emotional distress. However, both parents eventually accepted that Jenn's problems affected her mind and not just her body.

Now our shared understanding of Jenn's symptoms was that they fell into two clusters—physical and emotional. The focus of treatment was on exploring and expanding the two spheres separately, rather than confronting or interpreting the mind-body split. Neither Jenn nor her mother perceived any relationships among her emotional distress, her severe and disabling pain, and her inability to attend school. Jenn's father agreed (although he remained quiet for the most part).

Jenn and I now had her mother's permission to explore the emotional sphere. Because of the extraordinarily close relationship between Jenn and her mother, this permission was essential to proceed. The process was very slow for several reasons. First, Jenn was at that time unable to express any disagreement with her mother or with me. I was concerned that she would agree with my interpretations, in a false-self compliance, resulting in a split off and inauthentic therapeutic process. Also, Jenn and her mother had sought medical advice from many different physicians over the prior years,
and the family, as a whole, was quite mistrustful of mental health professionals. Having worked with many such patients, I knew that if I postulated links between mind and body before Jenn-and-her-mother were able to hear them, they were likely to flee treatment with me and seek more consultations and testing in the biomedical realm. Finally, approaching material expressed in the language of the mind without equally considering material expressed in the language of the body would have negated the most accessible realm of Jenn-and-her-mother's conscious experience.

I gradually introduced the possibility of mind-body interactions. Over time, Jenn began to make connections between physical and emotional symptoms. One day, about eight months after beginning treatment, in a remarkable leap forward, she told me that her inability to attend school was not because of pain, but rather because of longstanding severe anxieties, which she did not understand.

After Jenn made this crucial connection, I again accompanied her to a family therapy session. In the session she told her parents that it was her anxiety, and not her pain, that kept her from going to school. The mother at first protested, but then gradually accepted the connection. The mother's acceptance again gave Jenn and me permission to further explore connections between her somatic symptoms and her emotions and thoughts, both in the past and the present.

Jenn, her parents, and I were slowly establishing some trust and the beginnings of a therapeutic alliance. They no longer sought consultations from multiple medical specialists. After we discussed the need for Jenn to explore and understand her anxieties, they all agreed to my recommendation to increase the sessions to twice weekly.

Jenn's psychological symptoms rapidly increased in severity over the next several months. She had severe insomnia and repetitive nightmares of rape. Dissociative states occurred during the day, during which she would experience, as if real, the presence of a man who was raping her. She had episodes of uncontrollable rage, with destruction of physical objects in her environment. Jenn also described the emergence of voices, one male and the other female. The male voice urged her toward suicide, telling her that she was worthless. The female voice criticized everything she did. Jenn understood that the voices came from her, but that did not assuage the torment. I viewed the voices as representing savage and primitive superego introjects, and told Jenn and her parents, in responses to their questions, that she was in anguish for reasons we did not understand but was not psychotic.
Jenn's distress continued to escalate. About 1 year after treatment began, she experienced multiple pseudoseizures and episodes of bulimia. Her suicidal ideation was overpowering, and she made two suicidal gestures, followed by brief hospitalization. It became clear to Jenn, her parents, and me that hospitalization did not address her substantive chronic problems. All of us decided together that we would continue the psychotherapy and that the emotional and suicidal crises would be weathered at home, with the family providing safety (which, despite their problems, they were well able to do).

In the psychotherapy, exploration, insight, and understanding were accompanied by working on affect tolerance; awareness of mind, emotion, motivation, and agency; and self/other boundaries. Obviously, the holding environment and supportive approaches were necessary for this intensely distressed and suicidal adolescent. I avoided working in the transference, because Jenn's ability to play with reality and experience “as if” situations was shaky. It was difficult for Jenn and for me to contain the onslaught of material and crises in two sessions weekly. I recommended increasing the frequency, but Jenn's parents declined.

After months of anguish and distress, about fifteen months after we began treatment, one night Jenn told her mother of repeated severe physical, sexual, and emotional abuse by an older male relative, starting when she was about 4 or 5 years old, and continuing through early adolescence. Jenn's mother was aware of the controversy surrounding the emergence of memories of abuse. She called me to let me know what Jenn has said, that she and her husband believed Jenn, and that the details that Jenn shared were consistent with her memories and those of her husband. The older male relative was known to have abused drugs for years and to be deeply troubled and potentially violent. She wanted me to know this before I saw Jenn the following day.

With the emergence of this material, the parents agreed to increase the sessions to three times weekly. (However, because of external factors, my colleague was no longer available for family therapy.) Jenn described sexual abuse with oral sex and fondling starting around age 4. This progressed to a sadomasochistic relationship. For example, she described being beaten and burned with matches, and she detailed the relative's drunkenness and use of drugs. Jenn said the relative told her that if she told, no one would believe her and everyone would think she was a “dirty little girl.” Jenn described suicidal thoughts starting at the age of 7. She wanted to be with the angels. She told how a presence called Bubba joined her when she was

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alone, soothing and comforting her. Jenn and her mother remembered that she
did not grow normally between the ages of about 5 and 8, and this failure to
thrive was the focus of medical concern. Jenn wondered why her parents
never suspected that something other than physical illness was wrong. (Note:
for reasons of confidentiality, I have left out salient aspects of what Jenn told
me about the abuse. However, based on the extensive details supplied by Jenn
and her parents over time, and on various clinical aspects of the situation, I
believed that Jenn had been severely and chronically abused, that the male
relative was the source of the abuse, and that the material was not
immediately available because of a combination of repression, dissociation,
and disavowal.)

The Question of Analysis

I had discussed analysis several times with Jenn and her mother. Jenn was
interested but then decided against this step after discussion with her mother.
The treatment introduced intense loyalty conflicts for Jenn and clearly
threatened the exclusive and intense closeness between mother and daughter.

I knew by then that Jenn's mother did her homework for her, slept with her,
told her what and when to eat, and generally structured her existence. Jenn
hated this. However, at the same time, she and her mother saw any separation
as abandonment and sense of separateness as self-annihilation. The two clung
to each other. If Jenn's mother withdrew support in any way, Jenn's suicidality
increased. I was often perplexed and overwhelmed by the intense suffering
and ongoing torment. The necessity for suicide precautions made the
condensed symbiosis and rapprochement conflicts extremely difficult to
unravel and interpret.

Jenn reported that her mother usually told her what she should discuss in
her sessions and asked for a reporting at home. Jenn's role in this gradually
became apparent; she readily reported her session to her mother and asked
her what she should discuss. Major issues often came up at home with her
mother and not in the sessions with me. This included the emergence of
various altered self-states. For example, Jenn talked frequently about
"Cindy," describing the way she acted and what she said at home. We
discussed some reasons why "Cindy" emerged at home and not with me,
including feeling greater safety at home now that she had disclosed the abuse;
her fear of separating from her mother and of feeling close to me; and the

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use of flashbacks, details of the abuse, and suicidality at home to gain her mother's attention and to punish her and me. Her mother, in turn, was still somewhat suspicious of the therapy and welcomed Jenn's confidences. I frequently wondered whose therapy it was and who was the therapist.

Jenn often asked her mother to join us for part or all of a session, particularly when the two of them were experiencing difficulties, when painful material was emerging, when Jenn was feeling rageful toward me, or when Jenn's safety or health were threatened in some way (e.g., with intense suicidal thoughts or plans). Over time, I appreciated more and more the extent of the boundarylessness between Jenn-and-her-mother. I began to wonder if I should change the frame and treat the actual symbiotic dyad, with the mother present in all or most of the sessions, rather than focusing on the individual work along with parental guidance and support. After struggling with this idea for some time, I saw potential benefits and losses on both sides, and eventually decided to talk about it with Jenn. She vigorously vetoed this possibility, saying that she needed time with me by herself if she was to have any hope of ever separating from her mother. After some discussion, we decided together to continue the same frame, with the focus on individual work, supplemented by joint sessions, most with Jenn and her mother, and some with both parents and Jenn. (Jenn had always been clear that she did not want me to meet with either of her parents without her.)

Jenn's mother was often understandably perplexed about how to handle difficult situations at home, such as Jenn's altered self-states, rages, suicidal gestures, and other problems. We often discussed, with Jenn present, how to think about and approach these problems. During sessions with Jenn and her mother, it became clear that Jenn's malevolent and punitive superego made her perceive her mother as a witch (Dahl, 1989). I believe the mother was aware of this, and her suspicion of me was in part her fear that I too regarded her as a witch. The joint sessions appeared to help the mother realize that I appreciated her difficulties in caring for Jenn and that I could see she loved and cared for her daughter. Both Jenn and I needed her mother's ongoing permission and support for treatment to continue.

One day Jenn demanded that her mother come into her session. After all three of us were seated, Jenn said that she was in an intolerable position between her mother and me and that she wanted the two of us to work it out. She then proceeded to say that she did not want to hear negative things about me at home. Her mother agreed. Jenn also said her mother was talking about decreasing her sessions and that this was not acceptable. The mother again agreed. I saw Jenn's courageous confrontation of the loyalty
conflicts as signaling a beginning separation and individuation. This led, over the next few months, to Jenn and her parents deciding to start a four times weekly analysis.

**The Analysis**

The conversion from psychotherapy to analysis occurred approximately 2 years after the initial evaluation. It was relatively quiet, as Jenn was already coming three times each week, and our basic frame and mode of interaction remained the same. Rarely was she quiet within a session, although her mood and state varied widely within and between sessions. However, there were important qualitative changes. The sessions, although still tumultuous, were somewhat decompressed in intensity. Material that both of us knew had previously been avoided began to emerge. Because of the increased continuity and strength of the holding environment, we were able to work directly within the transference-countertransference matrix. The intersubjective realm became the fulcrum of treatment.

During one session, Jenn became quiet, put her head down, then jumped, looked startled, and began to talk like a child, appearing very disoriented. I asked, “What's happening?” Jenn asked in a childlike voice where she was and who I was. I answered, and remarked that this sounded like what she had told me was happening at home. She replied, “Jenny the 18 year old must have told you,” and that she was 7 and her name was Cindy. After a while she said it was time for her to go and for “Jenny the 18 year old” to come back. Then she put her head down, was quiet for a minute, and appeared disoriented when she looked up and at me again. She asked if “Cindy” had been there. I told her exactly what I had observed of her behavior, not commenting on the meaning nor ascribing any label.

As the months and years progressed, various self-states began to make regular appearances in the sessions. At first these states usually emerged at home, with the mother. As time went on, some states appeared first with me. With the emergence of each state, I focused on exploring experiences, thoughts, and feelings within that state, the dynamics of why that state emerged at that particular time, and what the states represented. We began to see how the emergence of disparate states enabled Jenn to experience and express feelings and conflicts that were otherwise unspeakable. If, for example, Jenn became angry with her mother, one of the “alters” (Jenn's word) would emerge and throw shoes. Jenn pointed out the secondary gain.

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of the child “alters” at home, saying, “My mom coddles them. She doesn't pay much attention to me.” In a joint session, the mother acknowledged that this was the case. I also was aware of the countertransferential pull for me of the child self states.

After a while, it became clear that at home, Jenn-and-her-mother viewed and treated the self-states as discrete persons. I stated my view that these personae were all aspects of her self. I saw similarities between the way I worked with Jenn's self experiences and the way in which I work initially with people with chronic psychosomatic symptoms (Shapiro, 1995, 2003). I followed Jenn's lead in the choice of words and descriptors. For example, after she used the phrases “coming out” and “alters” several times with regard to the emergence of various self-states, I used those words in the same way. In general, in exploring, I used her words; in interpreting, I used words indicating the presence of a total self in addition to the split off parts. My aim was to enter into her experience and portrayal of the world while at the same time not reifying any particular aspect, similar to our previous work when her world consisted only of physical symptoms. (Note: Jenn's diffuse pain and other physical symptoms faded as various self-states emerged and generally became concentrated in a few “alters.”)

A central theme of the analysis was Jenn's relationship with her mother. She stated that she and her mother were “… like twins—we feel the same. It is our life, not my life.” I replied that this closeness was both a burden and safety. She discussed her wish not to take such responsibility for her mother's well-being and to be her own self. She then got a small tattoo, which she saw as important for its symbolism in going against her mother's wishes, especially where her body was concerned. Later she told her mother, “As much as I love you I also hate you … I will have to deal with my anger toward you for me to go my own way.”

Jenn gradually revealed the extent of physical closeness with her mother. They usually slept together, with their joint attention focused on the care and well-being of Jenn's body. Jenn longed for her mother's physical closeness. In addition, she had sexual fantasies about her mother and perceived her father as a rival. Sleeping together served to get her mother out of her father's bed. She also had fantasies about her father; keeping her mother out of the marital bed served to preserve her father for herself. Thus the problems in separation were both dyadic and triadic (Holtzman and Kulish, 2000).

Depression ricocheted around the family. When Jenn became profoundly depressed, her mother rallied and cared for her, her own depression...
appearing to improve. Other times, the mother was severely depressed herself. Each appeared to gain strength when the other was depressed. I pointed this out, first with Jenn, and then at her request in a joint session with her mother. I urged the mother to obtain psychotherapeutic help. She was resistant to the idea and resented the suggestion, saying that I was presumptuous and intrusive. Jenn said, “My mother says she will get better when I do.” We agreed that this was quite a burden. Although the mother did not get treatment, we were able to ease some situations with the joint sessions.

My vacations and breaks were difficult for all of us. Jenn literally could not retain the image of a person who was gone. “First the sound of your voice goes. Then I cannot see you any more in my mind's eye. Then I get agitated and angry. Then you are just a name.” Jenn and I called it “losing me in your mind's eye.” One can speculate problems in object permanence as well as object constancy. Jenn reacted to upcoming separations not just with rage and terror but also with a dramatic increase in suicidality and regression of ego strength. Eventually we figured out that in Jenn's mind her suicidality simultaneously punished me for going away and ensured that I would be worried enough to keep her in my mind. This worked quite well; my concern and guilt kept her in the front of my mind. We related this enactment between Jenn and me to how Jenn used suicidality at home to punish and control her mother while also keeping her close. Jenn was convinced that the only way her mother continued to keep her in mind was to worry about her. Therefore she did whatever she felt was necessary in order not to lose her image of her mother having her in mind (see Coates, 1998; Fonagy and Target, 1998).

Jenn discussed how she would like to have her own life, separate from her mother but at the same time viewed any separation as abandonment and lack of caring by her mother. I remarked that the same thing happened in the analysis: she either felt controlled or abandoned by me and hated herself and me for both feelings. One day she reported a conversation that one of the altered self-states (Tina) had with her mother. Tina said that the mother had it “all wrong in regarding Jenn as weak and unable to do for herself.” Tina pointed out that the mother left during the day for work, leaving Jenn to take care of herself, but then would sleep with Jenn at night when Jenn claimed that she was unable to sleep by herself. She told her mother that she should understand the difficulty but should not treat Jenn as if she were unable to do anything for herself. “Tell her she is strong enough to make it through the whole night alone. I’ve been waiting my whole life to
hear this. It's always that I'm weak and crazy. You say you can't leave her. How can I feel strong?” (Note here the changes in who is designated as “I”—an indication of the dynamic shifts and permeability in the system of self-states.) After this discussion, Jenn began sleeping by herself most of the time, with a few regressions.

I was aware that Jenn and her mother were reading and discussing books on multiple personality disorder (MPD). Jenn was terrified that she had MPD. I empathized with her fears, discussed dissociative identity disorder and then asked whether there was another side to this—something positive for her. She talked about her need to have a name for what was wrong and to have a diagnosis. She associated to always being identified as the sick child, always taking and being given pills, always going to the doctor, and always having one diagnosis or another. “I always wanted to be sick rather than well. If you are well, they expect more of you.” This feeling highlighted an important area, which we continued to explore: the wish for a diagnosis, the need to be labeled as very ill or crazy, the dangers involved in any improvement or strength. I speculated to myself that this provided a vehicle throughout Jenn's life for Jenn-and-her-mother, as a merged unit, to displace and project inner, undefined badness into a less-threatening, external, medicalized entity. The hatred of mind and intrapsychic contents was safely held by physician authorities within diagnoses. The projection and the search for a name also unified disparate and chaotic inner states.

Over time, we built a detailed picture of Jenn's development. Her mother had recurrent problems with depression, although they were never identified as such. The mother told Jenn and her siblings that all her problems started when the children were born. Jenn recalled her mother constantly crying in the kitchen when Jenn was very young. Jenn would pat her face and attempt to comfort her. “I would do anything to bring a smile to my mother's face.” The mother reported that she never bonded with Jenn's older brother and sister but then felt intensely close to Jenn. She speculated that this was because of the effect of Jenn's numerous minor illnesses and allergies, which developed soon after birth.

Over the course of the analysis, it became clear that Jenn had never been able to separate from her mother. She and her mother recalled intense terrified screaming, to the point of exhaustion, at any brief separation or being put in her room to sleep at night. At the same time, as a toddler and young child, Jenn frequently wandered away from her mother, several times disappearing while on the beach or in a shopping center. She wished for her mother to come and find her but thought she would not notice her absence.
Other times she fantasized being found and adopted by a different and more loving family. In the sessions, running away emerged with certain “alters,” who wished only to run away from where they were. Jenn noted that the feeling was the same as when she ran away as a small child. The running away and getting lost appeared developmentally related to the problems of the dyad in attachment, separation, and aggression (see Fonagy, 2001). Jenn became lost and was unable to find herself in her mother’s mind’s eye. At the same time, in her rage, she killed her internal image of her mother and lost the image of her mother in her mind’s eye.

Jenn and her mother both experienced a great deal of difficulty regulating aggression—individually and as a dyad. Jenn reported her mother's frequent rages and related being hit and slapped and seeing the same happen with her siblings. Jenn herself had numerous prolonged and unmanageable temper tantrums, which disappeared totally after age 5 (perhaps when the abuse started). These tantrums and rage reactions later reemerged at home and in the sessions in the form of rageful and out of control “alters,” seeking to torment, control, and abuse me. We talked about her fear of being like her mother in being unable to control her rage. She perceived that her rage was responsible for her mother's depression and unavailability. She also felt that if her mother had not been depressed she would have prevented the abuse.

After several years of analysis, Jenn questioned why her mother turned to her for solace and not to her husband. She talked about this with her father and told him that the mother's welfare was his responsibility, not hers. The symbiosis between mother and child both created and was enabled by the father's lack of involvement.

**Case #2**

Four days each week, I heard Pat's sneaked feet slowly plodding across the carpet to my door. She would knock softly, peer around the corner, and glance at me as she shuffled into the room. Sometimes she smiled slightly—more often as the analysis progressed. She would lower herself painfully into a chair. (She could not lie on the couch.) After a short pause, she would speak—her voice low, quiet, even. If the heat was blowing, I had to lean forward to hear her. For two years, she started with a comment about a physical symptom. Then her first words started to change—sometimes her daughter, sometimes a symptom, sometimes a complaint about her parents.
or her husband. As the session would proceed, her words gathered force, with little change in her tone. Usually she would end up, in one way or another, talking about her mother. She told heart-rending tales of abandonment, abuse, bitterness, hopelessness, isolation, and despair—and sometimes of hope, love, pride, and beauty. Her words and phrases were articulate, poetic, evocative, and aloof. Occasionally she cried silently. As soon as I would announce the end of the session she would stop, get up with her head bowed, and plod back to the door. Our eyes would meet in a fleeting glance. “So—see you tomorrow?” she would murmur deferentially. “Yes, tomorrow,” I would reply. We then would nod, our gazes would meet again, and she would leave.

The Beginning

Pat was 39 when her physical therapist, concerned and frustrated by Pat's unremitting chronic pain, referred her to me. She came with some trepidation, as she had sought psychotherapeutic help from men before but never from a woman. Pat got along better with men. She was concerned that her relationship with her mother would pollute her ability to work with a woman. However, at the same time she was desperate and knew I had experience working with people with chronic pain.

When I first saw Pat, she moved slowly, stiffly, with obvious pain. Her face was masklike and downcast. I winced on seeing her. She was housebound, able to walk only a block, very slowly. Her days were consumed by stretching and icing her painful muscles. She was considering using a wheelchair.

Background

The pain started when Pat was in her late twenties. She and her husband had moved across the country from her parents. Pat, a bright, articulate woman who did well in school, decided to go to law school. One day she shared her plans with her mother, who was visiting. Her mother said, “You can't do that. That means you won't be able to take care of me.” The pain started a few days after this conversation, and in a few months had spread all over her body. It continued to worsen.
Pat's father was alcoholic and physically abusive to her mother. Her mother was deeply sadistic, self-involved, and depressed, and she had attempted suicide on numerous occasions. The mother had another daughter by a prior marriage, whom she had given away at the age of 3 years and never saw again. The mother herself had chronic severe pain. The problems spanned the generations. Pat's maternal grandmother had died when her mother was 3 years old. The grandfather remarried; Pat's mother described her stepmother as physically abusive and cold.

Pat remembered that when she was 3, her mother became withdrawn, sometimes not speaking. She beat Pat fiercely and often, prompting complaints from the neighbors. Then, when Pat was 6, her father left to serve in the military. Pat's mother abruptly and without explanation sent her to an orphanage, where she stayed for six months until her father returned from the war. No one in the family ever spoke of the orphanage or offered Pat any explanation.

After Pat returned from the orphanage, the house was filled with fighting, physical violence, and cold silences. Her father told her she was to blame for the mother's suicide attempts, and the mother told Pat that she was responsible for her (the mother's) happiness. Pat described being used as an object for her mother's rage, contempt, and envy. She recalled no humor or laughter in her house and reported that her mother, who could be very charismatic, laughed with others and then when back home became silent and rageful with her daughter.

According to Pat, her mother loved babies until they showed “a mind of their own.” Her mother had boasted about feeding her cream as a baby so she would be as fat as possible. Pictures confirmed that Pat was indeed a fat baby. The mother herself was anorectic, and after babyhood often did not feed Pat adequately. “I would be starving between meals and would steal plums from the trees. Then at meals she would stuff me.” Pat speculated that her mother could not abide Pat's becoming her own person as she grew out of babyhood. She linked this to the mother's abandonment of Pat's half sister when the sister was 3. Initial boundarylessness during infancy was followed by overt rejection and hatred at the first signs of differentiation and individuation.

The dyad was filled with envy. Pat's mother disparaged and attacked any areas in which Pat showed ability and interest, such as ballet, schoolwork, and art. Later, when Pat had a boyfriend, the mother asked to speak to him alone and persuaded him to break up with Pat. Pat had trouble seeing her own envy and contempt, but one day described walking next to her mother
when she was 10, assessing her mother's slim but feminine body. They were
dressed in identical spaghetti strap sundresses, which her mother had made.
Pat felt a sense of superiority—that her slim, hard, flat-chested body looked
better in the dress than her mother's.

The Analysis

I began Pat's treatment with some apprehension. I was relieved when she
talked and talked, with evident relief. Her symptoms lessened and her
function improved. We developed a solid therapeutic alliance. I often felt like
a nonperson. I liked Pat and was drawn into her eloquent and evocative word
images.

Pat feared that I would either attack her or leave her. “In the meantime,”
she said, “I will make hay while the sun shines.” I saw the “making hay” as a
metaphor for her islands of resilience and strength; she had been able to take
advantage of small opportunities for positive interactions during her
development.

Her transferences were reflected in the many dreams she had about our
relationship:

She dreamed she was on the beach and saw some shards from green
glass bottles. The shards looked smooth and inviting but in reality
were sharp and would cut if she picked them up. She associated to
her fear of the analysis and me; she felt plunged into a darkness in
which she could no longer see or anticipate dangerous objects.

She dreamed that she went into a public bathroom and saw an
apparently normal woman at the sink. The woman looked up and
she had no face, only slits for eyes. Then the woman laughed,
ripped off a mask, exposing a monstrous face.

A central conviction emerged—that I, like her mother, was unreliable and
likely to be cruel and abuse her, and, therefore, the safest course was to rely
only on herself. This protected her from betrayal, overwhelming
disappointment, and abandonment. She literally had no expectations of me and
so literally did not feel abandoned, disappointed, or angry. “I accept that you
are irrelevant.” We discussed the threat of destruction with any hint of anger
or frustration—destruction of her, me, or both of us. She stressed the
futility of allowing herself to experience painful feelings, which would have no impact on my actions, like my going away for holidays.

She said one day “I live between fury and terror.” Indeed that appeared to be the case, with the key word being “between,” as the zone between was devoid of words, intense feelings, and the fury and terror that lived between us were seen and experienced by her and me as omnipresent but in the distance. She put up walls of thick soft cotton to keep me at a safe distance, absorbing the intensity of sound and movement and yet also cushioning against what was clearly a greater danger—that we would be close enough to destroy one another, like her and her mother.

Despite all this, she reported progress. She went to the movies for the first time in 10 years—and enjoyed it. She and her family vacationed at the beach, and, for the first time in years, she was able to walk on the sand up to the water without undue pain. Her home rituals of icing and stretching quietly receded, taking less time.

Over time, a new element was introduced into the sessions. This consisted of rhapsodic, detailed, and moving descriptions of small things that brought pleasure and beauty into her life—for example, her garden and her bonsai. She described transforming a small plot of dirt into a blooming and colorful rose garden. I responded with delight, and she and I spoke of transformations and change, staying within the metaphor. This was the counterpoint to the negative and traumatic transferences and enabled us to continue.

**The Illnesses**

Her illnesses kept us at a distance. Pat had a history of allergies, asthma, and bronchitis. However, starting in the second year of analysis, these symptoms and ailments started to cascade. She developed disabling episodes of chronic and recurrent sinusitis, accompanied by severe asthma. She had sinus surgery, with a difficult postoperative course. She developed a cyst in her hard palate, which had to be removed surgically, hemorrhagic uterine bleeding, and assorted other serious problems. At times, various muscle groups would go into painful immobilizing spasm, and she would stay locked for days and sometimes weeks. She missed many sessions, sometimes more than one or two weeks at a time, because of the illnesses and pain. She said one day while leaving my office “You had better fix your
heat or you will kill all your patients and then you won't have anyone.” I was the sadistic, murderous, intrusive, and neglectful mother against whom she had no recourse other than to maintain both physical and psychic distance.

I pondered whether the analytic material was deepening too rapidly, contributing to changes in her immune system and spasm of smooth muscles. A psychosomatic split serves primitive defensive functions, and we were bridging this split around the area of her pain. At the same time, I realized that these problems were tormenting and binding her and that this turn of events was expected and perhaps necessary in Pat's analysis. The psyche and the soma, divided, must enter the analytic room, unified within the transference-countertransference matrix, or else the mind-body split will be eternal.

Pat related her asthma and her anger. “I can't get angry when I can't breathe.” I remarked on her perception of her anger as destructive to herself or to others. She said, “My insides are being eaten away by the bitterness. If I live long enough, perhaps something will happen to the people who have it so good.” When I asked about her feeling while talking about this she replied, “A feeling in my chest—like I can't breathe.”

She then spoke of the life and death struggle between her and her mother, in which she was responsible for keeping her mother from committing suicide and at the same time they hated one another. “It's as if my hands are around her neck and her hands are around my neck, choking me. Neither of us can let go because the other would win.” This vivid image became part of our analytic repertoire.

Pat described her mother as occasionally warm and loving. During those interludes she would be “seduced” by the possibility of safety and love. Rage and abuse would quickly and unpredictably destroy the warmth, but during the good periods, Pat would suspend her anticipation of what was to come. “I become undone by the smallest kindnesses that come my way. It's like instant glue, and simultaneously fear and the wish to get away.”

She feared losing her self-identity if she felt love—with her mother and with me. Somehow she fought back, and through anger maintained a sense of self. However, she said, humiliated by her longing, “If she had offered me love, I would have given my self up for it.”

These dynamics were reflected in the transference. Her warm feelings for me evoked the wish for and fear of merger, along with humiliation, rage, and terror that she or I or both of us would be destroyed. She responded

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by establishing a safe psychic and somatic distance. Talking about this she said, “It's like a planet revolving around the sun. As you get close, the warmth is lovely, so you get even closer. Then it gets too hot, hurts, and you go away. But then it gets cold and dark and you turn around to get close again.”

Pat came into one session complaining about a muscle spasm that started after the prior session. “If what I say here is going to make me limp, the idea is to get better, not to disable me.” I commented on her perception that I was making bad matters worse. She said, “I'm the one who has to pay. It's like with my physical therapist. She got to go home to her nice home, and I would suffer. There is no safety net. Yet staying where I am is no solution.” I was the toxic mother, living the good life while poisoning her body with my words and by my very existence. The transference-countertransference matrix became a life and death struggle, in which her body was “a monster—requiring all this time.”

**The Pain**

Pat suffered and she endured her suffering. Nowhere was this more evident than in her perpetual pain. The pain, along with her relationship with her mother, was one of the organizing themes of the analysis.

We saw how the pain motif intertwined with many aspects of her relationship with her mother. In her pain, she was like her mother, who also had chronic pain. She felt herself to be intertwined with her mother and at times was not sure of the difference. Pat noted that her mother had expected to die at age 30 (she did not); this was frequently discussed within the family. Pat's life “blew apart” when she was 30. She spoke of her mother as her “… mirror … my mother and I will die at the same time … our symptoms are uncanny mirrors of one another … I got depressed for the first time after she was very depressed… I was locked in with her and had to die if she did. After all I was her little ray of sunshine, and if she were depressed it was my fault.”

Pain served a fantasized masochistic function. “My mother said I was a bad child and now I have pain … she said I don't deserve a husband or my home or a child … what she can do I cannot do… I am not allowed … my mother wants my suffering as her present from me.” Pain protected against the double-edged threat of failure and of surpassing her mother. Significantly,
she developed pain after announcing to her mother her plans to go to law school (see Moulton, 1975). Pain kept her from having to visit her mother and care for her when her mother became ill.

Pat identified some of the pain as remembered sensations from the past (see Hopenwasser, 1998). For example, both her shoulders were frozen, and the degree of immobility was resistant to the best efforts of the physical therapist. When discussing this she said, “Maybe this is a crazy idea, but the feeling in my shoulders is just like the feeling I had when my mother would be hitting me and I would drop my arms and keep them immobile in order to avoid hitting her back.” We discussed how the pain was both a body memory and a protection against loss of control over her rage.

**Discussion**

Some occurrences of psychosomatic illness have been described as “one mind in two bodies” (McDougall, 1989; Seiffge-Krenke, 1997). This expression richly evokes the symbiotic aspect of the mother-daughter relationship in these situations. However, it leaves out other aspects, such as tormented conflicts in the dyad and the triad, involving aggression, humiliation, rage, malevolent envy, rejection, and hatred. Psychosomatic illness is highly complex, overdetermined, and multifaceted, as is the mother-daughter relationship. Therefore, I present these cases not to generalize about that which is fluid and highly complex but to illustrate a few of the myriad ways that psychosomatic illness and the mother-daughter relationship can be entangled.

Jenn clearly was a vulnerable child before the abuse. She probably had some constitutional difficulties affecting psychophysio logic regulation, conflated with the problems in attachment and interactional patterns with a depressed and intermittently explosive mother (see Tronick and Weinberg, 1997; Fonagy, 2001). The father was both uninvolved and excluded. Thus he was not able to serve the potential role of the second parent in loosening the highly conflicted and yet gratifying symbiosis between the child and the primary early care-giving parent. By history, the attachment sounds disordered and chaotic. This, along with these veretrauma, is consistent with Jenn's lack of self and object constancy and profound dissociation of multiple selves (Cicchetti and Toth, 1995). The mother's depression continued throughout Jenn's life. Early patterns of interaction could not be reworked during later
developmental phases, and without the interactional and protosymbolic basis for forming a coherent sense of self, Jenn could not navigate separation and individuation, regulate aggression, or achieve object constancy. The mother's own relational problems, family dynamics, and transgenerational patterns also maintained the symbiotic bond between mother and child (Fraiberg, et al., 1975; Hesse and Main, 1999). Illness became the glue for the dyad and for Jenn's chaoticsense of self. The illness strength ened the father's exclusion, removing him as a rival for each member of the dyad.

Trauma further fragmented Jenn's experience of herself and others, interfered with libidinal development, introduced insolvable oedipal conflicts, and strengthened her sadomasochistic solutions. Dissociation of self and affective states was defensive, expressive, and functional developmentally. The dissociation between mind and body was a major defense of the mother-daughter dyad and served to maintain the merged state while projecting the hatred and aggression into the illness.

By contrast, Pat most likely was born with a constitutional resilience (Weil, 1970). She described herself as “one of those people who can soak up any little hint of warmth that comes along.” Although there were few favorable developmental opportunities and objects, she took advantage of each of them. Yet, external impediments to her development were profound. Her mother never saw her as a separate and feeling being but rather as a repository for the mother's hatred of her own mother and stepmother and of herself. She was able to care for Pat's body during infancy, although she stuffed her with calorie-laden and nutrient-poor cream. The anorexic mother made her baby fat. Pat's strivings for independence and self-expression were anathema. She was overtly and clearly rejected, malevolently envied, and hated by her mother. In turn, Pat hated and envied her mother while longing for her approval.

The symbiosis between Jenn and her mother was ongoing, although conflicted by hostile aggression, rage, and guilt. For Pat, symbiosis dissolved and was replaced by a sadomasochistic struggle to the death, which kept mother and daughter close but not merged. The one was selfish love; the other was selfish rivalry (Bergman, 1987). The pain served different functions in each dyad.

Overall, these two cases illustrate two tormented and traumatized mother-daughter dyads. For both, the body was a primary arena of suffering and expression. Both mothers were depressed, affecting the daughters at all stages of development, including early attachment and interactional
patterns. The daughters felt responsible for their mothers' depression and well-being. Their guilt was profound. Both dyads were locked into a rapprochement-like struggle, and both were caught in unworkable triadic passions and rivalries.

In both relationships, for developmental and conflictual reasons, self and other could not be regarded as integrated thinking, feeling persons. Reflective function and symbolic capacity were stunted, resulting in a physical language (Bucci, 1997). These developmental problems spanned the generations.

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