Anniversary Reactions in a Five-Year-Old Boy

Unresolved Conflict, Guilt, and Self-Identifications

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This paper examines the important role of anniversary reactions in the psychological adjustment of seriously traumatized individuals. The clinical case study examines the impact of anniversary reactions on the

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posttraumatic symptoms and accommodation of a five-year-old boy. Unresolved conflict with the mother, an intense sense of guilt, and difficulty in self-identification were explored during subsequent sessions of psychoanalysis. The clinical significance of considering the possibility of anniversary reactions in children manifesting repetitive attempts of trauma mastering is discussed.

ANNIVERSARY REACTIONS (ARS) MAY BE DEFINED AS PSYCHOLOGICAL and/or physiological reactions that occur when the current time coincides with the date of a major traumatic event in the person's past. Through these time-cued reactions, the person attempts to cope with the impact of the trauma. The purpose of this paper is to suggest dynamics of such reactions in a severely traumatized young child.

LITERATURE REVIEW

ARs have been long recognized in the psychological literature. Freud (1895) gave us the first clinical description of a woman who re-experienced "vivid visual reproduction and expression of feelings" precisely on the dates of her various past catastrophes. Later, Freud (1920) generated the idea of the "repetition compulsion" that emerges through the individual's efforts to cope with earlier trauma that remain unresolved.

Systematic studies of anniversary reactions have been made by Hilgard, who noted (1953) that they were triggered in adult patients when their children reached the age at which the patients had experienced a traumatic event in their childhood. For example, she presented the case of a woman who developed pneumonia, pleurisy, and psychotic symptoms when her daughter reached the age of six. This woman's father had died of pneumonia and pleurisy when she was six years old. Hilgard (1969) emphasized that ARs in adult patients also may occur when the patient had experienced the traumatic loss of a sibling during the patient's childhood. Hilgard suggested that patients developed "temporal identifications" with a lost parent or sibling and that the onset of the ARs, coinciding with the time of death of these significant objects, resulted in the reemergence of repressed conflicts associated with the lost persons and in serious psychological and psychosomatic manifestations.

Pollock (1970) noted that ARs may also be caused by incomplete or abnormal mourning resulting from a severe trauma in childhood. He described trauma cases in which his patients exhibited ARs in a coinci-

dental fashion related to a particular year, day, or even hour (Pollock, 1971a, 1971b).

Cavenar and his colleagues provided clinical descriptions of numerous cases of patients suffering from ARs and presenting various physical/psychological symptoms (1976, 1977, 1979). They pointed out that these symptoms appeared to emerge from unresolved conflicts associated with incomplete grieving over a significant loss of a loved one.

Mintz (1971) categorized two types of ARs focusing on the individual's sense of time. In the first type the patient is consciously aware of the "trauma time" and the "current time." Such conscious remembrance helps trigger unconscious inner conflicts and in this way results in ARs of different symptomatology. In the second type there is no conscious awareness of the ARs precipitated by the patient's "unconscious sense of time."

Although the term "anniversary reaction" implies a specific cognitive and behavioral entity, it refers to a heterogenous group of physical and physiological symptoms that disturb vital homeostatic balances. The time markers trigger start-up signals, which result in these diverse symptom clusters. The patient may mirror symptoms that were experienced by the lost beloved person or may re-experience symptoms that he or she experienced at the time of the trauma. In this way the patient expresses the unconscious desire to somehow restore the lost love object and/or manifests self-punishment and survivor guilt, which propel the ARs set (Renvoise & Jain, 1986).

We found only three relevant citations of ARs in children.

Stekel (1923) gave an anecdotal description of a three-year-old boy who developed a stroke-like condition during the birth of a sibling. For thirty-six hours he did not move, talk, or react to appeals to do so. Two years earlier his mother had given birth to a baby, and on exactly the same day her other child became ill and died. Family members predicted that the same thing would happen when she gave birth: her three-year-old son would die. Through "energetic actions" of Dr. Stekel the child was forced out of his dangerous condition and restored to health.

Hilgard (1969) reported a similar case based on personal communication with A. C. Cain. An eleven-year-old girl became mute and motionless and stopped eating when she reached the age at which her sister had died. She was treated primarily for AR, and after a few weeks began to eat, talk, and walk.

In these two cases the surviving children identified themselves with the dead siblings because they strongly believed, or perhaps family

members helped them to believe, that they would die as their siblings had, at the same time and in the same way. Haesler (1968) noted that even young children can develop traumatic identifications, citing the case of a three-year-old boy who suffered severe injuries from intentionally running into a motorcycle when he was the same age that his sibling had been when he was killed in a motorcycle accident and whose loss had been insufficiently mourned by the parents.

Discussion

Knowledge about ARs has been drawn mostly from psychological evaluation and long-term psychoanalysis of adult patients. Children do not have well-developed speech and communication skills, especially in expressing their inner states, and they cannot describe their own psychological needs and problems to mental health care providers. Consequently, there are serious limitations in recognizing occurrences of ARs in children. Even those children who are in treatment usually have difficulties in helping the therapist to establish the links between their current reactions and past traumatic events.

The lack of evidences of ARs in children may be determined by their prematurity related to their ego development. It may be that the process of maturation includes not only the perceptual, cognitive, and emotional development of the person traumatized in childhood but also clearing and conceptualizing the essence of the person's trauma-related conflicts and sharpening the inner contradictions. Some authors (Wolfenstein, 1966; Nagera, 1970) insist that mourning becomes possible only with the resolution of adolescence, when detachment from parents has occurred. However, R. Furman (1974), insists that even a three-year-old child is capable of mourning. Also, E. Furman (1974) and Bowlby (1980) note that children are able to express their grief reactions as early as age two.

In our opinion, it is not the quality of the child's mourning process but the mere existence of specific post-traumatic reactions that is important for the development of ARs. Children appear to have the ability to manifest their unconscious guilt and misidentifications associated with incomplete or abnormal mourning after a profound traumatic experience.

Freud (1916) considered the unconscious sense of guilt the most powerful motivating and organizing force in the mourning process. A sense of guilt was found to be the most frequent precipitating factor of the ARs in adult patients (Hilgard & Newman, 1959; Pollock, 1970; Mintz, 1971; Engel, 1975; Cavenar et al., 1977). Children also can

experience deep guilt after a major trauma. Winnicott wrote that "the healthy child has a personal source of sense of guilt, and need not be taught to feel guilty or concerned" (1954, p. 270). Siggins (1966) considers guilt and self-reproach important markers of an abnormal mourning process for the child. Benedek (1975) noted that guilt is not necessarily the consequence of actual wrongdoing; it more often originates in the child's unconscience as response to repressed conflict.

Traumatized children frequently develop strong guilt feelings (A. Freud, 1973; Pynoos et al., 1987). Six months after the 1988 earthquake in Armenia, 31 percent of the children who were evaluated had posttraumatic stress disorder (PTSD) symptoms and guilt feelings (Azarian, Miller, & Skriptchenko-Gregorian, 1994). Toddlers exhibited guilt most frequently because they thought their bad behavior had caused the earthquake. Older pre-teen children, whose parents had perished in the earthquake, often felt guilt because of unresolved family conflicts. The children also manifested simultaneous guilt and anger toward their parents. They often vented their anger toward the dead parents who had controlled their pre-quake lives and blamed them for not preventing the quake from happening. Some were saddened by the loss of their parents but at the same time expressed anger toward the parents for leaving children alone to care for themselves and to face an uncertain future. These children obviously manifested the "specific signs" (Siggins, 1966) of inner conflict, which arose out of their abnormal mourning following the disaster.

Cain and Cain (1964) and Cain, Fast, and Erikson (1964) emphasized the important activating and distorting role guilt-related feelings play in young children's abnormal mourning process after the death of their siblings. Along with self-accusations, depressive withdrawal, punishment-seeking, and accident-prone behavior, these children are likely to develop "anniversary" hysterical identifications. Their trauma-related identifications are not necessarily with a lost sibling. They often identify with the dead or traumatized parents. Such intense identifications may lead to AR-like states. Davidson (1980) noted that the children of concentration-camp survivors tended to be referred for psychiatric counseling for their psychic state deterioration during their childhood or adolescence years. This often coincided with the age of their parents at the time of their concentration camp confinement.

Thus, if traumatized children, in their immature and unmastered mourning process, can use and manifest guilt and identifications in their efforts to resolve trauma-related conflicts and ambivalence, then they can probably experience ARs. These primitive but powerful mo-

tivating and organizing inner forces are likely to be triggered on an anniversary of a traumatic event.

Clinical Case Study

HISTORY AND BACKGROUND

The patient is a five-year-old boy born in Odessa and subsequently adopted by an American couple. The boy, Ivan, witnessed frequent quarrels and fights between his biological parents, who were heavy drinkers. Eventually the father left the family. The mother could not provide appropriate care for Ivan and his younger sibling, who were frequently left alone in a dirty apartment, usually hungry and scared. The mother became pregnant and gave birth to a third child.

When Ivan was three years old, a major tragic event occurred. One sunny day, his mother and father, who had recently reappeared, were drinking. Suddenly, a fierce argument arose involving accusations about the mother's giving birth to a new child in the absence of the father. The father mercilessly kicked this child. During the fight that followed, the father almost killed the mother with a kitchen knife. When he had realized what he had done, he committed suicide, in the presence of the children.

The seriously wounded mother and terrorized children were taken to the hospital. Within a short while, the mother escaped from the hospital and went into hiding from authorities. After about three months, the children were sent to an orphanage, because the family court deprived the mother of parental rights. In the orphanage, Ivan and his two younger siblings were separated and lived in different units, about one year. When Ivan was about four and a half years old, a childless American couple adopted these three children and brought them to the United States.

CLINICAL EVALUATION

Two months after the children arrived in the United States, the adoptive parents referred them for evaluation. The general physical examination showed no genetic disorders or prenatal toxins in Ivan, who had been renamed, "John." The boy was in good health during his stay at the orphanage. His only medical problem was enlarged tonsils. However, the adoptive parents reported that John had been having nightmares, periods of deep sadness, and sudden mood changes since coming to the United States.

Witnessing the trauma had a profound effect on the boy's emotional state and behavior. It was evident that he was experiencing the core symptoms of PTSD. About 18 months after the traumatic event, he was still exhibiting a strong denial reaction. Sometimes, he simply denied that he had witnessed the events and claimed that he had run out of the apartment and hid in the cellar before his father wounded his mother. The next time he bluntly refused to talk about them, saying "I don't know anything about that." He displayed anger when the psychologist began to question his two younger siblings about the traumatic event; he even tried to cover their mouths with his hands. But at the same time, the boy was still re-experiencing his parents' deadly fight through drawings and repetitive play, using puppets and toy animals to re-enact the beating, chasing, and eventual suicide. He often threw toys on the floor or against the walls or isolated them in boxes and put them into a closet. In his numerous drawings, he again and again painted bodies covered with blood. In other art work, John used chaotic brush strokes to create big black blots that he described merely as "adults are fighting." Almost every night he had dreams of being chased by "a big dog or a big man." He often exhibited anger and was aggressive toward the youngest sibling; he blamed the little child for the parents' fight. John was anxious and worried about his future, as if he did not believe in adoptive parents' love and was afraid of being sent back to the orphanage in his native country.

He also wondered about his mother: was she alive and how was she doing? He was saddened that she was wounded so severely. The boy was also concerned about his identity. He asked many questions about himself, because he could not understand why people called him "John" and not by his real name, "Ivan"—or his family pet name, "Vania": "Why do they not call me Ivan? Is John better than Vania?" and so on. When he was told that the American name "John" corresponds to "Ivan" in the Ukraine, he insisted they did not sound alike and had to be different.

TREATMENT

Ivan/John's long-term treatment by a Russian-speaking therapist began immediately after evaluation. The treatment included weekly individual and family sessions and involved play, art, storytelling, relaxation, role playing, and games. The treatment plans initially were focused on (1) developing a sense of personal security and family stability, (2) helping the new family members to establish mutual understanding and close emotional bonds, and (3) minimizing new stresses and adversities. Gradually, John began to demonstrate signs of im-

provement in his depressed state, aggressive behavior, and in general adjustment and functioning in his new socio-cultural environment. John started to talk with his adoptive parents and their relatives and neighbors. He accepted his and his siblings' new American names.

Interestingly, John never recalled his biological father and never mentioned his name. But he often recalled his mother in Odessa, and when he wondered about her life, he became very sad, tearful, and withdrawn. He sometimes expressed frustration and helplessness because he was powerless to help her. Generally, however, his thoughts about the biological mother were ambivalent. For example, he frequently drew pictures of her holding a bottle of vodka and showed it to the therapist with a laugh: "Mama Lena is drunk!" But on other occasions, John would recall a children's song or line of poetry and proudly say that his mama Lena had taught it to him. A few times John would whisper to the therapist that he knew "a big secret that should not be told to anyone." After a couple of months, the boy confessed that all that had happened to his mama Lena was because she behaved so badly that he wanted her to be punished for that.

GUILT, IDENTIFICATIONS, AND EMOTIONAL BREAKDOWNS

In the hot and humid summer of 1995, John's new parents decided to take a vacation with the children near the ocean. John and his two younger siblings were happy and excited; they had never had a vacation before. However, during the first therapy session after the vacation break, the therapist was shocked to witness a striking change in John's appearance and psychic state. He seemed so distressed, scared, and lost—as if there had been no vacation trip, no prior successful treatment. His parents reported that John was unable to enjoy the ocean and play activities during the entire vacation. Shortly after arriving at the inn, he became anxious and withdrawn. He had difficulty falling asleep and often broke into tears. He did not respond when was called by his new name, "John," or responded with angry outbursts.

John was able to explain his changes to the therapist. He said that one of the very first vacation days happened to be "just like that hot and bright day in Odessa" when the fight between his parents occurred, and he heard his mother call to him "Vania, Vania, help me!" During careful and detailed questioning, he also revealed that he saw his mother "in a green dress, staying somewhere, stretching out her hands and calling to him." The image of his mother was vivid and jarring and prompted the child to re-experience past traumatic feelings.

In the next intensively scheduled sessions, he had recovered and ventilated detailed memories repressed after the major trauma. He

drew and described colorful pictures of the fatal fight between his biological parents: "I saw our kitchen. A man with a big mouth began to shout. They spoke very loudly. Then he took a glass . . . drank water from washbasin . . . threw the glass and took the knife. . . . Then he fought with Mom. I saw much blood on her. She called to me for help. I took a towel and ran to her." His story usually stopped at this point; he couldn't exactly remember if he had given the towel to his mother or had hidden himself in the basement. This moment led to feelings of guilt despite therapeutic assurances offered by the therapist.

Subsequent therapy sessions focused on dispelling the boy's cognitive confusion and encouraging his active coping with intrusive traumatic images. After about two more months John's psychic state had considerably stabilized and he showed signs of improvement. He began unconsciously to prefer his new name, frequently repeating: "I am now John." Within a short time, there was a second breakdown. One day when he entered the clinic building where many patients, employees, and visitors crowded in the foyer, John experienced an intense panic-like attack. He was familiar with the daily activity of the place and had never felt such feelings. He explained that this time the foyer, particularly the crowd and the specific smell, had reminded him of a building in his native city and made him think of unpleasant things that had happened to him in that building: one woman had administered a painful injection in his buttock and another had hit him with a stick when he delayed obeying her order. He drew this stick in a few of his drawings.

Again, as during his first breakdown, he began to express intense feelings of guilt. John remembered well how he and his friend in this building spent time looking outside into an empty and dirty courtyard. "There was nothing for children to play with in this huge yard, [only] some pieces of iron, big ones. But we stayed together and looked there. . . . I forgot his name. He was my only friend in this building. How could I forget his name? I am bad, don't you think?" John might continue such guilty ruminations and self-accusations for a long time and needed the therapist's intervention to reduce his worries. Then, in his defense, the boy was making unconscious attempts at splitting his own identity. He began to declare that there indeed was a boy named Ivan, but this boy remained in Odessa; here and now, in America, is only a boy named John.

Consequently, several therapy sessions have been provided to help him in integrating his ego that had seriously been damaged by profound past traumas.

ANALYSIS OF JOHN'S ANNIVERSARY REACTIONS

The focus of the analysis relates directly to the temporal aspects of the two breakdowns John experienced, which phenomenologically resemble ARs.

According to court documents from his native country, Ivan/John's major trauma, of witnessing the fatal fight between his biological parents, occurred on June 15, 1993. His last therapy session before the summer vacation took place on June 3, 1995, by which time John was in psychologically stable condition. Therapy resumed when John and his new family returned from their vacation on June 18, 1995. At this session, the adoptive parents reported John's first intense emotional breakdown. The coincidence between the date of the boy's major trauma in the Ukraine and the time surrounding his first emotional relapse in America is noteworthy.

We cannot talk about the same exactness in temporal coincidence in regard to John's second breakdown. On August 21, 1995, he experienced the frightening image of a crowded building, which he described as a medical institution. In the medical records that accompanied the adopted children, we discovered that in August, 1993, John was in a general hospital in Odessa being treated for tonsillitis with injections. Thus the time of John's second emotional breakdown in the United States coincided within two or three weeks with the second anniversary of his trauma in the Odessa hospital. The temporal factors are so precise that it is difficult to entertain another explanation of these coincidences.

In order to somehow comprehend the trauma reason and to derive meaning from it, Ivan/John developed a pathologically strong feeling of guilt with disproportionate blaming of self and others. Thus, John was extremely upset about forgetting the name of a friend in the hospital, and he bitterly blamed his innocent youngest sibling for initiating their parents' fight. On the other hand, his intense sense of guilt stimulated his ego, provoking further attempts to master the traumatic intrusions through trauma re-enactments and then the ARs. John repetitively played out aggressive acts and drew pictures of bloody bodies. Such repetitive efforts, either through posttraumatic play (Terr, 1981) or drawing (Skriptchenko-Gregorian et al., 1996), never bring successful relief or resolution, as is clearly evident in John's case. The second anniversary of this child's multiple traumas found him experiencing vivid visual, auditory, and olfactory hallucinations of his estranged mother and the trauma-related hospital in Odessa.

The child's extreme trauma and posttraumatic symptoms profoundly altered his self. But in contrast to other reported AR clinical cases, this child did not identify himself during his AR with a significant person from the traumatic past, as, for example, the abusive father or the ambivalent mother. He had enormous psychological difficulties in self-identification caused by his own fractured personality. One self, Ivan, was linked to his violent past. The other self, John, was associated with the comfortable and much more secure present.

In the following therapy sessions, the therapist noticed that the child was stating preference for his new name as if he was trying to forget his old name, associated with the past trauma, and wanting to leave it finally behind him. However, the trauma itself had not yet been resolved. The second AR occurred as the next temporally suitable opportunity to master the trauma issues in this case. During this breakdown, the boy was abnormally absorbed in guilt about forgetting the name of his hospital friend. He even blamed himself for his inadequacies. In fact, these sentiments and thoughts were about his own name, as if he unconsciously felt that instead of resolving the trauma-related conflict, he was trying just to abandon his own old name and his identity associated with the past trauma. But the simple name change was not enough to bring comfort and resolution for this child. That is why in his next ultimate defensive maneuver the child chose to declare that the boy named "Ivan" remained in Odessa, while "John" lived in America. At this point, John dissociated what Ivan had experienced and accommodated those traumatic feelings into the defensive structure of his personality.

Surely, it would be groundless to expect more sophisticated defenses and radical resolution of his "cumulative" (Khan, 1963) past trauma from a five-year-old boy when even adult victims often are troubled by their coping efforts. Most importantly, this boy demonstrated a long coping struggle characterized by intense guilty feelings and complicated self-identification.

Unlike adults who suffer traumatization, children who are traumatized endure these experiences during critical developmental stages. The young victim processes the traumatic event by moving through a series of stages that Miller and Veltkamp (1988, 1989) refer to as trauma accommodation syndrome. In the intervention stage, a stage of re-evaluation and reconsideration, the traumatized child usually tries to reason through the trauma and deal with the factors in the environment that trigger thoughts of the original stressor (Azarian, Miller, & Skriptchenko-Gregorian, 1996). At this stage, the ARs of John/Ivan have been triggered by external and temporal stimuli as well

as by inner motivational forces, including a sense of guilt and re-examination of self. The final stage is one of accommodation and resolution, in which the child is able to admit a supportive psychotherapeutic environment and begin to address some of the issues related to the trauma. At this stage, the reintegration of his traumatized self is critical for John's recovery.

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