"What Is Genuine Maternal Love?"

Clinical Considerations and Technique in Psychoanalytic Parent-Infant Psychotherapy

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The question of what is genuine maternal love was posed by a mother struggling to understand and value the nature of her bond with her small baby. The question surfaced time and again in the context of this dyad's long-term parent-infant psychotherapy and has challenged me to examine my thinking and, indeed, has produced impassioned discussions within the Parent Infant Project team at The Anna Freud Centre. In this paper I will address this question through sessional material of this mother and baby and discuss issues of technique in response to it, including my countertransference and conceptualization.

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ASKED ABOUT HER POSITION ON THE DIFFERENT HEURISTIC MODELS OF
the mind, Anna Freud replied: "I definitely belong to the people who
feel free to fall back on the topographical aspects whenever conve-
nient and to leave them aside and speak purely structurally when that
is convenient" (Sandler with Anna Freud, 1981). Parent-infant psy-
chotherapy is a meeting point for the different disciplines addressing
infant development: psychoanalysis, attachment, and neurobiologi-
cal research. In facilitating our understanding of the ebb and flow of
the therapeutic construction, Anna Freud's advocacy of conceptual
flexibility in the aid of clinical expediency is often helpful.

The therapist working with young babies growing up in an envi-
ronment of intergenerational deficits needs to understand the qual-
ity of mothering and the baby's predicament. Psychoanalytic con-
cepts of "good enough parenting" and maternal failure, attachment
paradigms of "security" and "disorganization," and neuropsychologi-
cal discussion of relational trauma are useful frames of reference. Yet
there is an additional ingredient to do with love, captured by the pa-
tient in her question: How can we integrate love into scientific and
clinical discussion?

"Genuine maternal love" for the mother who asked the question
was defined by selflessness. My clinical work has convinced me that
the love of a mother for her infant and of a baby for his mother
needs both measure and passion. It contains the temperate—that is,
regulated kernels of love and responsivity, and passionate appetite,
ownership of the other and capacity to be consumed by the other.
These latter rest upon the mother's narcissistic love of herself in the
baby, her adoration of "His Majesty the Baby" (Freud 1914), and her
capacity to tolerate her hatred of her "bondage" to him (Winnicott
1949). Thus, her identification with her baby and yet her ability to
differentiate between herself and her baby and allow individuation
(Mahler et al. 1975) are required. Only then is the baby able to safely
love his mother, in the sense of moving from relating to object-use
(Winnicott 1969) and development of a sense of self as real. At the
same time, "love" is not a static concept. In this paper I attempt to de-
scribe the development of this mother's love, matched by changes in
her baby's expressed love for her, and the interventions that may
have contributed to this process.

"Maternal failure" in psychoanalysis refers to intrapsychic pro-
cesses in the mother which violate their infant's state of going-on-
being, such as projection and attribution resulting in distortion of
self (Silverman and Lieberman 1999), failure to protect the infant
from impingements (Winnicott 1962), inability to contain the infant
through "maternal reverie" (Bion 1962). "Disorganized" attachment describes a collapse of adaptive strategy when the infant is frightened, seen to develop in the context of mother's unresolved trauma and lack of reflective functioning thereof (Lyons-Ruth 1999, Fonagy 2001). "Relational trauma" depicts the neuropsychological deregulation of the infant in a situation in which danger emanates from the attachment relationship wherein the mother (a) disregulates the infant and (b) withdraws repair functions (Schore 2001, Perry et al. 1995, Tronick and Gianino 1986), leaving the baby in an "intensely disruptive psychobiological state" for extended periods of time (Schore 2001, p. 209). In this paper I consider those aspects of maternal "failure" and relational trauma that resulted from the mother's inability to meet her baby with passion and reverie. This included the negation of herself in him, dis-identification with his state of dependency, and projection into him with consequent distortion of self and object boundaries and impingements on individuation.

What is the experience of an infant within a primary relationship that fails to respond appropriately to his personal and intersubjective needs? From the observation of babies in this predicament, this maternal failure appears catastrophic. The infant patient, so dangerously dependent on his mother's/caretaker's capacity to identify and understand, expresses extreme anxiety, fragmentation and, finally, retreat. Because the anxiety is embedded in their relationship—often underpinned and driven by intergenerational patterns of relating—it is enduring. Therefore the concept of cumulative trauma (Khan 1963), the repeated breaching of the adaptive and defensive structures available to the immature ego, is pertinent.

Extreme maternal depression can constitute a situation of relational trauma. Green (1986) discusses a situation where there is a mutative transformation of the mother from a live, vital presence to a dead detachment from her infant, and the trauma this inflicts on the baby. This is a particular situation where the infant has had an early period of resonance and lost it in the face of maternal loss and depression. But what of those infants who have been born, so to speak, into a relationship with a "dead mother"?

The psychotherapeutic work informs us about the experience and the developmental endeavors of babies in this predicament. Psychically they display the "dead baby complex"—a decathexis of the maternal object and apparent identification with the dead mother (Bollas 1999). These babies lie slumped and blank. They seem careless of the maternal presence or non-presence beside them and appear non-present in their own bodies. Their precocious defenses of avoid-
ance of emotional engagement with the mother, freezing and disassociation (Fraiberg 1982, Perry 1997, Schore 1994) put them in a state of unraveled/derailed development. I suggest that this was the predicament of the baby in the case to be discussed.

Parent-infant psychotherapy intervenes in the parent-infant system to achieve the best accommodations that can be made between a parent and baby for the baby's development. As an applied technique within the psychoanalytic framework it has its roots in the groundbreaking work of Selma Fraiberg and her colleagues (Fraiberg 1980, Lieberman and Pawl 1999). In recent years a model has been developed at the Anna Freud Centre (Baradon 2002, Baradon et al 2005, James 2003, Woodhead 2004), the defining feature of which is the use of the analytic mind to scaffold the affective experiences and representations of parent and infant in relation to each other. Intervening at the procedural as well as declarative levels of self organization, the aim is to create meaning through validating and cohering the parent's experience and responding to the baby's requirement for an attentive, adult mind to meet his developmental and attachment needs.

In our model, the therapist straddles numerous roles in relation to her patients, both individually and collectively. She is a clinical “observer” (Rustin 1989), using observation as a mental stance and a technique to inform her understanding of the parent's and baby's (emergent) mental models of attachment relationships. She is, in parallel, an analytic therapist, employing psychoanalytic frames of reference and techniques in the work with what is manifest and conscious in the room and with the hypothesised unconscious fantasies and defenses underpinning these. Inevitably, she is a transference figure for the parent, sometimes benign but also at times perceived as hostile and/or persecutory. The therapist is a "new object" (Hurry 1998), offering a revitalizing attachment experience to parent and infant. As a new object for the baby, the therapist is also a "developmentalist," supporting the infant's development through providing contingent responses, stimulation, and regulation where the parent, at least temporarily, is unable to. In cases of severe maternal depression and withdrawal the therapist may also be the only "live company" (Alvarez 1992) for the child, providing the functions of "enlivening, alerting, claiming and reclaiming" (p. 197). Having the therapist to love, until the mother is able to receive and scaffold his love, may be pivotal for the baby's psychic survival. And finally, the therapist is an external affect regulator of the patients' disregulated
states, particularly crucial in light of research suggesting that external regulation of the infant’s immature developing emotional systems during critical periods may influence the experience-dependent structuralization of the brain (Panskepp 2001, Cirulli et al. 2003).

Parent-infant psychotherapy poses countertransference dilemmas particular to this method of intervention.

Primitive emotions and projections are the fabric of infancy and parenting and invariably resonate with the therapist’s past and present attachments. The actual presence of an infant in the room intensifies the sense of immediacy and clinical (and of course legal) responsibility toward the baby. With at least two, and often three, patients present—infant, mother, and father—the therapist’s attention and receptivity are often pulled in different directions and her identifications may shift between the infant and parent, challenging the analytic stance. As always, the therapist’s countertransference is used and must be watched—her own hopes and despair, riven identifications between mother and baby, and her rescue fantasies. Above all, the therapist needs to maintain sufficient emotional resonance with the mother, in the face of the acute emotional pain and helplessness of her infant. Without this there is no way for mother to empathically recognize the real infant as opposed to the infant within her whom she often treats with cruelty.

In the case under discussion, where the baby’s early attachment needs were thwarted by his mother’s failure to embrace him with “genuine” love, considerations of clinical process and technique were particularly charged. On the one hand, mother sought the ascetic and altruistic (A. Freud 1937) virtue of “genuine” love, devoid of all narcissistic investment and reward, and her severe depression was compounded by a sense of failing her own standards. On the other hand, her infant son was starved for the maternal appetite of ownership and adoration, and his experiences of going-on-being were distorted by her projections and hostility. These experiences of trauma for both baby and mother required ongoing scaffolding and regulation from me, the therapist, and I needed to be alert to the challenge to my capacities for “reverie” in my various roles and from within.

Thus the matrix of intersubjectivity, transference, and countertransference was extremely complex. It raised minute-by-minute questions of technique. Which patient/what material should be privileged at any given time, and in what domain of relational knowing
(Stern et al. 1998)—procedural (psychological acts) or symbolic (psychological words)—would the communication be most effective?

**CLINICAL MATERIAL**

Ms G was referred by her obstetrician just before her baby was due, with concerns about her depressive mood. A psychiatric report attached to the referral mentioned a long-standing history of eating disorders and self harm, and a number of attempted suicides requiring hospitalizations, the latest one year previously. Consequent upon the concern about this troubled young mother and her baby, a network of health and social service support was put in place.

Ms G was in a stable relationship with D, the baby’s father. However, Ms G requested to attend without her partner, explaining that D reassured her that she is a good mother and that she needed her fears to be heard and not brushed aside. Although we ask to include fathers in the therapy where possible, I decided it was important to enable this mother to indeed be “heard” in her request and to explore the possibility of including the father after we had established a therapeutic alliance. In the course of the therapy father did become involved, but in this paper I will not discuss the work done with the triad. Mother, baby, and I met once a week for a period of two years. This paper focuses on the first year of therapy.

**TENTATIVE BEGINNINGS: MOTHER, BABY, AND THERAPIST**

In the event, although I was in telephone contact with Ms G from the time of referral, we only met 3 weeks after baby Ethan was born. A vulnerable baby, he had required special care in the early postnatal weeks and Ms G stayed in hospital with him.

In the first session Ethan, still a fragile newborn, was asleep when they arrived. His painfully thin and pale mother sat sideways to me with her face averted. She spoke in a near whisper, her low voice and withdrawn facial expression camouflaging much of the terribleness of what she was saying.

Ms G explained that she had never thought she would have children as she was afraid that she would damage them. I wondered whether at the same time as being afraid to have a baby she had also perhaps hoped for one. Ms G thought not. She explained that the likelihood of conception was low as she has irregular periods because of her eating disorder. I asked how she had felt in her pregnancy and she said she had not wanted it, and had continued smoking and bingeing.
She had felt that the fetus was a parasite. She felt very guilty about this. I asked whether these kinds of thoughts were continuing. At this question Ms G became distressed, saying that she feels that she is "forced by him into an artificial position . . . of trying to be a good mother, who loves her child and takes care of him." Ms G said she does not feel like that much of the time. She added that she would not harm him physically.

Somewhere early in this conversation Ethan fretted a bit. Ms G immediately picked him up with extreme care and held him to her, his little body slumped against the palm of her hand. She checked with me whether she could feed him. She snuck him under her shirt, careful to keep her breast hidden. The "feed" was quickly over and Ethan went on sleeping. Ms G removed him from the breast and covered herself up.

We spoke about attending parent-infant psychotherapy. I wondered what she was hoping to get. She replied that she wanted a "filter" so that her feelings don't all come out on Ethan. I noted that I would not have been able to tell from her facial expressions and tone of voice when disturbing thoughts toward Ethan intruded during the session, and that from this I could tell that she was really trying to keep a tight grip on her feelings. Ms G reiterated her fear of damaging him through her depression as her mother, too, had been depressed and unavailable. I suggested that we would attend to both the good things that happen between her and Ethan, such as her gentle stroking of him that I had observed even when she was upset, and to her bad feelings and thoughts. Ms G hugged Ethan to her.

I felt that the central verbal and affective communication to me in this session was Ms G's sense of being damaged herself and, through her very being with her baby, of damaging him. Her state of primary maternal preoccupation had a particular quality to it: hypersensitive to the baby via herself, it seemed that projection did not aid her to "feel herself into her infant's place" (Winnicott 1956, p. 304) but that the infant was equated with her, as a disturbed extension of herself (King 1978). Moreover, his critical early hospitalization, in which her dread of damaging a child was actualized and exposed, seemed to have been a trauma which confirmed a psychic equation between her inner and external worlds (Fonagy and Target 1996; Target and Fonagy 1996).

In turn, I experienced Ms G and Ethan, separately and as a dyad, as extremely fragile and needing both to be reached out to and to be handled with care. On the one hand, I struggled with my own need to establish some contact with her averted face, as I strained to hear her whispers. I felt responsible for her very life, as I imagine rescue workers feel in response to the sounds of life after disaster. In this
process of projective identification I assumed the omnipotence attributed to the "caregiver" in relation to the infantile self. At the same time I was acutely aware of the danger-in-contact ricocheting between us during the session, manifested in her whispers and cautious handling of Ethan. My association was to a sea of shards in which any movement could be calamitous. Only later did I realize how her history of self-cutting had penetrated my subconscious. Thus, from the beginning this was a dyad with whom I engaged in an intense and worried way, responding perhaps to her unconscious invitation to assume this mantle.

In the second session Ethan, now 4 weeks old, was awake, a tiny little thing with big blue eyes and a peaky face.

Initially he slept on his mother's lap, fists tightly clenched. Ms G stroked his hands but he did not relax his fists. A few times she pried them open and stroked his palms. Ethan's eyes flicked open when he heard a door slam and he started crying. He seemed to move quickly into a loud cry, with no fretting or working up toward the upset. He cried hard. Ms G put him to the breast and he sucked, then fell asleep. She put him on the mat and he opened his eyes. I spoke to him about his experience being in a big room and hearing my stranger voice and not knowing where it came from. Ethan stared fixedly toward the ceiling lights above him. After a while he turned his head slightly in his mother's direction, and I confirmed that that was where his mummy was.

As I observed this tense baby, I wondered whether there was heightened sensitivity to invasive stimuli (lights, noise), carried over from the weeks in the special care baby unit. I also wondered whether he was already reacting to the conflicted and disregulated quality of maternal emotion, transmitted and received through the ministrations of care. His ordinary going-on-being seemed to be punctuated with periods of disassociation—as expressed in fixing on the lights, and "falling forever"—as expressed in his urgent cries.

Again my own emotional responses were strong. This time the pull was toward Ethan, so desperately in need of enveloping in maternal love.

We had 6 more sessions over the following 6 weeks leading to the first break. The sessions acquired form and pace. Ms G sometimes looked my way and I found it less of a strain to hear her. Ethan moved between brief periods of wakefulness and prolonged periods of sleep. I found myself accommodating to their muted tone, characteristic of depressed mothers and their infants (Betts 1988), by dampening my spontaneity, speaking slowly, riding the silences. But in-
creasingly I also found my way to address the affects expressed verbally and in behaviors. Wary of the sadism of her superego and the masochism of her submission to it, I took care to acknowledge negative affect as conflictual, and positive interactions were noted without hollow reassurance that she was doing well. With Ethan I was relatively active, representing his mental states and communications, offering contingent responses, linking him up with his mother. I tried to balance offering myself to him for use as “live company” with awareness of Ms G’s envy of what she perceived I had to give Ethan, and which she had never received. At times indeed I felt rich in resources, but at other times I felt dull and drained.

THE MEANINGS OF DEPENDENCY

When I collected Ms G and Ethan, now 12 weeks of age, from the waiting room after the 2 week break, Ms G gave me a very quick glance of tenuous pleasure and then turned away with an avoidance of my gaze and bodily withdrawal. I felt I had become dangerous again during the break, even more so as I believed from her darting pleasure that she had missed me. Ethan woke up as she put him on floor beside her. He looked bewildered. We settled on the carpet and Ms G placed Ethan against her feet, facing me. I thought she was in some way offering him as a “transitional object” for reengagement. I adjusted my position so that Ethan could see my face directly. In so doing, I was also placing myself in Ms G’s range of vision should she chose to raise her eyes.

I spoke to Ethan: “You’re not quite sure where you are, are you? . . . you haven’t been here for a while . . . have you?” He murmured. I asked him if it all right to wake up in this room now, and Ms G reminded me that the last time he was quite upset. I acknowledged this. Ms G asked Ethan if he wanted to sit down and placed him on her lap. I said, “that way you are with mummy and can still see me . . . and still give these gorgeous little smiles.” Ms G whispered, “yeh.” Ethan relaxed into her lap and looked back to me and made a gurgling noise. He gave a big smile and looked into my eyes for a few seconds, then looked away. Then he looked back, pursing his lips, and eventually produced a rolling sound. In a lilting voice (“motherese”) I to him, “It’s a little conversation, isn’t it?” His face opened and he smiled again, then looked away. I waited. After a few seconds he turned back to me. I said, “Are you ready to chat again? Hey . . . yes . . . yes . . . and when you’ve had enough you look away for a while, don’t you?” Ethan gurgled again. Ms G looked down at Ethan and said, “He can be quite coquettish, sometimes he turns his head
and looks from the corners of his eyes.” I replied to Ethan, “mmm . . . hmm . . . I guess you’re taking a breather then, aren’t you, we adults do the same. Yah . . . Take a little break in a conversation, ah, otherwise it gets too much, doesn’t it?”

Ms G’s response to me in the waiting room suggested that the break had been experienced as an abandonment, in which I failed her as her primary figures had, and left her to struggle alone with disintegration. Yet, she allowed me access to Ethan (suggesting some goodness was retained) and through him, to herself. In talking to Ethan I was engaging in a process of emotional regulation through scaffolding his efforts at regulation (looking away) and placing them in the intersubjective domain. Using Ethan as a displacement, I could model for Ms G the process of ordinary, developmental self- and interactive-regulation (Beebe et al. 2003) in the pacing of an interaction. I was struck that the coquetishness she attributed to him in fact described her own conflict between engaging with me and withdrawing (e.g. when it “got too much”).

Later in the session Ethan was sleeping, with Ms G stroking his head and hand. She related a visit by friends who played with Ethan. She asserted that he was happier when with them. I wondered whether she had felt the same when I was talking with Ethan earlier? Ms G prevaricated, “I couldn’t see the expression on his face so I don’t . . . he does smile at me, but he often spends a lot of time seemingly just staring at me with quite a pensive look on his face . . . .” I noted his looking to her earlier. She replied that she worried: “Should he be smiling at me more? Obviously he does smile at me and not something behind my shoulder that’s taken his interest.” I asked, “What are you like with people, do you carefully observe their expressions, maybe sensitive to what feelings they’re communicating towards you?” Ms G said that she was trained from an early age to be aware of what somebody’s going to need or want. I asked whether she was afraid sometimes of what he might see in her face. Ms G answered slowly, “I’m sure . . . that . . . that in my face there’ll be the ambivalence that I often feel towards him . . . or my own difficult feelings that may have nothing to do with him.”

In my experience, a mother questioning her baby’s love for her is attributing her own conflicts to the baby. Ms G’s fear that Ethan already preferred the company of others seemed multilayered, containing the fear of his rejection of her, a projection of her wish to get away from him, and the rivalry with him over me. At this point I was unsure whether words alleviated or intensified her conflict and I also felt that the urgency of Ethan’s need for her was overriding, I, there-
fore, chose not to follow the route of interpretation and simply commented that he had been looking at her. Ms G was able to make use of my validation of Ethan’s desire for her to express her conundrum—can she allow personalization: “Should he be smiling at me more?” This offered an opportunity to explore what Ethan might be avoiding. I learned that Ms G habitually scanned the object for their affective communications/demands and that, since Ethan’s needs and wants evoked her hatred, it felt dangerous for him to look into her face/mind as he may see those emotions in it.

I was aware that she had not related to Ethan for some length of time and asked whether she was feeling ambivalent about Ethan there and then in the session? Ms G said she was not sure ... perhaps her instinct was to touch him but she did not want him to feel smothered by her. She wondered if she is not perhaps too disengaged with him. I suggested that, on the contrary, I thought she was very engaged with him but that she is protecting him from the toxicity that she felt was passed to her by her mother and which she fears she may pass to Ethan. Ms G nodded. She said she wanted to make it clear that her mother did the best she could at the time and added that of course she feels that it wasn’t good enough. I rushed in too quickly at this point, saying that perhaps in her attempts to protect Ethan she was keeping a distance between them that prevented them from spontaneous exchanges, such as laughing and playing together. Ms G replied that Ethan may in years to come experience her as in a state of severe depression or absent from him. Almost under her breath she murmured that if she were to leave through dying she would not come back. Ms G was quite tearful and picked Ethan up, caressing him. Then she said that she is not sure whether she’s holding Ethan because he is a soft, comforting thing ... and she put him down on the floor, on his side facing away from her, and at a distance. He sucked hard on his hand and just lay there, looking into space.

The whole interaction was extremely painful as baby and mother seemed quite unable to come together. The essential elements of adoration and appetite for the baby were missing from Ms G’s love. It seemed that his dependency, need, and desire for her resonated with the representation of him as parasitic during pregnancy—depleting her of self-hood. The transference to Ethan was thus of a consuming object like the mother of her childhood. This dilemma is likely to have been accentuated by her feelings of abandonment by me during the break. In an identification with the aggressor (myself), feelings of dependency and need in herself and in her baby were denied. At the same time, Ms G cared intensely that her child should not experience the maternal toxicity or disappointment in the object that
she suffered. In this way, distancing him was an act of love as well as cruelty. Ethan, to my concern, veered between disintegration and precocious defense.

I felt caught in the middle and responsible for the devastation, as though during the break the therapy had replicated the hollow maternal stance—the offer of dependency withdrawn. Thus my maternal “best” was in fact toxic also for Ethan via the impact it had on his mother. Certainly my “too quick” response contained a veiled criticism (also reversing the attack on me): in protecting Ethan from damage you are in fact killing off a live relationship. Obviously, I may have responded from the countertransference reserves of my own tetchy narcissism. We also know from clinical experience that past relational trauma can be reproduced in the present therapeutic situation, in the transference-countertransference transactions. Yet I think I was also “nudged” into the patient’s unconscious wish-gratifying role (Sandler 1976), as Ms G went on to speak of Ethan’s (and of course my) possible future loss of herself. The habitual solution to overwhelming dependency and inevitable disappointment was destruction of self and object.

With my therapeutic goods thus spoiled, resonating her emptied state, I was unable to protect Ethan, who was put down and away from us. As he lay rigidly on his side looking into space, I felt I was witnessing his emergent identification with the dead mother (Bollas 1999)—a kind of dying in situ.

GOOD ENOUGH LOVING AND IMPINGEMENTS

“I am trying to understand,” said Ms G two months into treatment, “what is genuine maternal love?” She feared that when she did experience maternal feelings it was because of her “delight in his need (for her)” and that, therefore, her “motives are suspect.” She weighed her gratification about his complete dependency on her against her wish to walk away. “I have to keep asking myself what is this about? Is it about me? About Ethan?” She dismissed my suggestion that it may be about both of them, and I commented on her fantasy that the ideal mother is selfless. Ms G confirmed this ascetic representation of the genuinely loving mother and said that the “ideal mother could understand all the baby’s needs,” thus rearing “emotionally, mentally and physically strong children.” She said she was humbled now when she saw others managing to do this.

Ms G’s repudiation of gratification as a constituent of the maternal bond could be traced to her grievance with her mother, past and pre-
sent, in which she felt “used” by her mother for her own narcissistic needs. Moreover, she held her parents responsible for her damaged mental state and, even as an adult, had no real sense of volition to modify the childhood feelings of helplessness.

Yet, despite the relentless grip of the past, I observed her handling of Ethan extend to more animated exchanges. Ethan responded to these tentative “protoconversations” with widened eyes, excited kicking, and large smiles. He seemed to gain efficacy as a partner; for example when he lost her attention he would call her back by looking at her and cooing. When I pointed this out, Ms G said that friends visiting had commented that Ethan’s eyes followed her wherever she is—tracking her voice when he could not see her.

As the months progressed the sessions felt safer, more predictable, encompassing a broader range of feelings, allowing Ms G to offer less ambivalent parenting and Ethan aspects of “good enough” relatedness, and thus also development. Indeed, during this period in the therapy, there were times in the sessions in which Ethan was a contented little baby.

However, these quiet periods of regulated positive affect were also the backdrop to rapid transition into states of inconsolable crying. I noted that sometimes Ms G reached out to Ethan, and he, in the process of being attended to, became distressed. His tiny body became rigid and he clawed at his mother’s body. At such times Ms G moved through a repertoire of feeding, winding, rocking, walking—seemingly to act promptly and contingently to effect “interactive repair” (Tronick and Weinberg, 1997).

Four months into treatment. Ms G raised the question: Why is it so hard to soothe Ethan? Was he damaged at birth, would another mother get it right? I tried to explore with her what happens to her when he cries. Ms G confirmed that she gets very upset. I suggested that sometimes Ethan’s cries feel like her own. Ms G became tearful and then reprimanded herself for not always acting the adult with him. I said that when they are both crying she no longer feels the mother. I also spoke about the rage that she feels when he triggers her pain. Ms G whispered that she feels so guilty and ashamed.

Thus, it was becoming clearer the extent to which Ethan was the barometer of her own emotional state. When his needs did not resonate with her own conflicts, Ms G was able to respond. Unpredictably, however, his ordinary infantile needs could trigger or link in with her own volatility. This is another aspect of relational trauma—where the quality of affective communication with the baby imparts trauma from the mother’s internal world to that of the baby.
Through the most careful observation of their affective interaction and of my own countertransference, I came to understand a particular quality of interaction that was perilous to both. Ethan's cries re-traumatized Ms G as her own unconsolable state as a small child came flooding back. At this point he became the frightening child to his mother, re-evoking her own disorganized attachments (Main and Hesse 1990). Unconscious conflict then permeated her ordinary maternal ministrations of feeding, changing, and soothing, and Ethan was disregulated by his mother's care. Balint (1992) describes this as "unconscious communication"—direct communication between the unconscious mind of a mother and her infant, in which the baby perceives and internalizes aspects of the mother's life of which she is herself unaware. And just as the meaning of her own affective state was unrecognizable to Ms G, so Ethan's communications could not be understood and contained. Their distress ricocheted between them, escalating to the point of collapse. What could I model in the sessions in terms of a holding response?

(session continued) ... When Ethan got restless I spoke to him. He responded with attentive pleasure. At one point he cooed extra loudly and drowned out Ms G's soft voice. I said playfully, "I couldn't hear your mummy there, do you mind?" Ethan kicked gleefully in response to my crooning voice and smiles at him. Ms G became very tearful. She said it was the ease with which I relate to Ethan and she has to try so hard.

I thought that addressing her envy would undermine her further, but perhaps she was ready to perceive his desire for her. I therefore asked what could help her recognize the cues from Ethan about good things he gets from her. Ms G's face became very tense. I felt I had suddenly frightened her. I wondered whether Ethan's love and dependency were difficult to recognize? Perhaps because she could not have these experiences as a child, as her mother was too depressed to be able to tolerate such feelings in her? Ms G whispered she did not want to repeat what had been her experience. I said that I thought she was struggling between her wish for Ethan to have a better experience and her fear of recognizing her importance in this and thus his dependency on her. Ms G said forcefully that other people's dependency on her was enormously difficult.

By this time Ethan was fretting and I wondered whether he needed his mummy again. Ms G sat Ethan between her legs and he looked at her. I said to him that he had called his mummy and she had gathered him up. Ethan sucked and chewed on his mother's fingers. This was the first time, I think, that he did not have a feed in the session.

Faced with a baby responding with joy to interactions with me (in the absence of such exchanges with his mother), and a mother who
felt diminished by this, I was in a conundrum: to embrace the one seemed to be a rejection of the other. It was as though I had to experience the possibility that only one of the dyad could survive. If I was unconsciously being faced with the choice between them I, equally unconsciously, resisted it by replacing Ms G as the object of her son’s love. Perhaps I hoped that Ms G would allow herself the experience of Ethan’s giving her pleasure and making her proud. Because she was more able to respond to cues of distress but not those of joy in relation to her, he was missing out on swathes of exchanges around emotional sharing, crucial for his development (Stern 1985, Tep- varthen 2001). Indeed in this sense Ms G was not able to facilitate Ethan’s development as an “emotionally, mentally, and physically strong child.”

Yet, as the therapy progressed, it seemed that by my modeling more playful exchanges with Ethan while emphasizing my “not-mother” status, Ms G was sometimes able to respond contingently and offer herself to be used by him.

SEPARATION-INDIVIDUATION

In the course of a longer-term therapy the infant naturally moves from a state of total dependency on the mother toward the beginning of separation-individuation. This offers opportunity to work with the mother’s conflicts as they impact on her baby at each developmental phase.

In the treatment of Ethan and Ms G there were hints from the beginning that separation, like dependency, was an area of extreme difficulty. Ms G’s history held no personal experience of moderated separation, only that of violent, mutually destructive rupture. The risk for this dyad was that separation-individuation would plunge mother into narcissistic despair and rage.

Sleeping and feeding were ubiquitous arenas for expression of conflicts over separation in Ms G’s history and were, perhaps inevitably, the areas in which the conflicts were played out with Ethan.

In the early weeks Ms G reported that Ethan would fall asleep only when lying on her chest. This meant that any movement of his woke her up. She moved Ethan to his Moses basket at her side, but kept vigil through the night. She recalled childhood fears of the dark and of sleeping alone and felt unable to tolerate Ethan’s cries when put into a cot. At the same she felt driven to madness and despair by lack of sleep. D, with his own difficulties in this area, was unable to offer support, and soon Ethan was restored to the parental bed. Ms G’s chronic insomnia was thereafter channeled into nighttime ruminat-
tions as she waited for dawn so as to escape from the bed to a strong coffee and cigarette.

With Ethan waking hourly, sleep disturbances became woven into the conflicts around feeding and weaning. Ms G repeatedly expressed her feelings that feeding was the sole good thing she could give him and admitted her gratification that only she could provide this. However, these feelings also came into conflict with her experience of his dependency as depleting. In the sessions I observed feeding encompass many regulatory functions, so that Ethan was put to the breast when he cried, when he was tired, when they were both at a loss as to play. With feeding used to meet such a variety of situations, it became difficult to tell when he was hungry.

At around 5 months of age, Ethan's weight began to drop and professional concerns about failure to thrive emerged. Medical opinion moved toward supplementary feeds, with a bottle also offering a possibility of respite from the hourly feeds at night. Ms G came under increasing pressure to achieve some measure of weaning. Her internal split was thus effectively externalized, with the medical network and her partner now carrying for her the thrust for forced separation, while she maintained the ubiquitous place of breast-feeding. It seemed important that at that point I did not ‘know’ what would be best, and held neither a wish for Ms G to wean nor for her to continue feeding.

During this period, Ethan 6–9 months, many threads in the therapy seemed to coalesce around the question of closeness versus distance and the losses implied in each.

Week by week Ms G described her dread of the long days with Ethan while D was at work. She felt mired by his wish for her presence, for example crying when she left the room, and her inability to let him cry. She said that before Ethan was born she spent much of the time alone. I wondered if that was her way of keeping her emotions on an even keel and she confirmed this. I suggested that having Ethan with her all the time meant that she has no means of regaining her "emotional balance" (her words). Thus the closeness was experienced as loss of self, provoking rage. Getting away was a relief at that level, but it also brought with it the fear that she could disappear from their lives and it would not matter.

As Ethan became more mobile he could initiate movement toward and away from his mother.

7 months into treatment. I noted how Ethan seemed to want to be close to her today. Ms G said she did not know if she wanted him close or not. She said her guilt at not really wanting his "relentless"
closeness makes her try harder. I then witnessed this as Ms G finally allowed Ethan—who had been struggling for a while to get into her lap—to find a place there. He crowed and cooed and bounced. From the outside their little "reunion" seemed pleasurable and yet Ms G was talking about times when she feels she cannot go on. I asked whether those were times when she harmed herself. She was silent. Ethan seemed to get extremely boisterous in her embrace—sucking on her arm and blowing raspberries. He appeared to be both kissing and biting her and I said this to him. My thought was that they both moved between intimacy to destructiveness with confusing rapidity and that, despite being with them, I could not tell what felt good and what bad.

It is interesting that at age 8 months, when biting could be considered a normal expression of desire (incorporation) and/or exploration, I attributed destructiveness to Ethan’s biting of his mother. Was I taking on Ms G’s attributions? In which case Ethan was subject to my projections as well as his mother’s. Was I picking up on an aggressive quality of relating in Ethan that indeed would be a pointer to derailed development at this age? If so, why did I not follow this through with an explication of his aggression as reactive to his mother’s unresolved ambivalence? Certainly, addressing his predicament would then need to have been privileged. In retrospect, I think that my shifting identifications with mother and with baby were enacted here through muddled, partial interpretations.

Just as imaging the baby’s ordinary movement toward separateness was not available to Ms G, she was also not able to manage a normal loss through establishing the triad of mother, father and baby (Daws 1999). I noticed in the sessions that I felt increasingly forced to relate to Ethan, with Ms G watching and withdrawn, or to Ms G—with Ethan either observing or dis-engaged. Thus, the father/therapist was seen not as a gain but as a threat to the symbiotic tie. In the issue of weaning, the bottle symbolically represented the competent, third object, and there was a concrete idea that the bottle would deliver Ethan to his father. With this came powerful statements from Ms G that D and Ethan were doing so well together. There was affective undertone of not being needed anymore, and I was left with a concern that intense pressure on her to wean could precipitate a crisis, primarily in terms of her desire to stay alive. My anxiety about a possible suicide attempt was high, and I checked that the network was in place. In retrospect, I believe I was also caught up in powerful projections around loss of myself, as we were approaching another break (9 months into treatment).
Anticipating this loss Ms G thought she and Ethan would miss their sessions with me, but she continued to insist that the solution was disengagement and self-sufficiency. Separation, as an intrapsychic process leading to growth, still felt beyond our reach.

ENACTING RUPTURE

On their return after the holiday, Ms G appeared terribly thin and wan, while Ethan seemed to have gained bulk and weight. My first thought was “he’s feeding off her!” He also looked strikingly like his father, as though fulfilling her fears of losing him to D. They each responded to me with a measure of reserve.

Ethan took his time before he approached me; gazing at me from a distance and looking worried. After a while he gave me a smile and I smiled back and asked whether he was beginning to forgive me for the summer break. Ms G told me that on their holiday everyone had adored Ethan and that he had gone easily to the men but not to the women who wanted to pick him up. I wondered whether she was linking Ethan’s reserve with me to this. She shrugged. I asked her what she made of her observation. She said, “It’s like being run over by a red car and then not liking red cars afterwards.” I said it seems to have reinforced her fear that she was not a good mother and as a result all women were like red cars to Ethan. Again she shrugged, this time seemingly in agreement. Ethan was crawling about—initially energetically but then looking lost. A number of times he headed toward his mother and then veered away. When he absolutely ran out of resources he crawled to her and tried to clamber onto her lap. Ms G held him loosely, pulling away a bit and getting her hair out of his clasp. She then abruptly stood up muttering that he needs a climbing frame, carried him over to one of the chairs and stood him there. Ethan looked tiny and forlorn across the room. I felt shocked. She came back to her place on the cushion. I said she was equating herself with the chair, as though it was not her—his mother specifically—that he needed. She replied that she does not want him to depend on her for his happiness. Feeling very anxious about what I was about to say, I asked whether she wanted him to be independent of her so that she could do away with herself if she felt she needed to. Ms G looked pale. She whispered that this was very selfish. I said perhaps she thought that in order to continue living she needed to feel that she could kill herself. Ms G said everybody had their escape routes.

Ethan had crawled back to our vicinity and was searching Ms G’s bag. He pulled out a plastic container with food. We watched as he struggled to get an apple out. I accompanied him with words: is he wanting the apple, can he get to it? He managed to extract the apple
and tried to bite into it. I asked him if he can eat it, is it too big? I said maybe Ms G thought I was fussing too much. She moved closer to him and asked him if he needed her to cut it for him, but Ethan had in the meantime made indentations with his teeth. He chewed on the apple for a while and then tried to get the bottle of baby food out. Ms G watched him closely and I found it agonizing that she did not capitalize on his interest. When she finally, tentatively offered him some food, he spat it out. She immediately put the bottle of food away. Shortly after this he began to cry.

Ms G told me that at D’s insistence she had taken Ethan to a nursery that morning. I asked how they had felt about it. She said Ethan had choked on a brick during his visit. She conveyed immense sadness. I said she seemed torn between loving Ethan and wanting his love for her, and her fear that this dependency in both of them would take away her escape route. I suggested that the long break had probably also brought up these feelings in relation to me. Ethan was getting more upset and when picked up by Ms G he clung to her strongly. I said to him that he was showing his mummy how much he needed her and how frightened he gets when she thinks about leaving him. Ms G carried him over to the windowsill and sat him on it so he could look out. Ethan calmed, and soon after this it was time to end. Ms G fled the room clutching Ethan in her arms.

The story of the holiday could have been taken entirely as a transference communication: I had “run over” her dependence on me and left her, prematurely, to feed herself. Thus forsaken, she felt driven toward her habitual escape routes of self-denigration and self-harming, both to rid herself of her shaming infantile needs and as a retaliatory attack on me. Her rage with me was communicated in the narrative of the red car and enacted in substitution of climbing frame/chair for self, that is, in her refusal to embrace Ethan—again, an identification with the aggressor.

A central dilemma in parent-infant psychotherapy is when to take up the transference to the therapist? Certainly the negative transference was in the forefront and needed addressing. However, my initial attempt to relate to my perceived dangerousness (via Ethan’s avoidance of me) was shrugged off. I reckoned that to pursue the transference and/or her defenses could be experienced by Ms G as retaliation on my part (Steiner 1994). In retrospect, it is the displacements that perhaps could have been taken up for it is there that the experience of cruelty lay. Addressing her rage with me may have relieved Ethan from the burden of carrying it.

With the rupture (break) with me unsufficiently reflected upon, what followed was Ethan’s performing a transference enactment of
failed self-feeding while the intergenerationally depriving mother stood by. By this point I was able to address the struggle to manage alone, but although Ms G carefully watched Ethan, her active intervention came too late (like mine) and was rejected. I wondered whether in fact Ms G experienced me as empathic toward Ethan when I had been withholding toward her, and this perhaps contributed to her not helping him feed. I also thought she was possibly punishing me through forcing me to witness her abandonment of her child (which was painful to watch). In a similar vein, going to nursery was experienced as forced upon them, with life-threatening consequences. However, Ms G's sadness was here undefended and it gave coherence to the preceding narratives. Acknowledging the need and the pain allowed some movement—by the end of the session Ethan was enconced in Ms G's embrace.

The following session Ethan was unusually free and playful, particularly in relation to the apple. He held it, bit into it, he lay on the apple and rolled around. I noted Ethan's playfulness and Ms G said she too had noticed it—it was so different from his clinging. I suggested that he might be picking up that she and I were trying to work something out and it was a relief to him. Ms G said, "maybe he is being trustful."

"FALLING IN LOVE" AS REPARATION

In one of her earliest sessions Ms G asked, "When does one know that reparation has taken place?" "Reparation" was her choice of word, denoting making up for her destructiveness.

Toward the end of the first year of treatment we came back to this theme. It was a period of creativity following the enactment of rupture, described above. In the sessions there was a shift, with Ms G taking a slightly more reflective stance (i.e. less rumination and self-reproach) than hitherto. In the core relationship toward Ethan, so dominated previously by her ambivalence, there seemed to be a flowering of love. Between them there was a more robust link, which enabled Ethan to move to and from his mother and to refuel from a distance through gaze. Ethan also established his own little routine in the sessions. He would start by checking out the toys and re-establishing himself with me—little smiles, crawling over to me, gradually climbing up to explore me. Then he would go over to Ms G's large bag and get out his food parcel—an apple and berries in a plastic bag. He had to work hard to get his hand into the bag, but Ms G
monitored his endeavors and encouraged him. Ethan then ate his fruit, swallowing some and spitting some out. Gradually eating and playing/exploring became somewhat more integrated, and he moved between the activities and us.

He approached his 1st birthday and this preoccupied Ms G.

She said she still had not found the perfect present. She mentioned a cloth she’d had as a comforter which had worn away—she wished she still had it to give to Ethan. I said it sounded that she was wanting to protect and comfort him for the years to come. She replied that she had a lot to make up. I said this made me think of the perfect present as representing a wish to make good their very difficult early beginning. Ms G spoke of reparation and I thought she was also repairing something for herself. Her emphasis was on her wish to protect Ethan’s trust and expectations that people will respond to him kindly. I suggested she may have felt unprotected and that cruelty hit her abruptly as a child. Ms G spoke about her mother doing her best, but that it was not good enough. She added that her mother does a lot of charitable work but she wishes she could have given the same to her children. I said that perhaps she feels that sometimes both her parents didn’t really do their best and that some of the cruelty she experienced came from them—and this is what is so hard for her. Ms G struggled with this, though she did not deny it.

Ethan had finished eating and messing and was exploring under the table where he discovered the telephone wire and plug. Ms G initially asked him not to play with the cord and then went over and picked him up. Ethan gleefully crawled back to the table and Ms G became firmer in her tone of voice. I spoke about what was happening between them, reflecting that he really enjoyed being gathered up by his mother and had found a hide and seek game which he could play with her.

This session was characterized by a sense of calmness and reflection between Ms G and myself, the adults, and playful exploration on Ethan’s part. I felt that I was allowed to hold a position of the benign “third,” and this was perceived to be containing to both baby and mother.

The quest for the perfect present seemed to capture Ms G’s regrets about the lacks of their beginning together, and her wish to celebrate their coming together through the love she had discovered within herself for her child. In wishing to extend the “comforter” from her childhood to him, she also had begun to mourn the lonely childhood she had, and to relinquish some of the envy of her child for the maternal comfort he could still have in his. Ethan’s play with the tele-
phone cord seemed to represent hope for more genuine, encompassing communication between them through which he could be gathered up and contained.

**Discussion**

Ethan's first birthday also heralded the end of our first year of work together—a good time to take stock. The wish, and failure as yet, to find a "perfect present" seemed symbolic of what had been achieved and of that which still needed to be addressed.

Ms G had approached parent-infant psychotherapy with the wish for a "filter" to protect her baby from the transmission of damage she felt had been done to her by the parenting she had received. In equal measure, although more hidden, was the fear of being damaged by her baby. This mutual threat was created through their very existences in relation to each other. As Ms G said, "Can one damage one's baby just by being available?" In the transference I was also often a source of danger, most spectacularly around breaks when my unavailability confronted Ms G with her the extent of her dependency on me and my maternal failure to hold it. Ethan's post-natal vulnerability—his smallness, sensitivity to lights and noise, seemingly low threshold to "unpleasurable" experiences and the difficulties in comforting him—intensified the sense of fragility and risk. My countertransference fantasy that we were constructing the therapeutic space within a sea of shards highlighted the power of the emotions, projections and enactments.

In the course of the first year of the therapy there were some changes in the relationship between Ms G and Ethan. The most significant was the expanding sense of maternal love for Ethan. In the early months Ms G's fear of, and guilty hatred for, her baby's dependency overrode her ability to accept more benign feelings in herself. She defensively adopted an ideal of altruism that negated not only her passions but also his. Ethan was forced into precocious inhibition of attachment behaviors toward his mother. His turning from her, and her failure to meet her ascetic standards, compounded her depression. In the course of the first year of therapy there was a lessening of Ms G's preoccupation with the question of "genuine" maternal love and a move toward more ordinary, at times "good enough," mothering. She seemed more able to acknowledge and tolerate her wish to be central to Ethan and, albeit less consistently, her importance to him. Her gaze and facial expressions conveyed growing adoration of him. What facilitated these changes?
Perhaps “falling in love” could start to take root only after there was some measure of surviving the destruction and despair brought from her past primary relationships into her present ones. By the third quarter of the year Ethan, although delayed, was making up the early impingements and developmental tests confirmed he was on track. Thus Ms G’s psychic reality of the inevitability of damage could, sometimes, be challenged by a different, external voice. Ethan, for his part, seemed to capitalize on the openings in their relationship and became more forward in expressing his desire for her. This, too, was a positive reinforcement which Ms G could at times perceive.

In the transference relationship with me I, too, was surviving her destructiveness and was not retaliating with narcissistic demands of my own. Thus Ms G was meeting with a different “motherhood constellation” (Stern 1995) from the persecutory internal one, one in which the intergenerational mother could be experienced as containing and repairing of the damaged child.

The clinical process, as the sessional material indicates, took place in the procedural and symbolic domains. Interpretations—using words as a means of giving meaning—were important to this mother, as were verbal (vocal, tonal) representations of his mind to Ethan. The procedural processes seemed to cohere more slowly. At first, the misattuned emotional “dance” between mother and baby was repeated in the interactions between the three of us. In time, I became better at matching and repair of the spontaneous gestures and affects that constitute “authentic person-to-person connection” (Stern et al. 1998, p. 904) and this then framed the developing relationships between mother and baby and myself.

Because so much in the earliest transactions between Ms G and Ethan was driven by her negative transference to him, offering myself as someone who could simply be with mother and baby and could reflect on them in relation to each other without fear of damage, seems to have been important. For quite some time it seemed that only in my mind could their survival as a dyad be contemplated. This raised the question of which patient should be privileged from moment to moment—Ethan, mother, father (present or absent), the relationships? At times I left a session feeling that more work should have been done with Ethan, for example to enhance his efficacy in engaging his mother. At other times I felt that the focus should stay with Ms G, to address her depression and the defenses and distortions that constituted her zone of safety but also derailed the relationship with Ethan. Despite the compelling nature of Ms G’s narrative, it was cru-
cial to keep Ethan in my mind at all times, so as not to slip into individual therapy in the presence of the baby. These issues were all the more urgent given Ethan’s young age and the chronicity of Ms G’s difficulties, spanning critical periods in his development.

Alongside the changes that marked the achievements of our first year together there remained areas of great vulnerability in their relationship. It seemed that the quality of love Ms G was able to offer Ethan was contingent on her emotional state at any given time and the extent of preoccupation with herself. Often Ethan had to make do with the crumbs of emotional availability that penetrated her depression and withdrawal. Not able to love herself in her baby, or to allow his appealingness to reflect on her, Ms G could not really entertain exuberant passion and appetite in her relationship with Ethan. Moreover, to be “consumed by the other” was only too real a threat and to be avoided at all costs. Thus Ethan was not able to safely experience himself as an object of hatred as well as of love. His own actions directed at separation-individuation were still, at times, subject to transferential attributions that frightened Ms G and evoked her rejection of him. In turn, Ms G’s fluctuating emotional state, and particularly when she became extremely depressed, could be frightening for Ethan, betrayed initially in disintegrative crying, and later in occasional veering away in the midst of approach or a momentary freezing when mother seemed annoyed.

These thoughts about clinical process are relevant to the question of whether “genuine maternal love” exists.

It seems to me that what Ms G captured in this term was the affective quality of her love for her baby as described above. In presenting the question she was disclosing her knowledge that something was going very wrong for them. At the same time, bringing the question into the therapy also underlined Ms G’s commitment to do better by her baby: whatever her state of mind, however conflicted she was about the therapy, Ms G and Ethan attended their sessions without fail. In using the therapeutic space to risk intimacy, Ms G and Ethan were constructing their particular version of “genuine” love—somewhat more measured and a little more vibrant at the end of the year than at the beginning.

For myself—I was intrigued by this question in the context of my work with attachment disorders. It seems an important concept to hold in mind in the course of the therapy with mothers and babies. In the face of conscientious maternal care, it provides a framework for understanding a particular quality of “maternal failure” and ensuing relational trauma for the baby. It also suggests an outline of the
clinical process that may be needed to free up object hunger and to encourage the risks of appetite and dependency, identification, and individuation in a dyad.

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