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From parental to infant psychopathology, as reflected in a long-term mother-infant psychotherapy

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The presented clinical case of long-term psychotherapy shows the complex interplay between parental personality disorders, traumatic life events in the parents' life and the baby's temperament.

Key words: psychotherapy, psychopathology, mather-infant relation

Introduction

While looking at the impact of parental psychopathology on the young child's development, one must define the concept of motherhood , fatherhood or parenthood. Relating to motherhood, Stern [1] has suggested a psychoanalytically-oriented definition of motherhood as a special intra-psychic reorganization the mother needs to go through with the birth of her first-born. The four major themes embedded in the concept of "Motherhood Constellation" include: *The life growth theme*: Can I maintain the life and growth of my baby? *The primary relatedness theme*: Can I emotionally and authentically engage with my baby? *The supporting matrix theme*: Will I know how to create the necessary support system for assuring my baby's mental and physical development? *The identity reorganization theme*: Will I be able to change my self-identity to permit and facilitate these functions? Green [2] has defined parenthood as the parents' capacity to maintain and promote their infant in his/her growth. According to him, this function is independent from the level of their personality organization. Indeed, some individuals are much better in their functioning as parents than as individuals, and vice-versa. This might explain the great variability in the observed impact of parental psychopathology on young children development. The Rochester Longitudinal Study on children of mentally ill mothers and of psychosocially deprived mothers, from pregnancy to adolescence [3] showed that there was no specific effect of parent's psychiatric diagnosis on the behavior of their children during early childhood. When maternal mental illness was the only developmental risk factor, the child did well. When maternal mental illness was accompanied by other risk factors, such as poverty, lack of education, lack of social support, many stressful life events, the

child did poorly. Child did poorly with these above risk factors, also when mother was not mentally ill. Social circumstances were a more powerful risk factor than parental mental illness, and that no single risk factor, even if it is a major mental illness of a parent, determines the child's socio-emotional outcome**.** In addition, Sameroff et al [3] have shown that the child's outcome is not related to any specific parental diagnosis, but by *how specific parental behaviors impinge on the child's fundamental developmental tasks and needs* (regulation, attachment, autonomy, dependency, self-esteem). The nature of the child is also a significant determinant of how and how much parent psychopathology impacts on him/her.

From a more practical standpoint, parenthood is reflected in a cluster of behaviors aimed at meeting the needs of children. Kopp & McIntosh [4] have listed the main children's needs and the consequent parental responsabilities (Table 1).

In the light of these complementary intra-psychic and behavioral definitions of parenthood, the clinician's task, whenever faced with an emotionnally disturbed parent and a young child, is to determine what are the specific parental behaviors that impinge on the child's socio-emotional development, and what are the child's characteristics that impact on the parent. Then, the treatment process, as we will show through a clinical case, is aimed, first at identifying and then, at unfolding the distorted projections on the young child, that underly the maladaptive parent-child interactions.

The presented clinical case is aimed to show how the complex interplay between parental personality disorders, traumatic life events in the parents' life and the baby's own "slow-to warm-up" temperament required a long-term therapy, with changing modalities along the first 4 years of the child's life. The young child's presence in all the therapeutic sessions enabled to work simultaneously on internal representations and interactions. This in turn, allowed us to identify some of the mediating factors in the process of transmission of parental to infant psychopathology.

Clinical Case

S., a one month-old baby girl, first-born and only child of two young parents, was referred to our Infant Mental health Unit by the community health care nurse because the unusual mother's behavior: she would stay at the community health center long after the routine examination of her baby, sitting there and *watching the nurse's interactions with other mothers and babies*, without asking anything. She looked sad and at loss.

Background

The first session was a home visit, triggered by the fact she missed the first two scheduled appointments. The visit was initiated by the therapist (M.K). This active reaching out was due to the nurse's concern of post-partum depression, and our fear for the baby's welfare. S. was already 2 months old. Mother and baby were sitting on the sofa, surrounded by an incredible mess: nothing was at its "natural" place. A., the mother seemed overhelmed by the situation, hold Baby and breast-fed her. Baby was irritable and fussy, and the first sentence Mother said, after formal greetings, was "You

see, *she's angry at me all the time*, even when I feed her". She explained why she did not come to our clinic in these words: "nobody can help, that's what life has taught me, why should this change now?" In spite of her severe basic lack of trust, loneliness and helplessness created in her an urging need to talk.

Questioning A. about her pregnancy with S. revealed a chaotic life story of deprivation, abuse, and loss. She was the oldest of two girls, her father left home when she was 3 years old and kept no contact with her until she was a grown-up. Her mother led a chaotic promiscuous life, and had been intermittently on alcohol and drugs. Her sister was the fruit of a second marriage. The stepfather would sexually abuse her, and at the age of nine years, A. was declared by Social Welfare as a "high-risk child". The court ordered a residential placement. The younger sister stayed at home, exposed to the mother's chaotic lifestyle, and developed a dependent and clinging relationship with her older sister. A. described herself as a parentified child towards both her sister and her mother. The sister died at the age of 9 (A. was 15 years old) in a car accident on their way back to the A's boarding school. A. found herself alone with her sister lying dead on the road. "Even then, my mother was not able to take care of us: she simply fainted". From that time on, A. developed a pathological grief syndrome. She came back home to her mother, who slipped further into alcohol and drugs, and took care of her. At the age of 16, she had a boy-friend to whom she eventually married six years later. Their relationship was "stormy but stable", based on a mutual need for the warmth they did not receive in their respective childhood (he was battered by his mother), mixed with her fear of sexual relationships and his unsatiable need for narcissisitic gratification.

Pregnancy

A. did not intend "to bring children to this bad world", until she had a dream of her late sister telling her " I can't wait anymore". A. understood this dream as the expression of her sister's wish to be reborn, and became pregnant as if she was ordered to have a baby girl. Her husband had no idea of the source of her new motivation to have a child. A baby girl (!) was born uneventfully and healthy. A. chose a first name *almost* similar to her late sister's. *She felt compelled to do so, even though she admitted her tendency to mix up the two names.*

Baby's clinical status

S. was a healthy baby. She developed a social smile on time. At 3 months of age, she showed a tendency to often switch from state of alertness and positive vocalizations to state of fussiness and crying. At first glance, the irregularity in her daily routines and her fussiness seemed to reflect a difficult temperament. Detailed description of their day routines revealed that the *mother could not stand S.'s cry* and therefore would hold her in arms almost continuously (which explained her inability to do the house chores). S.'s poor sleep during the night and good sleep during the morning was very much related to the mother's own pattern of sleep, as she explained: "I never slept

well during the nights, I always waited for the morning to fall asleep…at home, my sister and I would sleep together, then when she died I slept with my Teddy Bear… and now with S. Talking about her inability to let S. cry revealed the mother's perception of S.'s cry as both a sign of parental incompetence, and later, as a reminder of her sister's clinginess.

Diagnostic formulation

At three months of age, we diagnosed Baby S. as a high-risk infant because of the complex psychological context she was born into. The maternal history of affective deprivation, abuse and unresolved loss with pathological grief of her young sister was putting at serious risk the process of attachment (supposed to take place from 2 to 7 months). At the time of the evaluation, she already had developed a sleep problem "by proxy" and manifested a "slow-to-warm-up temperament. Her father refused to be involved in the therapeutic process, stating his wife "just has to wipe away her past" (it will turn out, much later, how this dismissing stance was his way to deal with his own difficult past). Baby S. did not have any medical diagnosis. Her psychomotor developmental milestones were within normal, though in the lower range. The parents' chronic marital problems were listed as additional risk factors. In dynamic terms, Baby S.'s main diagnosis was her status of replacement child/sister, in addition her parents' psychological risk factors for good-enough parenting.

Treatment plan and modalities

We had three goals in mind: 1. To help the mother identify her pathological projections on the child, so that differentiation between child and dead sister can happen. 2. To provide developmental guidance to mother, in the light of her almost total lack of internalized normal motherhood. 3. To create a potential emotional space for the child's true self, by voicing the child's needs. We chose to combine two modalities of treatment: mother-infant psychodynamic therapy and interactional guidance.

Deciding upon a psychodynamic approach was based on the mother's relative ego strengths that were manifested in the parenting role she was able to take towards both her sister and her mother (though at a very high psychological price). Fraiberg [5] recommended infant-parent psychotherapy in situations where the baby has become "*the representative of figures within the parental past, or a representative of an aspect of the parental self that is repudiated or negated. In some cases the baby himself seems engulfed in the parental neurosis and is showing the early signs of emotional disturbance. In treatment, we examine with the parents the past and the present in order to free them and their baby from old "ghosts" who have invaded the nursery, and then we must make meaningful links between the past and the present through interpretations that lead to insight. At the same time…we maintain the focus on the baby through the provision of developmental information and discussion. We move back and forth, between present and past, parent and baby, but we always return to the baby.*" (p.61)

Along Fraiberg's line, Stern [1] introduced the concept of the "clinical infant" to describe these infants who are the recipient of distorted parental projections, such as

the "evil" infant, the "destructive" infant, the "independent" infant, the "insatiable" infant, the "invisible" infant. In these parent-infant psychotherapies, the "identified patient" is the parent-child relationship, and the goal of the therapy is to unmask the "ghosts" which are covering the infant and prevent the parent to perceive him/her as an individual on its own [5].

In our case, S. was a "replacement sister/child", litterally masked by the ghost of her mother's late sister. For instance, the way A. perceived and interpreted S.'s cry, at the beginning as a protest of her late sister at her maternal incompetence, and later as a reminder of her sister's dependency and clinginess, illustrates how parental transferential components on the infant obscure the baby's selfhood for the parents. Their own past traumatic experiences make them perceive their infant's behavior and personality in a colored and distorted fashion.

Because of these pathological projective processes, the baby's presence during the therapeutic sessions is a central component of infant-parent psychotherapy. As Lieberman et al [6] wrote: "*Parental report cannot be a substitute for direct observation of the baby and of the parent-baby interaction. The therapist's observational skills allow her to identify themes, detect defensive distortions, capture emotional nuances, and monitor infant development in ways that would not be possible in the baby's absence. Moreover, the baby's real contributions allow for therapeutic intervention in the immediacy of the moment, while affect is being keenly experienced and can be addressed most directly* ." (p. 473).

Coming back to our case, identification of A.'s pathological projections on S. was an essential component of the treatment plan, but not the only one. Indeed, A. had absolutely no representation of a "good enough" mother, and even less developmental knowledge about children. Therefore, an additional necessary component of the treatment was to provide the mother with developmental guidance. The concept of developmental guidance, through direct work on the behavioral component of the parent-infant interaction, has been introduced by McDonough [7], under the name of "interactional guidance". Interactional guidance is explicitly based on strengths, and emphasizes positive transference. Its main components are to convey the message that parents are doing the best they know how to do, to address what parents believe to be the problem, to answer questions posed by the family and provide information when asked, and to jointly decide with the parents the definition of treatment success [7]. This approach is different from the psychodynamic parent-infant psychotherapy in the sense that the former addresses the behavioral components of the interaction, while the latter focuses on thoughts and fantasies about the infant which can be identified through the analysis of microevents that happen during the interaction [8, 1].

Mother-Infant psychotherapy course

The mother-infant treatment lasted almost 4 years (on a weekly basis during the first year and half, then every three weeks). For the sake of presentation, we may differentiate its course into the following stages:

1. Slow development of positive transference between mother and therapist, or "The good grandmother transference" [1].

The need of certain mothers to be first nurtured, in order to gradually become able to nurture their baby [5, 9], was obvious in A.'s behavior when she would sit for hours at the Well-Baby Clinic, as if telling the nurses "It is my turn now to be taken care of". Up to a certain point, any new mother feels "a desire to be valued, supported, aided, taught and appreciated by a maternal figure" [1] in her new maternal role. In the transference situation, this desire is intensifed and focalized on the therapist. Stern calls this form of transference "the good grandmother transference".

For A., the psychological unavailability of her own mother was once again, painfully obvious. She could not stand being alone, and her behavior at the Well-Baby Clinic could be interpretated as a mute request for a maternal figure. Her borderline personality organization was such that at the same time she desperately needed such a figure, she could not trust any. Her missing the first two appointments at the clinic, was a test of the therapist's level of commitment (even before she knew her). The therapist "passed" this first test by coming to A.'s home. This approach of allowing the therapist to be more active and less "neutral" is thought to be central in the formation of the working alliance with severely deprived mothers [5, 6].

2. Reenactment of trauma (accident with baby's craddle), provoking exarcebation of fear of loss, distorted sleep pattern of both mother and baby, increased stranger anxiety in child.

On the fourth therapeutic mother-infant session, while S. was whiny and irritable, A. angrily said: "I can't stand her crying, therefore I hold her in my hands almost all the time, but I can't take it anymore". Therapist added "and she makes you angry". A. replied: "This is the worst part…because…you never know, whenever you get angry at someone you care for, you might never have the chance to repair it…" Following a tense silence (while, amazingly enough, S. had stopped whining), she added: "This is what happened with my sister. On the day of the accident, she had exasperated me with her clinginess to me, I yelled at her, and we did not talk anymore… I remember thinking, just the minute before the accident, this quarrel is stupid, I should talk to her...but I did not, and then, she was not there anymore". A. was overhelmed by the memories, S. was looking at her and at therapist, as if asking for the meaning of these heavily loaded moments. Therapist directly adressed her, saying: "Mummy is very sad because she remembers what happened to her sister, your aunt". A. was puzzled at this therapist's direct and verbal reference. The question of the potential impact of her intense emotional turmoil on S. surprised A., as if she was seeing S. for the first time. The therapist's voicing the baby's "thoughts, questions, worries", as if speaking from the infant's mind, is a technique often used when there is a lack of representational space in the parent's mind for the real infant, or, in Fonagy's terms, a lack of reflective parental function [10]. Francoise Dolto [11] was actually the first to use this technique, intending it for the infant's ears as well as for the the parents'. Though a causal link is difficult to prove, we, in our clinical practice, do see the impact of the therapist voicing the infant's concerns and perceptions on the actual infant's behavior in the room. Stern conceptualized this approach as "the infant's representations (as

imagined) as port of entry" (1995, p. 134) to the the final aim which is to change the parents' distorted representations of their child.

On the way back home after this session, with the mother's reexperiencing the traumatic loss of her sister with the ambivalent feelings that characterized their siblings relationship, S. accidently fell from her craddle on the road. A. had "forgotten" to fasten her seat belt. S. was admitted at the hospital for observation only, and recovered quickly. A. was in a dissociative state for two days, endlessly saying "she's dead, she's dead".

3. Grief over dead sister leads to a depressive state. Difficulty to accept the real child, with her real needs. The child becomes oppositional at home, but is extremely shy outside.

Along the following months of therapy, the gradual increase of S.'s motor and cognitive skills somehow differentiated her from the ghost of the late aunt. In parallel, A. grew sader: "I feel my sister is really lost forever, nobody will ever replace her…it is as if I'm loosing her again, this time for real". A. entered a severe depressive state, with suicidal thoughts, and an adult psychiatric consultation was added to the therapeutic setting. Improvement was slow, but steady. When S. was a year and half, mother decided to start working, and asked to "have a break" from therapy. This move was interpreted as a parallel "practising" behavior, both in mother and in child. Therapist and mother agreed therapy would resume whenever the mother would ask for it. Several months went by. The mother would call from time to time to tell therapist she and S. were fine.

When S. was two years and half, A. called for help with A.'s temper tantrums and increasing oppositional behavior at home. A. arrived in a state of helpless exasperation: "I can't stand her saying "No" all the time to anything, she makes a fool out of me, there is no use, I'll never be a good mother, I don't even know if I want to..". It turned out A. gave a special and distorted meaning to her daughter's growing up: the more she grew up, the closer she was to the age of the sister's death. A. verbalized it in these words: "Growing up means separation and loss, I'll commit suicide the very moment S. won't need me anymore". She could not handle the child's needs for autonomy, making her more provocative at home, but also more fearful outside, with significant separation anxiety. As a parallel process, "growing up" in therapy was threatening, and no further improvement was made at that point. Also, the relationship between the two parents deteriorated. Up to that point, the father had refused to come to the clinic, stating "I don't believe in psychological "stuff", my daughter is fine, the only problem is S. and she just has to decide to forget her past !".

4. *Transient selective mutism of child. Father-child-mother sessions.*

At the beginning of the new school year, upon return to the nursery school, S. became mute with strangers. Father, worried for the first time, agreed to come for a few sessions. This was the beginning of a short triadic phase of the treatment, where several important topics emerged, such as the father's own suspiciousness towards strangers, his lack of trust towards women in general, and his difficulty to be consistent in limit-setting to his daughter. S.'s selective mutism resolved amazingly fast, which put an end to the father's participation in therapy.

5. *Termination of the dyadic psychotherapy.*

S. reached the age of 4 . Her functioning at the nursery school was pretty good, though an overall inhibited behavior still characterized her. The therapist was struck by her "pleasing" behavior both towards therapist and mother during the dyadic sessions. The decision to end the dyadic therapy was based on the feeling that time for individual growth had come, but the termination process was, as expected, painful to A. and therefore took several months. Mother and child were finally referred to individual therapies.

Discussion

One may conceptualize this case in Stern's terms of "major themes" of the motherhood constellation: A., the mother of a baby doomed to replace a late 9 yrs-old maternal sister, was totally at loss: maintenance of the baby's life and growth seemed uncertain from the very first weeks of S.'s life because of the mother's early feelings of incompetence triggered by the infant's cry during breast-feeding; A.'s ability to "emotionally and authentically engage with the baby" was also very much at risk because of the sister's ghost masking the real baby, and the consequent distorted perceptions she had of S.'s behavior. The third major theme, the supporting matrix one, was not less problematic, taking into account both parents' backgrounds. The fourth and most sophisticated one, the identity reorganization theme, seems, by definition, problematic for parents suffering from personality disorders.

The parent-child interactions that took place in the therapeutic sessions "translated" these major intra-psychic difficulties related to parenthood into observable phenomena in both the child and her parents, such as S.'s anxious reaction to the mother's unpredictable responsiveness, emotional lability and impulsivity, or her "pleasing" behavior towards her father in constant need of mirroring, mixed with fear of his anger bursts. It also enabled us to see the child's own contributions to the development of symptoms, such as social withdrawal and transient selective mutism that may be related to her very inhibited temperament. This temperamental trait was definitely reinforced by the parents' basic lack of trust towards strangers.

In figure 1, we try to resume the complex interplay of the parental and infant psychological and biological risk factors involved in this case, while we suggest that it is the combination of all these risk factors, and not one of them specifically, that lead to the child's insecure attachment, sleep problems, extreme stanger anxiety and later, social withdrawal with an episodic period of selective mutism.

One may note, though it is beyond the scope of this article, that this case also shows the typical interpersonal relationship that take place in a family where a child has been lost and replaced by another one [12]. A. would often call S. by her late sister's name. S. was not perceived by A. as a baby in her own, but always as a reminder or a deceiver of her young dead aunt, who was literally what Fraiberg named "a ghost in the nursery". For example, S's babyish cry reminded A. of her 9 year old sister's clinging behavior, and evoked in her the same impatience and anger that her sister provoked in her years ago. S. developed symptoms of anxiety (first, increased stranger anxiety, then

social anxiety), passivity and dependence: indeed, A's perception of the outer world as dangerous and bad, and her overhelming fear of losing S., had an augmentation effect on S.'s slow-to-warm up temperament.

At the end of 4 intermittent years of therapy, we summarized the impact of therapy as having lessened the damage to child's basic trust via creating some basic trust in mother. S.'s need for a narcissistic recognition [13] in her mother's eyes has gradually been understood by A.., but not yet fully internalized. A late maternal attachment behavior appeared after 4 years of therapy in the form of this sentence to therapist, in the transition period between the termination of mother-child psychotherapy and the beginning of individual therapy for herself and for the child: "I'm calling you because I know you always listen to me…".

Still, continuation of therapy for the child is obviously needed. As the years of therapy went by, S.'s tendency to develop an "as if" personality became evident. One of its manifestations was her tendency to ask permission for any little thing with an artificial high-pitched voice, as if she was trying to please the grown-ups. At home, she would be provocative and oppositional, but very aware of her mother's emotional state.

The course of the therapy reflected the problematical functioning of parents with borderline/ narcissistic personality disorders with backgrounds of emotional deprivation and abuse. S.'s father never really engaged in the therapeutic process; his attitude towards therapy was a dismissing one, saying "The past and its figures (i.e. parents) is not worthy to talk about, and has nothing to do with my actual parenting." This attitude is typical of adults with Dismissing type of Attachment [14] and common among subjects who have endured harshness and rejection in their childhood. The only time S.'s father opened up a little was when S. developed selective mutism. This symptom looked strange and scary to him. As soon as S.'s symptom resolved, he stopped coming. The therapeutic relationship with the mother, in the context of the infant-parent psychotherapy, was typical of the work with multirisk families, described by Wieder & al [9]: Regularity and stability as the first dimension of the therapeutic relationship, enabled the second dimension of attachment and affective relationship to emerge, followed by the process of self-observation, leading eventually to parental reflective functioning [10]. The process is typically long and slow, while repeated active reaching out and combination of guidance with insight-oriented intervention are required.

Conclusion

Regulation, attachment, autonomy, dependency and self-esteem are the child's fundamental developmental tasks and needs. Parental psychopathology, combined with past loss and abuse, put in jeopardy parental functions. The course of parent-infant psychotherapy with multi-risk families may be viewed in developmental terms: The therapeutic relationship starts with the establishment of regularity and stability, or "homeostasis", followed by a corrective attachment experience, and then by gradual formation of new representations of the "schemas-of-being-a-parent-to-this-child", replacing the distorted ones that under-lied the maladaptive early parent-infant interactions. Facilitation of parental reflective functioning may become a major factor in preventing "deterministic" transmission from parental to child psychopathology.

Table 1

Variables of parenthood

Children's Needs	Responsibilities of Parents
Nurturance	Affiliation
	Social support
	Caring (emotional care)
Physical Care	Food, shelter, clothing
	Hygiene
	Health care
Teaching	Information facts, "how to"
	Family "does" and don'ts"
	"What" and "when"
	Emotion within social norms
	Moral and legal systems
Temporal/Spatial structure	Routines and schedules
	Time demands

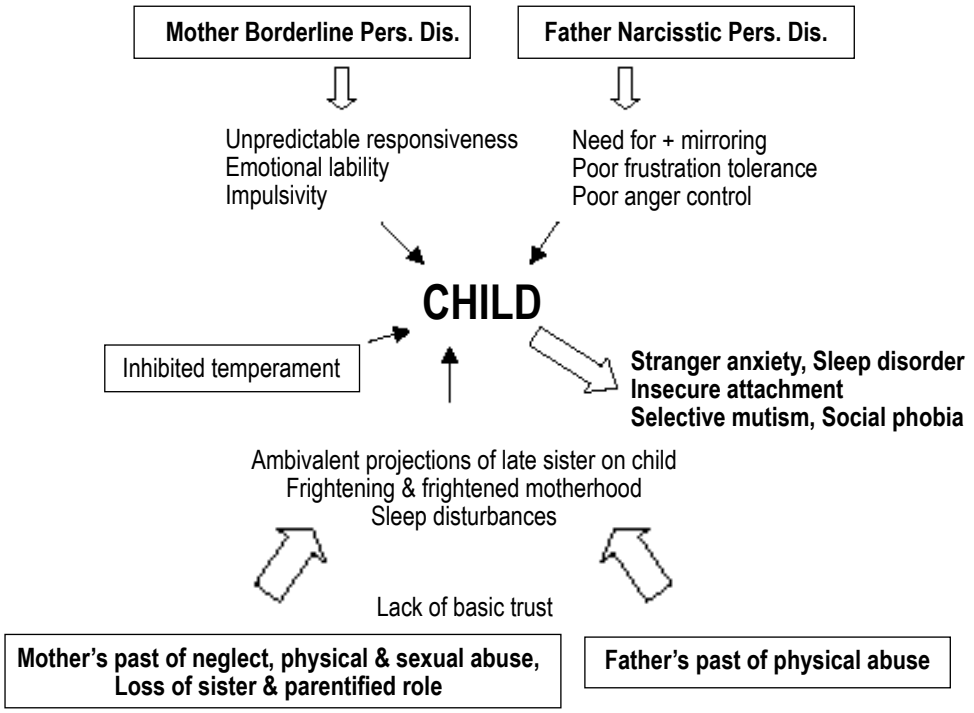

Fig. 1 **The impact of parental psychopathology and life events on the young child S.**

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