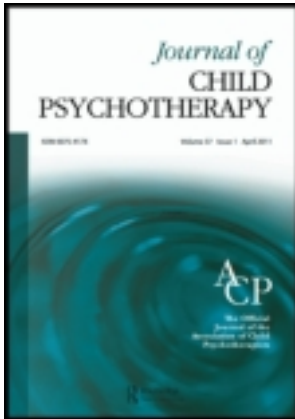


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Publisher: Routledge

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## Journal of Child Psychotherapy

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rjcp20>

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Published online: 04 Jul 2013.

To cite this article: Björn Salomonsson (2013) An infant's experience of postnatal depression. Towards a psychoanalytic model, *Journal of Child Psychotherapy*, 39:2, 137-155, DOI: [10.1080/0075417X.2013.806052](https://doi.org/10.1080/0075417X.2013.806052)

To link to this article: <http://dx.doi.org/10.1080/0075417X.2013.806052>

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## An infant's experience of postnatal depression. Towards a psychoanalytic model

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Despite the high prevalence of postnatal depression (PND) and the focus in psychoanalytic theory on the importance of the infant's primary relationship with the mother, few case studies have been published. This applies to PND mothers in psychoanalysis and mother–infant dyads in psychotherapy. A case of a girl in treatment from 16 to 40 months of age is presented in three clinical vignettes. She was first in treatment with mother and then continued on her own in regular child analysis. Her main symptoms were restlessness and craving for the breast, later followed by a fear of holes and a phobia of ghosts combined with difficulties falling asleep. Based on this case, a psychoanalytic model is suggested of how the infant might experience being with the PND mother. The author suggests that infants of such mothers do not react to their depression *per se* but to a faltering containment. This leaves the baby with frightening emotions. The experience of insufficient containment may be represented in different ways such as, in this case, a fear of holes and voids and, in the next step, a phobia erected in defence of this fear.

**Keywords:** Postnatal depression; infant development; mother–infant psychoanalytic treatment; mother–infant psychotherapy; absent object; containment

### Introduction

Beate, your mum says that when you were a little baby, she was very sad. She couldn't help you as much as she wanted because she was so worried. Now, as she is speaking about it, she's crying. I wonder how you felt then ... when you were little, perhaps mum was like a hole, one that couldn't be fixed and that scared you? You had so many things inside, but mum was perhaps like a sad hole that couldn't listen to you as well as she wished.

I conveyed these words to Beate, a 22-month-old girl in psychoanalytic treatment with her mother Nadya. It had started when she was 16 months and continued into child analysis from the age of two until three and a half. Six months into treatment, Nadya had started talking to me about her depression during Beate's first months of life. It was this my intervention above referred to. The interplay between my words to Beate, her attention to me as I was speaking and Nadya's silent crying was a turning point in treatment. It inaugurated a reconstruction of how Beate's craving for her mother's breast, her restlessness and phobias of holes and ghosts related to her mother's postnatal

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depression (PND). This paper suggests a psychoanalytic model of how an infant might experience being with a depressed mother. It also discusses the model's generalisability. Briefly, it views PND as affecting a child via the mother's faltering containment resulting from her depression.

For Beate, it seemed that emotional communications with her mother had met with a void or had disappeared into a hole. The ensuing fear made her erect defences by creating phobic objects.

These terrifying objects assaulted her, made her restless and unruly. This, in turn, frustrated the already distressed mother who became more low-key and withdrawn. A vicious interactive circle was thus established between mother and baby.

The psychoanalytic model aims to complement and illustrate the vast body of research on PND and mother–infant interactions. While such research has made remarkable discoveries about how PND and infant behaviour are related, little is written about how the baby might experience such interactions and how his/her fantasies are shaped. I suggest this paucity results from the fact that not enough use has been made of findings from psychoanalytic work with the mother and infant dyad. If we want to learn about the internal world of a depressed mother's infant, such work provides essential source material.

### Postnatal depression research

PND is a common disorder with a point prevalence of 8–15% (O'Hara and Swain, 1996; Wickberg and Hwang, 1997) and a combined period of prevalence during the child's first year of 19% (Gavin *et al.*, 2005). Questions have been raised as to whether PND is a specific nosological entity (H.P. Blum, 1978; O'Hara, 1997; Riecher-Rossler and Hofecker, 2003) or rather a depressive episode occurring after pregnancy. Whatever the case, it is a major health problem (Wisner *et al.*, 2006: 2616) since it 'affects crucial infant and adult developmental processes'. Evidently, PND does not simply 'cause' disturbed infant behaviour. Rather, the two phenomena are linked. For example, innate mechanisms (Goodman, 2007) in the infant may contribute to a disturbed interaction. Neonatal irritability predicts maternal depression when the child has reached two months (Murray and Cooper, 1997). Other studies imply that prenatal depression is associated with prematurity, low birth-weight and less optimal Brazelton scores (Field *et al.*, 2004). This could be interpreted as the foetus being affected by maternal prenatal depression. The old adage about the chicken and the egg is applicable in this context.

PND mothers exhibit more negative affects towards their infants (Field *et al.*, 1990; Tronick, 2007b), show less optimal dyadic states of consciousness (Tronick and Weinberg, 1997), and regulate their babies' affects less well (Reck *et al.*, 2004). They have less optimal affiliative behaviour, attachment representations and distress management (Feldman *et al.*, 1999; Leckman *et al.*, 2007). They also seem less prone to interact 'with the infant in a special way, calling him/her by a nickname, imagining the infant's future, or idealizing the child' (Leckman *et al.*, 2007: 95).

Behavioural studies of the infants of PND mothers indicate less social engagement and play (Edhborg *et al.*, 2003), less mature regulatory behaviours and more negative emotionality (Blandon *et al.*, 2008; Feldman *et al.*, 2009; Moehler *et al.*, 2007; Weinberg *et al.*, 2006). Furthermore, they are less prone to develop secure attachment patterns in early childhood (Toth *et al.*, 2006, 2009).

It has been asked how pathogenic interactions between PND mothers and their babies come about. In Tronick's general developmental model of 'mutual regulation'

(2007a), every mother and infant regulate affects by interactions in which affective mismatch and repair occur continuously. However, for PND mothers this reparative capacity is compromised. Depressed mothers are often disengaged or intrusive towards their infants (Cohn and Tronick, 1989). Babies of disengaged mothers protest and seem sad, while babies of intrusive mothers tend to look away from her. Tronick suggests babies of disengaged mothers fail to connect because of the mother's lack of response and repair. They become angry and then 'dysregulated, fussy, and cry' (2007a: 285). In contrast, intrusive mothers' babies look away but seldom cry. Data (Cohn and Tronick, 1989: 247) suggest that since 'infants may continue to be withdrawn and negative even after mothers resume normal behaviour ... clinicians should be alert to the possible need to direct intervention efforts to the mother–infant dyad, as well as the mother herself'. Quantitative studies on whether maternal psychotherapy may also improve mother–infant relationships and the infants' emotional states have been inconclusive (Forman *et al.*, 2007; Poobalan *et al.*, 2007). Clinical single-case studies that focus on maternal and infant development during therapy might shed further light on these issues. This paper is one such example.

### Psychoanalytic studies of postnatal depression

Lawrence D. Blum (2007) points to the paucity of psychoanalytical studies on PND. A recent search in the PEP database yields eight psychoanalytic papers focusing on 'postnatal' or 'postpartum' depression up through 2005. Searches on PsycINFO after 2005, using the same criteria, only yield a handful papers. This might reflect a general hesitation among psychoanalysts to use psychiatric diagnoses as points of reference for clinical or theoretical discussions. However, the PEP database contains hundreds of titles on diagnoses such as 'depression' or 'schizophrenia'. In conclusion, analysts rarely consider PND as a nosological entity that merits separate publications. This is in contrast to the increasing interest in PND among obstetricians, psychiatrists and experimental researchers.

Many attachment studies demonstrate the connection between PND and infant attachment insecurity (Campbell *et al.*, 2004; Toth *et al.*, 2006. See also a summary by Lyons-Ruth and Jacobvitz, 2008: 666–97). However, some authors find attachment theory insufficient to explain the varied unconscious maternal fantasies discovered in the psychoanalytic situation (Laplanche, 2002; H.P. Blum, 2004; Zepf, 2006). Instead, they suggest a theoretical model based on concepts such as drives, fantasies, defences and object relations. This perspective applies to this paper too.

The few analytic papers on PND focus on the mother's experiences and do not highlight the infant's experience. Lawrence D. Blum (2007) focuses on maternal conflicts concerning dependency, anger and identifications with their mothers. Dependency conflicts often result in a clash between the mother's wish to be taken care of and to be independent. This may result in a vacillating motivation to enter into a transference relationship with the therapist. Conflicts of anger, in which enraged fantasies concerning the baby meet with a merciless super-ego, may result in anxiety and obsessive–compulsive symptoms. Regarding maternal identification problems, PND women tend to express that 'their mothers were not interested in or did not enjoy taking care of them' (L.D. Blum, 2007: 53). This has been corroborated by quantitative studies on PND women who reported poor relationships with their own mothers (McMahon *et al.*, 2005). A few psychoanalysts have illustrated this type of conflict (Halberstadt-Freud, 1993; Likierman, 2003). Halberstadt-Freud (1993: 412) speaks of a trans-generational feminine lineage,

grandmother–mother–baby, in which the mother is merged with her own internal, imaginary mother. This leads to a ‘symbiotic illusion’ with the baby, which makes her lose sight of ‘the real baby and its needs’.

According to many parent–infant therapists, PND is a ‘relationship disorder’ (Cramer, 1997: 244). Put simply, this implies that two people are having trouble with each other. Logically, we should therefore try to study the experiences of mother and infant. To this end, the parent–infant therapy setting provides an excellent opportunity. When Cramer addresses this issue, he suggests that the baby may concentrate the mother’s concerns about their relationship, illustrate her distorted perceptions and enable the therapist to interpret their interactions ‘in terms of maternal conflicts’ (ibid.: 258). I would add that we may often interpret them in terms of conflicts in the infant as well. The prerequisite is that the therapist tries to establish contact with the infant. The extent to which this is necessary – and possible – depends on the extent to which the infant is drawn into maternal conflicts. It also depends on the infant’s age. With a child of Beate’s age, I believe the possibility of interchange is astounding, provided we listen, look keenly and allow space for psychoanalytic reflection. I will now describe the technique used with Beate and her mother.

### **Mother–infant psychoanalytic treatment**

In mother–infant psychoanalytic (MIP) treatment (Norman, 2001), the analyst uses the child’s presence to bring his/her disturbance into the here-and-now of the session. As in work with adults, the baby’s symptoms may be interpreted in terms of affective impulses and defences. Interventions aim to help the baby free up these affects and reach a more satisfying relationship with the mother. This resembles the technique of Thomson Salo (2007: 965), who argues that ‘relating to infants in their own right usually seems to bring about a change in their thinking, feelings and behaviour, and the parents as well’. Norman (2004: 1115) however, insisted more on developing a specific analytic relationship with the baby, which he thought was marked by ‘infantile prototypes’ of transference. In other words, the baby’s un-modulated affects might emerge vis-à-vis the analyst.

MIP sessions take place with infant and mother present. The duration of treatment and the frequency of sessions are flexible, from a few weekly sessions to a year or more of four-times-weekly analytic work. The reason for this elasticity is that the pathology of mother and child, as well as the mother’s motivation and her ability to continue therapy, may vary considerably. Whatever the length and frequency, the setting enables the therapist to focus on unconscious manifestations of mother and child and to regard transference and countertransference as the central arenas in which they emerge. The method emphasises containment of the infant and assumes that a troubled baby will be prone to look for such containment when s/he experiences the therapist’s attention. Consequently, the therapist tries to establish a relationship with the baby to become that container. The aim is to help the child retrieve hitherto un-contained parts of her inner world and thereby establish an internal ‘thinking object’ (Bion, 1962a).

Elsewhere (Salomonsson, 2007a), I have suggested that containment, beyond our holding and being present with the patient’s anxieties, also implies an act of translation. We express the emotional import of the baby’s behaviour – but we do it in a more advanced form. We achieve this through receiving and processing within the countertransference the distress which the child evokes in us – and then communicating it back in a form the little one can assimilate. Evidently, the baby does not understand the

lexical contents of interpretations (Salomonsson, 2007b). The idea is rather to utilise her ability to process the emotional wavelengths of the words; their 'auditory, visual and kinaesthetic elements' as Freud once described them (1915: 210). As the baby gets captured by them, this may free up distressing affects beneath her functional symptoms. The mother is emotionally affected by this interchange and will understand better how her baby's symptoms and affects are linked.

It is also important for the therapist to address the mother's low self-esteem and guilt feelings. Only if this is done with tact and empathy may her maternal care and the infant's attachment to her become vitalised. For example, when I made contact with Beate, Nadya might have felt she was a bad mother who did not have good contact with her child. This risk was aggravated in situations when the girl listened attentively to me but was unruly with her mother. Ever since childhood, Nadya had a history of low self-esteem fuelled by the fact that her parents had sought child psychiatric help for their 'hopeless girl'. Accordingly, I focused on how projections (Cramer and Palacio Espasa, 1993) of Nadya's bad self made her regard Beate as a hopeless case, too. I also investigated how 'ghosts in the nursery' (Fraiberg *et al.*, 1975), such as experiences of parental neglect during childhood, prevented her from seeing the child in her own right.

## Clinical case

### *1. Clinging to the breast*

Nadya phoned me about "some problems" with Beate, her and her husband's only child. She had been on regular visits to the Child Health Centre (CHC) but had not dared to bring up her problems with the nurse. CHCs provide standard health care in Sweden up to six years of age. Almost 100% of mothers with newborns and infants visit the CHCs. Nurse calls follow a schedule: weekly the first month, monthly up to four months and every second month during the rest of the first year followed by check-ups at 18 months, three, four and five years. Check-ups comprise weighing and measuring the baby, providing inoculations, nutritional advice and paediatric check-ups. Nurses are also instructed to keep alert to any signs of PND. When Nadya finally dared tell the nurse about her worries concerning Beate, she was advised to contact me at my private practice. Due to felicitous circumstances, I was able to provide therapy free of charge.

At our first consultation in my office, I ask for Nadya's permission to audiotape the sessions to help me better understand and assist them with the problem. This routine is standard in the Stockholm psychoanalytic mother-infant group. She consents. Beate is a shrill-voiced, spindly, alert, tense and officious girl who uses very few words. She picks up a little plastic stool from the toilet, returns to the consulting-room, runs to the waiting-room to get her ball, returns again, plays with Mum for half a minute and then pulls back into a corner. She wants to leave and I say,

Analyst: You want to leave. I wonder why ...

Beate is silent and avoids me anxiously. She throws the ball to Mum and leaves it in her lap. Suddenly, she approaches Mum and starts tearing at her blouse. She wants the breast and she gets it.

Mother: (sighs) It's often like this ...



Analyst: Is this why you came to me, to get help with this breast problem?

M: Mmm ... As soon as she got her own will, the problems started.

A: You still breast-feed her. Is it full-time?

M: Yes. If I were to decide, it would be morning and evening only. She doesn't suckle, she's just got to have the breast.

Two days later, Beate continues anxiously to enter and leave my room. She throws some toys to Mum but never engages in play. She shakes a doll as if it had a bell inside, grabs for fruit in a bag and then for the breast.

M: She tends to tear things out from everywhere (sighs).

I tell Beate:

A: Something seems to ache inside you. I wonder what it could be.

She avoids me and continues leaving and entering the room. In the countertransference, I feel powerless as Beate interrupts our dialogue. I tell Nadya, in order to explain the change of frame I feel is necessary,

A: The next time Beate wants to leave, I'll tell her to stay. Then we'll gather things in my consulting-room, so we can talk about them.

As Beate wants to leave again after some minutes, I say calmly,

A: I want you to stay in the room.

Beate obeys but starts grabbing at Mum's breast and inside Mum's mouth, giving me an eerie smile. The mother seems resigned. It is a bizarre and sad scene. I address Beate,

A: I guess you think I was nasty when I told you to stay. I can understand that. But this is the room where we work.

The third session, two days later, Beate hesitates to enter. Nadya carries her over the threshold. She is stunned by Beate's reaction when I told her to stay in the room, "It's a relief to see she can obey. I thought it was impossible." Beate's play does not start and she listlessly avoids me. I say,

A: You don't want to look at me. Last time, I told you to stay here. You didn't like that. You got angry with me, and now you are afraid because of it.

Beate's possessive focus on Mum continues. Sometimes, she dares look at me reproachfully from mother's lap.

A: I think you are angry with me, 'Mr. No'. You are looking at me, but only when you sit in Mum's lap. You feel safer there. To be angry and afraid, those things scare you. We could talk about them so you won't have to be afraid of them.

Beate wants the breast again but Mum puts her down. Beate cries and grabs Mum's cellphone. Mum looks ashamed and distressed as she lets Beate play with it. I describe to Nadya that it is confusing to Beate when she has it her way, Mum gets annoyed and they end up quarrelling. Nadya sobs.

Analyst: You're sad?

Mother: Yes.

A: Perhaps you felt I criticised you.

M: No, that's not it. It's more like ... it's so hard, this thing.

A (to Beate and Nadya): So there are two sad people in here: Beate and Mum.

### *Comments on vignette I: communication and transference*

Evidently, Beate did not understand much of my words but I assumed she would understand our emotional communication. In a previous paper (Salomonsson, 2007b) I investigated if we may attribute communicative value to an infant's behaviour in a therapeutic setting. I suggested that kicks, facial expressions, cries, coos and babbling might be interpreted as signs of a feeling state. Although such an assumption cannot be directly confirmed, our openness to such a possibility increases the area of the investigatory field. Indeed every analyst, whatever the age of the patient, is accustomed to observing and interpreting what goes on beyond words in the analytic situation (Olinick, 1985; Beebe *et al.*, 2005). As Freud put it regarding young Dora, 'No mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore' (Freud, 1905: 77).

Thus, we should be open to the possibility that a baby in therapy is trying to communicate his or her emotional state. One might agree with this position but hesitate before the next: that the analyst speaks with the baby and assumes that s/he partly understands him. Here, formulations by Bruner (1990: 72) may support the argument. Communications to the child become 'acts of meaning' because the baby has a prelinguistic readiness for meaning. These 'protolinguistic representations' are structured like narratives. They 'serve as early interpretants for "logical" propositions before the child has the mental equipment to handle them by such later-developing calculi as adult humans can muster' (*ibid.*: 80). For example, imagine our girl in mum's lap, digging into her mouth with her hand while looking at the analyst who says, "You think I was nasty when I told you to stay in the room". We may regard this interchange as a little story whose emotional backbone Beate seems able to grasp. Her logic of the narrative would go, 'Beate naughty Mum tired→Mr. No angry with Beate→Beate angry and afraid of Mr. No→better turn to Mum→Mum embarrassed Beate afraid of Mum, too.'

If we want the baby to experience containment and to extract meaning from our interventions, some conditions must be fulfilled. They concern the analyst's language, the countertransference and the frame. The first is not to use 'motherese' since this may confuse the little patient. She will grasp the essence of her emotions better if she observes our unintentional and 'marked' (Fonagy *et al.*, 2002) affect display. For example, my slight emphasis when I said, "I think you are angry with me, 'Mr. No'"



captured Beate's attention. Second, the analyst must investigate if the countertransference parallels a temporary confusion with mother and/or child. This happened when I let the girl run in and out of my room. As I noted my sense of impotence, I realised that I was unconsciously identifying with the indistinct limits between mother and daughter. This insight cleared up the countertransference and led me to secure the frame, "I want you to stay in the room".

The question if and when transference appears in child psychoanalysis has been debated since the birth of the discipline (A. Freud, 1929; Klein, 1932). The question is even more complicated with non-verbal infants and a full discussion falls outside the scope of this paper. As I see it, if the analyst maintains the frame and observes the child's reactions, s/he is entitled to interpret this as an emotional reaction to the analyst. For example, when I told Beate to stay in the room, I then interpreted her sore look from Mum's lap as a negative reaction to me, "You think I was nasty ...". It is true that we discover transference 'with only the slightest clues to go upon' and that 'the risk of making arbitrary inferences has to be avoided' (Freud, 1905: 116). I, however, see no undue stretch of imagination in hypothesising that Beate's fearful and angry behaviour towards me represented earlier feelings vis-à-vis her mother. As I will show, this hypothesis was later tested in the clinical situation. I emphasise that I do not speak of a transference neurosis with such a young child, but rather of fleeting transferences or infantile prototypes.

Nadya had described Beate's repeated cravings for the breast. This was probably why she did not calm down in Mum's lap. I assumed she was thinking something like 'I have not been nice to the breast and therefore it will take revenge on me'. In theoretical terms, Beate had projected her distress into the breast. Mother's depression corroborated the girl's suspicion that she had damaged it. Their arguing about the breast illustrated that they were caught in a vicious circle of projective identifications. As Beate got caught in this trap, she could not let go of the breast but clung to it instead. Perhaps she both wanted to continue her efforts at getting containment from the breast and to check if she had damaged it. As for Nadya, she wanted to be released from breast-feeding but was too guilty to wean Beate. I will now analyse how the breast problems were associated with a deficient containment due to the mother's PND.

## **2. *Fear of the hole***

At the end of the second week in analysis, we are working four times weekly. Beate places a stool on an armchair. She sits down on what now looks like a throne. With an anxious and yet imperious look at me, she repeats, "Dinnn ... Dinnn". Her elevated position and majestic appearance give the impression that the strange word is an incomprehensible injunction to me. There is something strange about the little queen. She tries to look happy, but her strained smile and restless movements indicate anguish and sadness.

Beate leaves the 'throne' to investigate the armchair, an oblong cushion on a wooden frame. She pulls the cushion away and starts climbing through the lower opening of what now looks like an H-shaped wooden frame. She steps into the H, crawls through and emerges from it, only to start restlessly all over again. Obviously, this provides neither satisfaction nor peace of mind. I notice the resemblance with situations when she has been sitting in Mum's lap for some seconds, only to sneak out of it impatiently. Neither Mum's lap nor the H-game provides containment. It is as if they cannot hold her distress and return it in a metabolised form (Bion, 1962b). Certainly, the H-game at the armchair could be interpreted as a non-specific way of getting rid of her distress.

However, her insistent playing makes me suspect that she wants to communicate something more specific. Figuratively speaking, her anxiety seems to seep through the hole of the chair instead of being held by a solid and reliable frame.

We will now follow how we reconstructed, by interpreting the armchair game and her mother's associations, the link between Beate's experience of containment and Nadya's depression. I will leap six months into treatment. Twenty-two-month-old Beate, whose speech development was deficient at the beginning of treatment, is now better equipped to express herself in words. I regard this as a therapy effect. As she has calmed down and developed more trustful relationships, she has become able to absorb language and express herself verbally.

One day, as is quite common, Beate is initially quite active. I find it difficult to make contact with her. She bangs a toy tiger on the play table. This game results in a little wound on her finger. Her mother puts a plaster on it. Beate says, "Pat Mum", but Mum says, "You are hitting me", which matches my impression. There are some signs of violence on Beate's behalf. She does not want to talk to me.

Mother: That's strange Beate. When we got home yesterday, you were happy and said you'd been talking to Björn. You seemed content but now you don't want to talk to Björn.

Beate: It's the wound. It's blood.

Analyst: Mum told you something now. You answered about the blood.

B: Mum told. Mum told.

A: Sometimes you want to bang the tiger doll, sometimes you want to talk.

B: Old wound is there.

A: What kind of wound is it ...

B: Old wound.

A: Baby wound?

B: Mum.

A: Where is Mum? Where was she when you were little?

B: Mum is crocodile.

A: Was Mum like a crocodile? Were you afraid she wouldn't like you since you were biting and hitting her? (Turning to the mother): It must have been hard for you having these angry feelings about Beate when she was hitting you.

Mother: Difficult to say, it's so hazy when I think about these times.

A to M: Like an old wound.

Mum nods and B fills in: Old wound.

Beate is now in good contact with me and her mother, and listens intently. Nadya has started speaking about her PND. Up till now, she has been secretive and afraid that I would condemn her. I start getting more material for reconstructing their early relationship. Beate's rephrasing her cut in the finger into "Old wound" inspires my interpretation that she is referring to their early contact. "Mum is crocodile" leads me on to assume there is an oral aggressive element in their relationship. After a while, Beate says:

Beate: Girl in ambulance car. Doctor car.

Analyst: Earlier today, you did not want to talk to me. Now you do. I'm a doctor.

B: A girl doll (she indicates that I should put a plaster on it, which I do).

A: You banged the tiger today. You got a wound and Mum put a plaster on it. Perhaps you want me to put a plaster on your old wounds.

Beate looks confidently at me and smiles. The session ends on a calm note. The next day, Beate runs into my consulting-room calling out, "Escato! Escato". Nadya explains that they had seen an underground escalator being repaired. Beate stood rooted to the spot. Mother had to explain that "the hole" was there because some workers had taken away the escalator to fix it. Beate seems fearful and thrilled.

Beate: Will it be good again, Björn? Escato not dangerous!

Analyst: You want me to say it's going to be OK. Yes, they will repair it. You are afraid of the escalator. I wonder why.

Beate and I talk about what scared her with the "Escato". Was it the workers in helmets? Beate shakes her head. Was it the noise? "No", says Beate. "It was the hole!" Meanwhile, she becomes fascinated with a little hole in the upholstery of the armchair and puts her finger through it. The reasons why "old wound" and "Escato" are frightening to Beate become apparent as Nadya continues to unfold her history following Beate's birth. It is excruciating for her to speak of her PND, since she was responsible for a baby and feared it has affected the child.

Mother: I felt worthless when Beate was born. There was a time when I felt social services might as well come and take her away from me ...

As I reflect on Nadya's account of her PND, Beate's "Old wound" and "Escato" and her preoccupation with the hollow armchair and the hole in the upholstery, I get a visual image of a baby in front of her mother who is physically present but emotionally unavailable – like a hole. The mother is depressed, but to the baby she might rather seem like a hole unable to provide containment. When the baby seeks comfort from this hole- or wound-mother, she is overcome with a fear of disappearing into her.

Shall I dare speak about this? Will Beate understand? Will Nadya feel offended and guilt-ridden? I feel we are at a decisive moment in treatment. If my image has any validity, it shows Beate's original traumatic situation. Though it is painful to convey my impressions and Nadya is weeping, I agree that 'even the most horrible things that go on between mother and child lose some of their destructive force when formulated,

sincerely, in words. Children are seldom surprised by the truth when they already have intuitively grasped what is going on' (Norman, 2001: 96). I begin with addressing the mother:

Analyst: Maybe your depression was like a black hole to you.

Mother nods and Beate fills in: Beate, Mum's girl, falling down.

A to B: Yes ...?

B: Mum's girl go doctor.

Mother: Come to think of it, lately Beate wants to sleep on top of me. She says she will crawl inside my tummy.

A to B: You want to crawl inside Mum's tummy. Once, you were there.

B: Come out of Mum's tummy. Girl falling into hole. Blood come.

This is the moment when I decide to tell Beate the words from the beginning of the paper,

Mum says that when you were a little girl, she was very sad. She couldn't help you as much as she wanted. Now, when she speaks about it, she is crying. I wonder how you felt then ... You are so afraid of the escalator hole and the old wound. When you were little, you had so many things inside you. Maybe Mum was like a sad hole who couldn't listen to you as well as she wished.

Beate listens attentively and responds, "Black door, Escato." Meanwhile, Mum is crying softly.

### *Comments on vignette 2: reconstructing the original trauma*

Let us first investigate the justifications for my reconstruction of Beate's original trauma. Fundamentally, I based it on three sources: Nadya's story, Beate's play and comments and my internal visual image of a baby in front of an object experienced as a hole. Nadya's story focused on her pain and feelings of inadequacy and guilt as a mother. She suspected that Beate had been affected but did not know how. At this point, Beate's contribution was of substantial help. At first, the H chair game had seemed incomprehensible; but its link with the preceding Dinn game and with her restless behaviour in Mum's lap put me on track. I began to conceive of the chair as a deficient container but I kept this idea to myself for a while. Beate's new expressions such as "Old wound", "Mum is crocodile" and "Doctor car" added substance to my idea of how she might have experienced containment in her "old" days of infancy.

My visual image of the baby and the hole-mother were reflected by the Escato incident. Its validity can always be questioned since it was produced in the analyst's, not the patient's, mind. However, as it arose in the context of careful analytic work and its informative value was not overtaxed, it helped make sense of unconscious processes. Anthi (1983) notes that increasing emphasis on free associations in psychoanalytic technique led to a shift in interest from visual to verbal material. However, to quote

Freud (1923: 21), we should neither ‘forget the importance of optical mnemonic residues’ nor deny that thought processes may become conscious, ‘through a reversion to visual residues’. Similar formulations were also expressed concerning dream-formation (Freud, 1900). They indicate the close connection between verbal and visual thought processes. I regard the analyst’s visual imagery as an important facet of the ‘psychoanalytic instrument’ (Balter *et al.*, 1980: 489). Such images may condense ‘various elements in the patient’s emotional experience’. Provided the analyst uses fantasy in allowing these to be created spontaneously – and judgment in interpreting their potential meanings – they may inform emotional processes which otherwise might have escaped attention.

In other words, the visual image of the baby and the hole-mother was a result of my analytic  $\alpha$ -function (Bion, 1962b). Ferro and Basile (2004: 677) use Bionian theory in describing a chain of events in the analyst’s mind, from a visual image or ideogram, via  $\alpha$ -function to dream work. The clinician may take one step further and verbalise the image, as I finally did with Beate and her mother in putting forth an explicit intervention. Bion’s words are pertinent; ‘interpretations are really “imaginative conjectures” about the missing pages’ (1987: 179). Nadya’s PND and Beate’s experience of it was in truth a missing page, mostly for Beate, but also for her mother. My contribution was to help them fill in some essential words of the missing page.

In retrospect, I suggest the transformation of Beate’s affects had started when she experienced a deficiency in her mother’s containment. First, they emerged as a general restlessness and anxiety and later as a fear of holes. Several authors suggest that trauma may lead to a lack of psychic representation. In Cohen’s (1985: 178) words, this may lead to ‘an absence of structure and representable experience in a region of the self’. The patient cannot represent her wishes and thus cannot modify them by intra-psychic defences but only by ‘need-mediating objects’ (*ibid.*: 180). This corresponds to the beginning of treatment, when Beate could not represent her emotional wishes. All she could do was cling to the breast. Her impatient sucking showed that she did not actually want milk. She wanted containment but did not get it sufficiently. If such a situation persists, ‘no representations of need-satisfying interactions ... provide the basis for symbolic interaction with the world and for goal-directed behaviour’ (*ibid.*). This was illustrated by Beate’s silence and incomprehensible behaviour.

Green (1998: 658) suggests that if the container cannot assimilate projective identifications, the individual suffers ‘a haemorrhage of the representation, a pain with no image of the wound but just a blank state ... a hole’. However, in contrast to Cohen and Green, I wish to emphasise that a hole is indeed a mental representation. We cannot articulate anything about something devoid of representations since, as the philosopher Peirce says, ‘we think only in signs’ (Kloesel and Houser, 1998: 10). I regard the hole as a sign, though it is primitive, iconic and frightening. The sign appears in treatment as play (the H-shaped armchair) and as words (“old wound” and “Escato”). Its function is to indicate the emotional state of a little girl in despair faced with her depressed and unavailable mother.

During infancy, Beate seems to have suffered from the relative absence of an attentive and containing mother. I suggest she has only implicit memories of these events and that they form part of her ‘early unrepressed unconscious’ (Mancia, 2007). The therapeutic action does not reside in such memories reaching consciousness – because that is not possible. Instead, therapy helps through containment including my reconstruction of the trauma in cooperation with Beate and her mother. As therapy proceeds, Beate creates new representations of the trauma via the armchair play, the Escato fear and by coining expressions like “old wound” and “Mum crocodile”.

Analysis thus helps her to signify her infantile experience in a more elaborate way. This enables her to approach the containment ‘hole’ in a roundabout way. The final vignette will illustrate that we reached this phase only after the ghosts began to haunt her in the transference relationship.

### **3. Retaliation by the no-thing**

At the time of her second birthday, Beate and her mother have been in joint analysis for eight months. Nadya’s depression has abated considerably and she has access to love, appreciation, interest and adequate anger towards her daughter. Beate is vivid and charming – and she may also get angry when things do not go her way. She feels immense warmth for her mother. Her breast-grabbing is gone and she has started kindergarten.

A new symptom appears. Beate wakes up in tears and runs to her parents’ bedroom. She tells me, “There are ghosts and monsters in my room at home!” When I ask about them, she jumps into mother’s lap and becomes quiet. She uses mother’s presence to resist further probing. There is no longer any interaction disturbance to address. Rather, Beate has an internalised problem with the ghosts and she argues and fusses with Nadya to avoid talking about them. I suggest Beate and I continue in child analysis. The mother is relieved and Beate accepts after some protest. We work together for another year and a half. She begins hesitantly to speak of ghosts and monsters that haunt her at bedtime.

Analyst: I wonder about the ghosts and the monsters at home ...

Beate: I can’t tell you.

A: Maybe you don’t know what they look like.

B: No. They don’t show themselves!

A: Maybe you’re afraid of them.

B: Yes, very ... They come when I fall asleep ... and ... they’re up there, too. (Beate points to a roof ventilator.)

I link the nocturnal ghosts and monsters to when she and Mum have quarrelled at home. Beate does not comment. I notice the same lack of response when I link the roof ventilator ghosts to situations when she got angry with me. In one session, however, Beate inadvertently makes a tiny red crayon stroke on my table. She becomes terrified and looks up at the ventilator.

Analyst: You got scared?

Beate: Yes!!

A: Is it the ghosts?

B: Yes. There are ghosts and monsters!



A: You didn't want to paint my table. It just happened. But maybe the ghosts and monsters think you did it on purpose because you're angry with me. We know that you are, sometimes. Then, you think they will do something mean to you. It's not easy for you, this ghost thing.

B: They have no mouths. They could eat me up.

A: Because they think you are a bad girl.

B: But I am not!

Beate draws a mouth-less ghost and then makes several crayon strokes to indicate where the mouth is not.

### *Comments on vignette 3: the phobia*

In contrast to the transient Escato anxiety, Beate's fear of the ghosts represents a persistent phobia. In treatment, it manifests as her fear of the ghosts in my ventilator. My interpretation of their function proceeds from ideas suggested by Bion (1965: 106). The task of the developing mind is to tolerate the 'no-thing', that is, the absent yet wished-for containing object. A personality that can make use of such a no-thing is able to think. She can accept that the absent breast, the 'no-breast', is something other than the real breast. Furthermore, she is able to represent the absent breast by a visual image or a thought. In contrast, more disturbed patients reduce it 'to a mere position – the place where the breast was' (ibid.: 54). They strive to handle an absence which they do not experience as such. Furthermore, they will experience it as if time were reduced to 'now'. 'Time is denuded of past and future' (ibid.: 55).

Though Beate is not psychotic, Bion's description is applicable to her earliest relationship with her mother. Initially in treatment, she had to have the breast NOW. Once she had a drop of milk, it did not provide any consolation that she could recall the next time she became anxious. Instead, she must have the breast again NOW. The no-breast was intolerable and must be replaced by Mum's breast again and again.

This model accounts for Beate's initial restlessness and anxiety. At the treatment phase referred to in this section, her general anxiety was replaced by a ghost phobia. I suggest Bion's model is applicable to this symptom as well. If one cannot think about the absent and longed-for breast, the place where the breast was earlier will now be invested 'with characteristics that less disturbed people might attribute to an object they would call a ghost' (ibid.: 76). The ghost is thus a 'sensible manifestation' of the absent breast. Like a mathematical point, Beate's ghost has no recognisable features. It is 0-dimensional – still it can eat her.

The mouth of the mouth-less ghost is a complex representation. It indicates her hunger for reciprocity with the container, her rage when she does not receive it and the ensuing vengeance invoked by the container that has been transformed into a ghost. This vengeance probably also reflects her mother's rage, which Beate fears is hiding beneath her depressed demeanour. Her phobia of ghosts is thus a defence formation. The ghosts represent her affective impulses (hunger for containment, rage at the failing container) and defences (an erasure or a disavowal of the area on which her oral-aggressive impulses centre; the mouth).

### The infant of a depressed mother – a psychoanalytic model

Beate's case illustrates how an infant might experience maternal depression. If we want to extend it into a general model, the following must be emphasised:

- PND does not cause certain infant behaviours or experiences. We may rather speak of a 'circular causality'. Maternal negative mood 'compromises the child's functioning and makes the mood even more negative' (Tronick, 2007b: 377). Innate factors in the baby, such as temperament difficulties, may also contribute to the mother's sense of hopelessness.
- The infant is not disturbed by the mother's low-key affect *per se* but by experiencing a faltering maternal containment.
- Any infant who seeks containment projects onto the mother his/her negative emotions. The problem for a depressed mother is that she finds it so hard to receive and process them. As a result the infant's emotions remain in an un-metabolised state. They frighten the baby who becomes restless and fretful.
- The frightened baby seeks comfort again from the mother. When s/he does this, she is once again drawn into an experience of malfunctioning containment. Alternatively, s/he is reminded of earlier such situations. As a result, s/he avoids mother or becomes pushy and fretful. Needless to say, this increases the mother's despair.

I assume that the points above apply generally to interactions between a depressed mother and her infant. The following two points were discovered in Nadya's and Beate's case.

- The baby may experience insufficient containment as a hole or a void. This experience may appear clinically as fears of being alone, breast-feeding difficulties, sleeping problems, for example.
- At a later stage, the child may seek to counter the void experience by creating phobic objects, which represent a defence formation. It seems more bearable to be afraid of a phobic object than constantly to be restless or in emotional contact with the void experience.

To establish this model's generalisability, we need to investigate it through other cases. I will apply it to some published clinical cases. Norman (2001) describes analytic work with six-month-old Lisa and her mother, who was hospitalised for PND during Lisa's third and fourth month of life. Lisa avoids looking into her eyes. Norman interprets that she is avoiding a mother whom she feels has been ruined by depression. In parallel, mother's psychic pain is increased by Lisa's avoidance. She becomes reluctant to open up emotional links to her daughter and rejects Lisa. As with my case, this dyad was locked in mutual avoidance. Since Lisa was 10 months younger than Beate she had neither the time nor mental capacities to develop fears of holes or phobias. She was in a primary relationship with her mother and used a 'pathological defense in infancy' (Fraiberg, 1982) of avoiding looking at the frightening object. The same conclusion could be drawn from Calvocoressi's (2010: 40) case of a seven-month-old boy with his PND mother. He looks at the ceiling and smiles at an unknown observer but seems to have 'no expectation of a response from his mother'. I did not notice such gaze avoidance in Beate's case, probably because her age allowed

her physically to withdraw from her mother. This masked the fact that she was avoiding a closer emotional contact with her. Furthermore, she was able to develop more elaborated defences such as the ghost phobia.

Emanuel (2006: 252) reports from her parent-toddler work that a baby may 'unconsciously experience a depressed mother's inability to receive and contain its feelings as a lack of willingness to do so, or hostility towards it'. The author suggests that the baby may defensively 'intensify its efforts to evacuate the persecutory sensations which threaten to overwhelm it, to attempt with greater force to gain entry to the mother's mind so that its communications can be received and understood'. Emanuel's idea tallies with my hypothesis that Beate clung to mother's breast to check if she had damaged it. Nevertheless, my model does not emphasise the baby's experience of the mother's hostility as much as her insufficient containment. Such experiences may cause what Arons (2005: 5) calls 'black holes' or 'pockets of emptiness [which] can be hard to observe in a rapidly moving scenario that also contain positive mother-baby relating'.

To explore the model's relevance to other cases, lengthy high-frequency parent-infant treatments are necessary. Only such in-depth studies will allow us to investigate the infant's experiences and formulate psychoanalytic models of them. One might also probe the model through published case studies – provided one differentiates studies based on psychoanalytic techniques from those that rely on supportive interventions. The more the technique relies on the uncovering of unconscious material, the more it will enable a psychoanalytic investigation of how an infant might experience her depressed mother.

### Epilogue

Three years after we ended treatment, I received a message from her mother. 'Beate is six years old now and is well. She is active and has a lot of temperament. Sometimes, she is taxing when she wants it her way, but when our wishes clash we are able to solve it. She sleeps well and is not afraid any more. The other day something remarkable happened at the breakfast table. Suddenly Beate said, "You know Mum, when I was little I was afraid of an escalator in the underground. Isn't that weird?!" She said nothing more. I understood what she was referring to, of course. I asked her to tell me more, but she just shook her head saying "How weird!" Then it was time to go to school. I thought about you and wanted you to know about the event.'

This message concerns treatment outcome. Beate's insomnia, fearfulness and phobia are gone. In contrast, character traits linked with the experiences in infancy still remain to some extent. The message mentions her memories. Unlike the memories of infancy, the Escato events arose in the verbal period. What remains to six-year-old Beate is no longer the fear of an escalator but a memory and a feeling of, "Isn't that weird?".

### Acknowledgements

I wish to thank Beate's parents for giving permission to publish anonymised case material. The paper was supported by grants from Ax:son Johnson, Children's Welfare, Olle Engkvist Byggmästare, Groschinsky, Jerring, Kempe-Carlgrén, Mayflower Charity, Solstickan and Wennborg Foundations and the Research Advisory Board of the International Psychoanalytical Association.

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