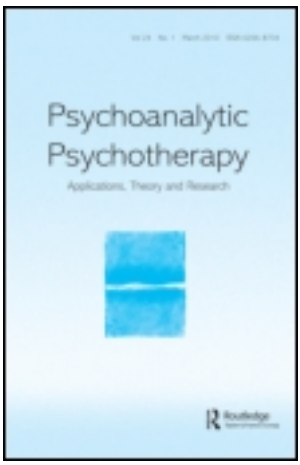

Psychoanalytic Psychotherapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rpps20

MOTHERS' THINKING AND BABIES' SURVIVAL

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Version of record first published: 18 Aug 2006.

To cite this article: Anne Ward (2005): MOTHERS' THINKING AND BABIES' SURVIVAL, Psychoanalytic Psychotherapy, 19:2, 135-159

To link to this article: http://dx.doi.org/10.1080/02668730500115101

Psychoanalytic Psychotherapy (June 2005)
Vol. 19, No. 2, 135–159

MOTHERS' THINKING AND BABIES' SURVIVAL

ANNE WARD

This paper offers a spectrum of cases, in which the mother's ability to think about painful issues shaded from sensitive to near psychotic, and in which the outcome for the infant varied accordingly. Where the mother is free to contemplate her own thoughts, the infant is relatively uncontaminated by her projections and distortions, and she can be curious about its mind. Where defensive structures predominate, however, the infant becomes enmeshed by virtue of its unavoidable and persistent intrusions into the mother. The vignettes illustrate the interplay between the mother's mindfulness of her infant, and the infant's actual physical survival. The paper is not intended to 'prove' the argument, which has in any case been more rigorously developed by developmental psychologists, rather it offers a clinician's experience of its veracity, adducing extreme examples, and the clinical corollary that the mother-infant mind can be a vitally important focus. The therapist experiences something of this system, either by noticing it directly and allowing it to impinge, or by interacting with the mother and noting the counter-transference. By offering a mind that can bear to think about the experience, she is a thinking mother that metabolizes and returns it in a manageable form. The paper also highlights how ideas from the attachment literature may complement and enhance a more traditional psychoanalytic perspective.

'I think, therefore I am' will not do as a psychological model of the birth of the self; 'She thinks of me as a thinker and therefore I exist as a thinker' perhaps comes closer to the truth' (Fonagy 2000, p. 1132).

Four-week-old Ag lay on a satin covered pillow, facing his mother. He was wide-awake, his eyes swivelling around, his little hands exploring,

Psychoanalytic Psychotherapy ISSN 0266-8734 print/ISSN 1474-9734 online

http://www.tandf.co.uk/journals
DOI: 10.1080/02668730500115101

> intermittently looking at his mother in an interested way. G said she thought he couldn't see. She passed her fingers quite close to his eyes, and he didn't react. However, she thought he seemed to see her face, which was farther away. She sounded puzzled. He eventually reacted, pulling away as if he didn't like it. G playfully directed him to look at me, and also tried to get him to follow her hand movements, which he resisted. It was a little as if he was a doll and she wanted to make him do things, e.g. she moved his legs for him – 'cycle for A (myself)' – which he seemed to like. … G leant over him, puzzled: 'Do babies think? … I don't think they do. You're not thinking anything, are you? It's all instincts'. The baby seemed absorbed in what she was saying, as if to give the lie to it (Extract from an Infant Observation).

By treating children in play therapy, Klein developed an understanding of infants and small children and applied her findings to adult analyses. She focused on the mother-infant relationship, finding evidence of unconscious conflicts in the first year of life. Her ideas were developed by, among others, Bion, Rosenfeld and Winnicott, establishing the post-Kleinian and British 'object relations' traditions. This was a significant shift from Freud's drive-based account to one that accorded greater significance to the mother-infant relationship. 'There is no such thing as an infant', i.e. whenever one finds an infant one finds maternal care and without maternal care there would be no infant (Winnicott 1960). Winnicott's ideas on holding, the transitional space, and the capacity to be alone in the presence of a benign other, develop the idea of an interpersonal field within which growth takes place. Addressing these ideas from a more theoretical perspective, Bion evolved a model in which the ability to think is developed and refined through interaction with a thinking object. Thus beta elements (disintegrated, semi-psychotic, sensory experiences) are taken in from the infant by mother, metabolized, and returned as alpha elements (manageable, containable proto-thoughts). Bowlby, although gradually eclipsing himself from the mainstream British Society (Van Dijken 1998), provided a more traditional scientific paradigm in which attachment issues could be explored. More recently, there have been advances both in developmental psychology and attachment theory that have enriched our thinking on the very early and complex developments between mother and infant (Stern 1985, Fonagy and Target 1999, Trevarthen and Aitken 2001). There is converging agreement on the importance of the mother's ability to think about the infant's state of mind and to communicate that process to her child. The corollary, one familiar to many psychiatrists, is that a non-thinking caregiver risks her infant's psychic development, even, in extreme cases, its psychic or physical survival 'without the good object at least to some extent becoming part of the ego, life cannot continue' (Klein 1960, p. 265).

This paper arose from my experience of observing a mother-infant pair over the course of a year. I was struck by the mother's attempts to think about her

baby's mind, and the effects this appeared to have on the developing relationship. When these attempts collapsed, as they often did, I found it difficult to be an observer in the household; this resonated with more extreme experiences as a therapist and clinician, faced with gross maternal abandonment and neglect. The experience of motherhood increases access to primitive emotional states which can lead to a psychological growth spurt, equally however it can lead to a defensive shut-down. In the paper, I present a spectrum of cases in which the mother's ability to think about painful issues ranged from sensitive to impaired to near psychotic, and in which the outcome for the infant varied accordingly. In the first three cases the mother was referred to a psychiatrist as a result of perinatal disturbance. The paper addresses the potentially disturbing effects of pregnancy and motherhood, and how this can manifest in an impairment of thinking that affects the baby's growth and development. The effect on the therapist is also described, and how this might be harnessed for therapeutic benefit. The first mother was seen for long-term psychotherapy and so her case is presented separately, followed by cases of the second and third mothers, seen for assessment only. I then include excerpts from my Infant Observation, selected to show the oscillations between understanding and avoidance, and the gradual emergence of understanding. The mother's interaction with her three-year-old is also included, representing split-off aspects off the mother-infant relationship. Finally, by way of contrast, I present a very brief vignette of a more thoughtful mother-infant interaction, equally painful in ways, but with a correspondingly hopeful outcome. A mainly post-Kleinian approach is used and (I hope to show) complemented by ideas from an attachment perspective.

CASE 1

Ms A, a 23-year-old African woman, was referred for psychotherapy. She had been charged with murder of her new-born baby girl and the court discharged her to a Medium Secure Unit as a voluntary patient. Psychotherapy was recommended, but was not a condition of her disposal.

Events surrounding the birth

On giving birth, midwives stated that she did not seem excited on handling the baby. She said she did not want a girl. One observer regarded her as looking at the baby in disgust and with a detached manner. She was discharged the following day, and reportedly arrived at an 'uncle's' house without the baby. She told different people different things, e.g. that the baby had been dead before the birth and she had just had it removed; that the baby had been sent back to Africa. Midwives eventually called the police on the sixth day. Over the next two days, she failed to disclose the baby's whereabouts. It was found dead, stuck

in a rubbish chute, eight days after birth. The patient subsequently gave a confused, nightmarish version of events, which included being beaten up by her boyfriend, and his later telling her that she had dropped the baby down the rubbish chute. She said he told her to keep quiet, that if she told anyone what had happened she would be deported, and her stepmother would be glad to see her. She interpreted this latter statement as a threat as she believed her stepmother to be a witch who persecuted her in Nigeria.

History

Her mother was a businesswoman living in Africa. Ms A knew nothing of her real father. There was someone whom she called father, genetically unrelated, but who seemed to have adopted her when she was young. His partner was the 'stepmother' referred to above. There were four younger half-siblings from two different fathers. The younger children's father sexually abused her regularly as she was growing up, which is why she went to live with her adoptive father. She had disrupted primary schooling but, despite that, obtained a place at University to study law. However, an earlier pregnancy supervened and she did not complete the introductory course; this first child was 5 or 6 months old when she became pregnant on this occasion. She had also been pregnant at the age of 17 years, but had an abortion on that occasion.

Her mother apparently took her to church regularly for the casting out of demons until she was 14 years of age. Her stepmother regularly beat her, and she believed that her stepmother had special black magic powers. When she became pregnant with her surviving child, her mother refused to support her, and her adoptive father was angry. Her boyfriend, the baby's father, obtained a false passport for her to come to the UK, and she gave birth some 3 months later. Having arrived in the UK, she reported being raped, and subsequently striking up a brief but loving relationship. She apparently believed the current pregnancy to be a result of that second liaison. On admission to the Unit, some 2 months after the birth, mental state examination was reported to be difficult 'as at times she appears suggestible as to the recent presence of symptoms'. The diagnosis was of a severe depressive episode.

Psychotherapy

The patient was seen in weekly therapy for 2 years, although her attendance dwindled significantly during the second year until she effectively dropped out. The sessions were marked by an air of unreality, described by the therapist as 'intriguing, bewildering and bizarre'. Ms A blithely referred to the sessions as 'sections',[1] and they not infrequently had a slightly tea-party atmosphere, as if

[1] 'Section' is a term referring to compulsory detention under the Mental Health Act 1983.

she was meeting to discuss her social diary. This consisted of a series of visits to social workers (bad), probation officers (bad) and psychiatrists (good), as well as contact visits with her older daughter (good). The index offence, evacuation of unbearable reality down the rubbish chute, was repeatedly re-enacted in the sessions, as these banal exchanges dissociated us both from the enormity of her plight. Ms A eclipsed ambivalence from the interactions – thus it was almost impossible to engage her in thinking about the mixed feelings she undoubtedly had about her older daughter returning to her care (it was, of course, a good thing), making planning for her return especially precarious. Instead, when the time came for the child to return, Ms A had an unexpected row with her aunt that effectively rendered her homeless and so the planning was disrupted. Talking was often a form of action, in which she carried out a type of behaviour therapy on herself, e.g. 'I should be positive', repeated with a mantra-like quality as if that in itself would have the desired effect. During the second year, these rather manic defences seemed to be less intact, and a more depressed, stressed and irritable woman briefly emerged. However, these more realistic responses were rapidly infused with paranoia, such that it was almost impossible to work with them. Any thoughts of the therapist about what might be going on were seen as potential threats to her precarious equilibrium. The bizarre quality to her communication remained, such that the therapist wondered at times if she was being wound up. However, it was probable that she was then in projective identification with a patient who experienced most communication as suspect, and for whom truth had a chameleon quality. Ms A serially obliterated what could not be tolerated from her mind, as the infant was obliterated at birth. The therapist was left with a sense of horror at the world she inhabited, cruel, unforgiving and ultimately murderous, but also with a respect for the enormity of her struggle.

Comment on Case 1

From a Kleinian perspective, the relative capacity of a mother to know her infant's mind parallels her ability to tolerate her own experience without resorting to primitive defences such as splitting, projective identification or dissociation. The more split off her experience, the greater the sense of external persecution, projected into and apparently embodied in her developing child – thus knowledge of her infant's mind would be tantamount to accusation or condemnation. In fact such a feeling is not uncommon among women with post-natal depression generally, who may express a sense of the baby looking at them accusingly. Raphael-Leff has written of the variations in preconscious maternal representations underpinning defensive structures during pregnancy, and the effects of these imagined dyads on the postnatal exchange (Raphael-Leff 1996). In this classificatory system, Ms A represents an extreme of the 'good' maternal, 'bad' baby split that has become so persecutory that it has to be

annihilated in the form of the child. The persecutory return of warded off internal states is not specific to post-natal disturbance; however, where the infant becomes a focus for maternal 'dis-ease', this may represent a specifically disturbed relationship with the patient's own mother that attacks the state of motherhood. The infant becomes psychically confused with the patient's mother, both of them underscoring her ineptitude for the task. She has not separated from her mother and so cannot be an adult mother to her baby. This is illustrated in Case 1, where mother/stepmother was associated with lack of support, physical abuse, black magic, and persecution. The infant was almost aborted *in utero* and finally annihilated. Pines writes about women who consciously abort a foetus, suggesting that the nutrient mother may be seen as a Janus-like figure, one face representing that of a powerful life-giving object, contrasting with the face of a witch-like murderous murderer who will bring retaliation to bear upon her daughter (Pines 1990). The patient's various stories of sending the baby back to Africa, the baby being dead before birth, or of having it removed before birth might have been less confabulation and more a representation of psychic reality – the impossibility of sustaining a live relationship with this baby. Clearly there were other determinants to the infanticide, particularly as she already had a live child; however, the mother's evil intent was an important thread in the story. Persecution was also an important theme in the therapy, where she was almost literally haunted by her actions.

There is little written about psychotherapy with women who have killed their babies. A review of the psychoanalytic database (PEP 1v4) revealed just two papers with 'infanticide' in the titles, neither of which dealt with this topic. Knowles has written briefly of her experience of seeing three women who killed their children, highlighting the dissociation of the mother and her own anger on behalf of the infants (Knowles 1997). She makes the point that therapy should not be seen as a means of making the woman into a safe mother, but of allowing her space to explore the act and its meaning for her, even if some of that meaning can leave the therapist with uncomfortable feelings in the counter-transference. I would want to add that the freedom of that space is necessarily constrained by the involvement of external agencies, perhaps a reflection of the persecution within, but also a potentially containing structure as I think it was in Ms A's case.

The literature on infanticide itself is extensive, a review of which would need another paper. However, I was struck to learn that infanticide seems to have been a part of Western European life until the late nineteenth century, when women finally gained some control over their reproductive capacities (Thurer 1994, p. xxv); and that the rate of (female in particular) infanticide in fifth century Athens may have ranged from 10% to upwards of 20% (Thurer 1994, p. 54). This raises the role of cultural factors, probably relevant in all of my cases but, again, too large a topic for this paper.

CASE 2

Background

Ms F was a 35-year-old woman of Afro-Caribbean origin. She was referred for an emergency assessment following an initially concealed stillbirth at approximately 35 weeks' gestation. She presented to an A/E Dept with PV bleeding the day after the birth, initially telling the staff that she was 16 weeks pregnant and then denying that she was pregnant at all. The pregnancy itself was largely denied and concealed. She had a sudden onset of abdominal pain and delivered the presumed dead baby in the bathroom at home. She later concealed the baby in some bin bags, asking a friend to leave the bags outside. The friend was unaware of the bag's contents, although she told her friend that she had miscarried at 16 weeks. The bags were later found in the garage by the police, and a police investigation was ongoing at the time of the referral to establish whether or not she had murdered a live child.

Ms F had other, older children, who were initially placed by the Social Services with a relative. However, they were later returned, as Ms F's mother planned to stay with her for the foreseeable future. The recent pregnancy was unplanned, and she had only occasional contact with the father, who was unaware of the pregnancy. She herself worked in a skilled job, and was able to do some work from home during the pregnancy. She was apparently keen to return to work as soon as possible.

There was no formal psychiatric history, nor was there evidence of clinical depression when examined by a Consultant Psychiatrist about 2 weeks after the birth. The examining psychiatrist felt that Ms F had coped by denial and detachment, but was now in a very vulnerable situation as she could hardly ignore the police and social services involvement.

History

Her background was apparently unremarkable. Both parents were alive and well, and she had a younger brother and sister. The family was described as 'close'. She was born in the Midlands and described an uneventful schooling, achieving a handful of 'O' levels and leaving school at 16 years of age. She moved to London with a friend in her twenties. She had a small social network and one close friend. There was no information about relationships, apart from a reference to the father of this baby with whom she had a relationship several years ago, but this ended 2 years prior to the current episode. In the course of police investigations, information emerged about a previous stillbirth, but this was not available at the time of assessment for psychotherapy.

Psychotherapy assessment (six weeks post-partum)

Ms F was 30 mins late, leaving the time quite restricted. She was elegantly attired, but appeared thin and rather tired. Rather haltingly, she described her

recent experience as 'mind-blowing'. It was clear that she was uneasy, and she soon asked what this meeting was about. Apparently she had been told that the assessment report could be used in the legal proceedings against her, which actually wasn't the case. I commented on the difficulty for her in disentangling reports/assessments from help, given the pending investigations. She immediately agreed, saying that she was not sure why she was seeing the other psychiatrist.

She again referred to the 'concealed' pregnancy; apparently she had concealed it from herself as well as others. She said that the whole episode had made her think about things, about everything. Her mother had asked her why she kept it hidden, and she didn't know. It wasn't the first time either – she had only told her daughter's father she was pregnant when she began to bleed at 6 months, and the baby was delivered about a week later. I remarked on the extreme prematurity, but she corrected herself – the baby could have been anywhere between 24/26 and 31 weeks, her dates were inexact as she had not been thinking about the pregnancy. Similarly with her 14-year-old son, her mother recalls that she only told the father's family a week before the birth – she's not sure herself that it was that late, but she conveyed that she could not really trust her own recall. After the last time, she swore she would never do this again – she would enjoy the next pregnancy. I had a myriad of questions spinning in my mind – was it pregnancy or what would follow that she couldn't bear to think about, did she consider termination, had she been raped at some point, had she had an eating disorder, what about the relationship to her children now? Most awfully in retrospect, I began to listen for her relationship to the new baby, 'forgetting' that it was dead. It was only as she left the room that this knowledge returned, and I felt shocked at how it had disappeared.

The session was proceeding very much in slow motion, as if reflecting her 'mind-blown' shock and paralysis. She was thinking and responding, but I found it difficult to get a picture of her outside her current circumstances. I asked her how things would have seemed if I had met her a year ago – would she have felt that there were difficulties? She seemed unused to thinking in these terms; looking slightly puzzled, she said that things were 'okay'. However, they were clearly not okay now, and there were a number of references to 'the things that are going on', by which she meant police and social service investigations. She wished she had done things differently – told even one person that she was pregnant. Apparently bemused, she wondered if she was going mad. I asked if her daughter had known about the pregnancy, as children sometimes pick things up. She initially denied this, but then recalled her daughter touching her stomach and asking 'Mummy, are you going to have a baby?'. Hearing this, I could imagine her 'concealing' the pregnancy from herself, as she apparently believed her own denial, and only recalled her daughter's question when pressed.

Nearing time, I suggested that we meet again to take things further. I said that the assessment could stand alone, as an attempt to try to understand better what had happened, or it could lead on to a period of individual therapy. She seemed ambivalent, worried but tempted. She did not in fact return, cancelling several subsequent appointments, until I wrote to say that it did not make sense to send her any more at present.

CASE 3

Background

Ms W was a 36-year-old illegal immigrant, with few friends, and only a smattering of English. She became pregnant as the result of a casual encounter. Unaware that she was pregnant, she moved in to live with another man. She did not tell him (or anyone else) about the pregnancy, and he did not recognize her condition. Presenting to a local hospital in labour, she gave a false name, and maintained that she had a husband to return to. She left hospital the following day, and after wandering aimlessly for a time, found herself outside a church. She placed her baby daughter carefully inside a compost bin in the grounds of the church and closed the lid. The baby was found some time later, cold but apparently otherwise well, and was taken into foster care. Three weeks later, Ms W presented herself at a local police station, apparently remorseful in relation to her actions, and desperate to have her baby back. She was charged with child abandonment and remanded in custody. At the time of interview she had been released and was in supervised contact with her baby. I was asked to do a Court Report where the question of ongoing child custody was the issue.

History

Ms W came from a middle-class, East European family, the eldest of three daughters. The family lived in a village where her parents still live. After her birth, her mother returned to work, but they had a loving grandmother, and a nanny equivalent. Ms W painted a warm picture of her childhood, and of her parents, and is unsure now why she did not confide in them about the pregnancy.

Her schooling seemed unremarkable – aged 15 years she went to a boarding school in a town where relatives also lived. She was at this school for 4 years, and was very happy there. There was some confusion about her final results that was difficult to resolve, but she did not go on to become a professional as her sisters subsequently did. Instead, she worked in a variety of government offices, increasingly hit by economic recession. She was struggling financially for the last 5–6 years, and had no work at all for the few months before leaving for the UK. She came with the promise of work from a compatriot; however, this turned out to be badly paid to the point of exploitation.

Psychosexually, Ms W had one long-term (1-year) relationship prior to coming to the UK, although she didn't think he was a 'boyfriend'. However, it was a sexual relationship. She stressed that she was not promiscuous, and that the episode with her baby's father arose from a kind of desperate loneliness. She said that this was her first pregnancy.

Ms W denied any family history of psychiatric disorder. However, it emerged that her father drank heavily when she about 7 or 8 years old. He drank at home and she remembers her parents arguing. She was concerned by this, and ashamed, as he was a professional. However, she conveyed that his drinking was not abnormal for the society they lived in. She added, quite passionately, that her parents had a good marriage and provided a good environment for their children. She denied any psychiatric history of her own, but it subsequently emerged that she had an admission for alcohol problems in the early 1990s. When challenged about this, she said she had lied for fear that it would brand her as an unfit mother.

Individual interviews

She appeared to be forthcoming, appalled by what she had done, and distressed by the continued separation from her baby who was now with a foster family. Her story was consistent in the main, although with one or two discrepancies that left a sense of unease. The presence of an interpreter helped in that it defused the intensity, but it also added to any potential confusion. Ms W spoke dramatically, often through a storm of tears, and it was difficult not to feel moved and sympathetic. Almost paradoxically, her remorse was so pronounced that caution for the baby's safety could be minimized, as one felt impelled to respond to such enormous feeling by expediting the reunion. She presented an unwavering picture of devotion to this infant now, even pleased to clean her nappy as a sign of love. She smiled almost beatifically as she described her baby. 'I knew she would be beautiful'. There was a manic quality to this 'Mother-Madonna'-like picture.

She said that N was born very quickly, but also that her contractions were not strong enough to push the baby out, and that she was given a drip. After the birth, N was placed on her breast – she was unsure if the umbilical cord had been cut at this stage. Despite being torn and in pain 'I thought I could give birth everyday for this moment'; she breast-fed her while being stitched by the doctor. Mother and baby were together all the time after that; she told me that the baby lay across her breast and slept. She had no further plans, and was apparently expecting to be kept in hospital longer. 'I was hoping they could keep me for ever'. She went to the Underground – 'I had to know what I was doing but I don't remember'. On leaving the train, she remembers a busy street with shops, where she thought she could buy some baby clothes. There were signs of wealth surrounding her, and she thought that someone here could give

N a normal life, unlike her. She spotted a church and entered the grounds. At this point, she was not afraid of anything. She then fed N a mixture of breast and bottle milk, telling her she loved her, and that this was difficult for her. There were lots of people around and she thought that someone would find her.

For 3 weeks she was like a vegetable – she didn't know if she was eating, day and night were mixed, and she didn't feel any pain after the birth. She was absolutely convinced that N was safe, but was terrified because she needed her baby. Praying to God she wanted Him 'to create a horror from my life so someone will hate me to save my baby'. She came to the conclusion that she would have to have N – there was no alternative; she went to the Police: 'I went to get my baby back – I was becoming insane. I would go insane or die because my heart would break if I waited one or two more days'. She said that she had 'no clue that I was wanted – I didn't think that I would be arrested or go to prison'.

Her account flowed in the main, but there were sudden sticking points, when the interview encroached on areas that she did not wish to explore. This might be conveyed with a flat statement to that effect, otherwise there would be a sudden inexplicable confusion in the translation process. This, together with the rather idealized way she spoke of her background and of her baby, rendered the account somewhat two-dimensional. However, despite this and her actual deliberate prevarication, there was little doubting her current devotion to this infant.

Comment on Cases 2 and 3

The second and third cases presented rather bland pictures of 'normal' upbringings, but there was little sense of emotionally close relationships with their own mothers in the rather cut-off narratives. Presented with this scenario, Kleinian/Bionian concepts are less immediately helpful, as the women were not in therapy at the time thus allowing only limited access to their phantasy worlds. One could speculate about lack of containment, or the defensive use of splitting, but these would be hypotheses at this early stage. However, the attachment literature had an immediate resonance; these narratives were typically 'dismissive' in quality, in that they presented a rather thin, idealized or normalized account of childhood that was not backed up by more discrete early memories. In attachment terms, this narrative style has been empirically linked to a defensive disavowal of attachment concerns arising from insecurity in the primary attachment relationships. In Case 3, for example, Ms W was afraid to tell her parents of her pregnancy until the police and social services had become involved and she had no choice. One can see how this detached stance impacted on the pregnancies, as both women detached themselves from their condition to the extent of endangering the babies' development, even prior to birth. Staying with the broader picture, findings from the attachment field

suggest that maternal dissociation may be a particularly malevolent experience for the infant, rendering it almost impossible for it to devise a coherent attachment stance. The idea is that the partial intrusion of normally dissociated memories may lead to frightening/frightened maternal behaviour in the presence of her infant. As the threat is internal to the mother, the infant cannot learn to anticipate it and to devise a coherent defence strategy (Hesse and Main 2000). Interestingly, Ms W's social worker (Case 3) volunteered her concern about Ms W's propensity to break away from the baby and stare into the middle distance for perhaps 10 s at a time – precisely the type of behaviour that is rated frightening by the attachment theorists. Considering the effect on myself, it was as if part of these dissociated mothers were so convincingly elsewhere as to be obliterated from my mind. It was a profoundly disturbing experience to have my normal thinking capacities so convincingly hijacked and gave me a taste of what a child would have to tolerate – if it survived. Attachment theory thus provides a framework for thinking about the transgenerational transmission of attachment, and the empirical evidence that it occurs.

I now turn to excerpts from an Infant Observation, an equally intense situation in many ways, but illustrative of the more 'normal' (i.e. non-clinical) spectrum of mother-infant interactions.

CASE 4

The family was immigrant, with a small child living in a very deprived area, and M was about to give birth to the second child. I was both surprised and relieved with the ease to which M agreed to the observation, with little apparent curiosity, almost carelessly. I had some trepidation, however, as if the ease with which I was taken on might reflect the ease with which I could be dropped. The first 3 months were marked by a sense of unpredictability – now you see M, now you don't. In fact, it took me a while to see the baby (a boy, G) on my first visit, as he was tucked away in a corner amidst the celebrating relatives and friends. By the second visit, the visitors had vanished and an air of exhaustion permeated the house. Mother was snappy with the older child (V), and the demands of the baby were more evident. Apparently she had been told that G might become hypoglycaemic if she did not wake him for feeds, as if his survival instincts were not to be relied upon. Although he slept for long periods during the day, his nights were disturbed, as were mother's. In fact, it became apparent over time that she could not let herself relax. There was something manic about her activity, and she would frequently leave the baby to get on with some apparently essential household activity. Such switches were often quite abrupt, from tender, loving mother, to efficient but automatic work-mode. I watched in some trepidation, as G seemed to learn to screen his mother out, looking to one side and beyond her eye gaze. The abrupt switches were mirrored in my own

reception, as there were several times in these first few months when I called to find no-one in, or just managed to catch them going out. In retrospect, I felt that my really quite grinding anxiety reflected the life-and-death fantasies around a baby who might not feed, and a mother who might not manage. In the heat of the moment, I simply wondered whether the observation would survive. It was during these early stages that M wondered 'Do babies think?', concluding that they were just a bundle of reflexes. However, there was a certain openness to her musings, perhaps prompted by my presence – what on earth was I so interested in observing? Of note also was the reassuring presence of 'Daddy' (D), threaded through V's games, and often alluded to by M. A certificate for 'Couple of the Year' shared pride of place on the wall with their wedding photograph. G himself was a sturdy baby, growing inexorably, but whose 6-week vaccinations were delayed 'because he isn't social smiling'.

Excerpts from visits

An excerpt from Week 8

> M then began to confide in me. She said G cries a lot now, and doesn't like noise. 'It's like he has temper – Oh, its hard to explain, I don't know. He cries if he wants to go to sleep, until he settles. Maybe now because he is constipated, his stomach is hard. His belly button sticks out when he cries – the GP said it doesn't matter. I can't always go to him, I have to look after V as well. I can't cope. I'm not doing the laundry any more, D (husband) does it when he comes home. I put all our clothes in the washing machine, but not G's. D does them by hand, and launders them. I'm not coping. I only did this today because they are sleeping. I've asked my cousin to come over from Africa and help. I want to go back to college – I've applied … for a nursing course. I don't want to use a child minder. I didn't sent V till he was two. He picked up swearing there, started saying 'shut up'. I gave up working – prefer to look after him myself. He picks up behaviours I don't like when he goes to nursery.

'Cousin' E arrived, looking very young and shy, and rapidly appeared to become the principle child-minder. I hardly saw M for weeks to months, but when I did she seemed happier. E was rougher with G than his mother, as if that was how she had learned to handle children. G appeared to adapt and at 24 weeks, I saw him sit for the first time, at 29 weeks he crawled. It was most exciting to see him struggle onto all fours – E almost might have missed it as she was strung out exhausted in front of the TV. Although habitually solemn and alert, he also beamed a lot. He seemed quite happy with E, perhaps seeing her as the more stable figure, but the children were visibly more excited by their mother's presence. M appeared intermittently over this period. At those times, I was often struck by the split she maintained between the boys, as if she had no

understanding of sibling rivalry, or at least did not see it as her role to mitigate it.

An excerpt from Week 16

> M began to sing to G – 'I'd do anything for you, G, anything for you'. Clearly jealous, V tried to insert his face between M's and the baby's. M laughed and began to tease him. 'He doesn't want you V'. Then, to baby G 'Do you want Mummy? Yes. Do you want Daddy? Yes. Do you want Anne? Yes. Do you want V – No!' G was loving this, laughing and smiling. V seemed uncertain how to react, but then laughed, apparently joining in the game. M moved onto humming 'I'm going to buy you a rocking horse'. Again, V wanted to be part of it, but seemed uncertain of his welcome.

At 23 weeks

> V had been playing with a water bottle, alternately throwing it around and drinking from it. As he snuggled up to M, the baby reached for it, and V was told to hand it over. This rapidly escalated, with V howling, and M almost egging G on to want the bottle. Left to himself, I thought he might rapidly have lost interest in it. V continued to howl, with mother telling him off. She indicated that his brother was enjoying the bottle: 'You should be happy – why are you crying?'. Gazing into her eyes, V howled 'I don't know'. He then abruptly switched tactics, offering G the bottle, almost pressing it on him. He asked his mother if she was tired, suggesting that she should go to bed. M agreed – she was tired. She left us shortly after this to lie down, placing G back on the floor. Observing, I felt that V's mind was being scrabbled – he should be 'happy' in the face of a blatantly (to my eyes) distressing experience. His response seemed to be to develop a pseudo-adult concern for his mother – she (not he) was tired and needed to rest.

The following week

> V answered the door, smiling cheerfully and telling me they were upstairs. I could hear what sounded like voices and wondered about visitors, but it turned out to be M reading to the children. Unusually, there was no sign of E. M was sitting on the long couch with G on her lap, and V then cuddled up bedside them. There were books strewn on the couch and she was just finishing one. She smiled and told me that the Health Visitor had brought them yesterday. She indicated a

> Sainsbury's canvas bag, and that it was some kind of sponsored project. There was an air of calm in the room. V in particular looked happy with her attention – his eyes were shining. G was more solemn, looking at me, then back at the book. He appeared more restless than his brother – M laughed and said 'You want to look at Anne, not at the book'. She continued reading. The next book was 'Books for Babies'. M was loving and interactive, naming the characters in the book as 'G' and 'V', and pointing to what they were doing. She endorsed the statement 'Books are for sharing' with 'That's right, we do that – V is sharing with G'. The story was about parents reading to their children, worried that they wouldn't do it right, but being encouraged to do whatever they could. After some time, G became increasingly restless and she put him down on the floor where he began to move around slowly. She had almost finished the book, and continued to read to V for a short time. She then rather abruptly stood up, with V pleading for more reading. She told him she had already read the other books and left the room.

One can see M's reaching out towards something more integrated, less polarized, which she still, however, finds hard to sustain. There is also an idea of babies having minds in which books will have a place. The family went to their home country for a long holiday over Christmas (when G was 10 months old); 'Don't come next week' was my formal introduction to this! I had to ask how long they would be away – about five weeks. By this stage however, I did not feel personally affronted – this was just M's way. E, a stranger to the country and with no friends of her own, stayed to mind the house. I was left unsure as to the precise date they would be back. Despite checking, and then writing to M to confirm, I only just managed to catch her as she left the house to pick V up from nursery. Again, this did not appear to be deliberate, as she seemed pleased to see me. The holiday had been great and, as she expanded in a rather idealized fashion, I realized how homesick she was. M was around more now – apparently E could work instead of her and she could stay at home. G walked in the next few weeks and rapidly gained his balance.

At the second to last visit

> M appeared at the door, trying to operate a mobile phone. She looked up and seemed surprised to see me … After some time, G reappeared in the hall. I asked M if he would be one on Saturday. 'Yes – the 10th'. Holding out her arms to him she smiled broadly: 'My big boy!'. He came towards her and settled on her lap, but she again became preoccupied with the phone. I noticed that he seemed more observing of his mother than of E, as if she needed working out. There seemed more distance between them, as if she couldn't quite be taken for granted in the way that E was – or maybe she was just more interesting, or perhaps he wanted her more.

> He cocked his head slightly to one side and seemed to take her in, mostly when she wasn't looking. … G wandered out and then back in again, eyes fixed on mother's face. She continued to read. He repeated his wanderings, again watching her face as he came towards her. This time she smiled at him in response, encouraging him verbally. He beamed, looking across at me as if to show me what was happening, or maybe to include me. This happened again, and again he responded in delight, making sure that I could see too. M returned to her book and he edged across to me.

He was one-year old now – walking, gurgling, and with a handful of teeth. There was a sense of storms weathered and survived. My last visit was marked by photos – M dressed proudly in traditional costume and sat for me with her two handsome sons. She also wanted one of me with G.

> M asked me if I would write a report now … She seemed pleased, and told me that babies are all different. Comparing V and G – V hated noise; he also had no use for a dummy, whereas G goes to strenuous lengths to find his. She played with him as we talked, picking him up and putting him on the floor at one point, and running her feet across his tummy. He didn't seem sure whether he liked this or not, whimpering and reaching for his dummy, then laughing as she tickled him. She told me how much notice G takes of V – more than he takes of her. As if to illustrate this, G had wandered away behind the couch, and didn't respond to her calling, apart from staring at us both. She said that he would have come if V had called him. V is apparently doing very well at school, and remembers everything. M told me that G is learning from V. 'Babies are clever'. G understands things … I thought of her query in the early months, 'Do babies think?'. She told me that V understands Creole – apparently she had said something about bedtime in Creole when he was very little, and he had said 'not sleeping time!'. I thought about V, who 'broke everything' a year ago, and who now seemed such a clever child.

A follow-up visit 3 months later found both boys having fun together, M at nursing college, and E planning to stay on in the UK also to study nursing. Five months later, with G aged 20 months, I found him wary, almost sullen. This was after an initial hug, when he almost leapt into my lap, followed by M's disappearance from the room. He did not engage in play with me, and uttered only one brief babble in the hour. Reappearing later, M told me that his GP was referring him to a speech therapist as there is a problem with his talking – he is not even saying Mommy or Daddy. I left extremely concerned about this child's internal world, feeling helpless in my observer role, now officially well expired. One final visit (to reassure myself as much as anything else) found him lively, expressive and involved. E was in charge on that occasion; neither was he left

alone with me as he had been at 20 months, perhaps frightened and angry at his mother's sudden disappearance. My helplessness may have been a vivid counteridentification, now mitigated by E's less abrupt comings and goings. I left feeling more reassured, but still with that niggling doubt: Does this (mother-baby couple) think?

Finally and briefly, Case 5 presents a contrasting scenario, in which it could be argued that the mother's capacity to bear her infant's experiences in mind had a life-enhancing quality. This was not a clinical case, but a situation I experienced, for which I have received permission from..., even encouragement, by the mother to record.

CASE 5

Vignette

Ms C was a 38-year-old married woman with a 20-month-old son when she became pregnant for the second time. The couple's initial delight at the pregnancy was followed by a growing recognition on the mother's part that she might have got more than she bargained for, as she was horribly sick in the first trimester. The diagnosis of twins was followed by a late summer holiday abroad, during which Ms C began to bleed. The family returned home, worried about the viability of the pregnancy, to be told that the twins had a rare condition – twin-to-twin transfusion. The survival figures were not good. However, they were booked into a maternity hospital with a worldwide reputation for research, and techniques had been developed there to aid survival. In practice, this meant frequent visits by Ms C to have her amniotic fluid levels measured, with transfer of fluid between the two sacs when critical levels were reached. The twins were still less than 20 weeks old. I was following the process step-by-step; falling asleep one night I had a vivid image of two tiny people fighting to survive – not blobs, or foetuses, but people. This was sufficiently unusual for me to recognize it largely as Ms C's conception rather than my own. The word 'permeable' came to mind, as if she could be especially open to her baby's struggle, despite the suffering entailed. The pregnancy continued in a worrying way, but each potential disaster was averted. However, Ms C finally went into premature labour and the twins were delivered by emergency section at 26 weeks and 2 days. They weighed just under and just over 2 pounds. A stormy period ensued, with issues of survival gradually replaced by fears of handicap. There were wearing trips to Intensive Care, then Special Care, heroic amounts of breast-milk expressed, and an attempt to keep the older child involved. I watched, as Ms C remained intensely involved, trying to make sense of it all. There were grim scenes, where a throw-away remark from a healthcare professional could take the form 'Oh – M was a naughty boy today – he stopped breathing'; or where other babies, perhaps less apparently unwell than her own, did not survive. She strove to empathize with her babies' experience, talking to them

about what was happening, and concerned too that they should recognize her as their mother amongst all the caregivers. From the start, she differentiated between the boys, watching their varied responses to stimuli and wondering how these might relate to later personality traits. There were many thoughts and discussions about the possible experience of being a twin, and how one had to be concerned not just with each baby's survival, but with the effect that any tragedy would have on the remaining child. Finally, against expectations, both twins were fit to be discharged to their home, albeit on oxygen, some 5 months after delivery. They are not out of the woods yet – in particular there are concerns about minor neurological disability in the bigger twin. However, even these seem to be abating. The parents are now left with the overwhelming task of ministering to these children, no time for themselves, but still with time to think.

Comments: Cases 4 and 5

Cases 4–5

Both are families from the non-clinical 'normal' population. In the infant observation, baby (G) certainly had a more auspicious start in life than the cases hitherto. Although the mother could abruptly disconnect at times, it seemed like a situation of 'good-enough mothering' overall, at least by the end of Year 2. The basic bond was there, despite the mother's unpredictability. In addition, there was the clear presence, both physically and symbolically, of a supportive father; the container (mother) was apparently contained. Mother was functioning, father working, and the family integrated within its own community. The observer's fear of annihilation in the mother's mind may simply reflect the 'normal' anxieties about an infant's survival; however, mother's propensity abruptly to disconnect is likely to have exacerbated these, and it remains to be seen how G will develop beyond his babyhood. Finally, the twins who have survived against the odds, whose mother did not dissociate, but remained connected to their terrifying early battle for survival. This may represent 'normal' or even 'supra-normal' mothering – fortunately, perhaps, we do not have a large enough sample to pronounce. In this case too the basic family unit was present, as well as a supportive network of professionals and friends. As an unofficial observer, there were gut-wrenching concerns to be felt, but these seemed relatively uncontaminated by split-off parental anxieties.

Discussion

The vignettes illustrate the interplay between the mother's mindfulness of her infant, and the infant's potential for growth and development. Findings such as those of Piontelli (1992) points to the complexity of that interaction occurring even before birth, and the cases presented here expand on this. The paper is not

intended to 'prove' that argument, which has in any case been more rigorously developed by developmental psychologists.

> Elaborate intuitive behaviours on both sides facilitate communication between the infant and adult caregiver, and when there is a fault in either one, the infant is unable to benefit from care, and its psychological development will be affected quoted in (Trevarthen 2001, p. 98).

Rather they offer a clinician's experience of its veracity, including extreme examples, and the clinical corollary that it matters to engage the mother-infant mind, even before birth.

The first three women presented a spectrum of reactions to childbirth, all evidencing shock with more or less dissociation. The therapist found it hard to keep reality in mind, perhaps a counter-identificatory dissociation, certainly a powerful experience. The first case was of a woman with a grossly disturbed background, whose personality disturbance intermittently had a psychotic flavour. The therapist had to hold onto her own sanity at times in treating her. Nevertheless, the patient did not attract a formal diagnosis of personality disorder in the psychiatric system, but of depression. In neither of the other two cases was there a formal diagnosis of personality or mood disorder made around the time of the birth, although in retrospect the last mother almost certainly suffered from a post-natal depression. In addition these two women displayed features suggestive of 'Dismissive' attachment style, i.e. a 'normalization' or an idealization of experience together with a dearth of coherent supporting memories.

There was denial of the pregnancy to a greater or lesser extent in all three situations, less certain in the first – it was also possible that this pregnancy may have been the result of rape. In no case was there a supportive partner present – he was either violent or absent in all cases. A final disturbing but intriguing similarity was the disposal of the baby in a receptacle for rubbish in all three cases, perhaps symbolic of the mother's disposal of unwanted material from her mind. As Raphael-Leff describes, the persecuted pregnant woman feels 'internally prey to a dangerous alien … polluting her with its waste products' (Raphael-Leff 1996, p. 385). Finally, all three cases had legal and social services implications, so that the therapist was to a greater or lesser extent constrained by outside agencies.

In contrast, the final vignette presents a mother who could allow herself to know about her babies' imperilled state, metabolize her own anxiety, and carry them to a successful delivery and beyond. I am suggesting that her ability to do so contributed materially to their survival – this is not the place to develop the neuroendocrine and immunological arguments for this hypothesis, which would in any case be tentative; however, these mother-infant interaction has been credited by professionals with these infant's satisfactory development of speech, normal even for their 'non-corrected' ages. Of note was the benign containment

of partner, hospital staff and social services in this case, as the mother received significant support and help. Finally, the observed mother-infant experience was also fraught with internal and external pressures; however there was some support, including that of a containing observer, so that thinking could evolve despite the pressures.

Klein described a model of psychic development in which the structure of the mind is built from archaic phantasies fuelled by primitive processes of introjection and projection. Although rich and complex her theory did not explicitly address the development of 'thought', a central concern of this paper. According to Wilfred Bion, thoughts require an apparatus to cope with them, an apparatus that he labels 'thinking' (Bion 1962) – in other words, thinking has to be called into existence to cope with thoughts. In terms of increasing sophistication, there are pre-conceptions, conceptions, thoughts and concepts. When the pre-conception is brought into contact with a realization (reality) that approximates to it, a conception is formed. Thought arises from the mating of a pre-conception with a frustration. This process breaks down when the capacity to tolerate frustration is exceeded, either through innate factors in the infant, or through the inability of the mother to contain and modify her baby's distress. A mother who construes her baby as 'a bundle of reflexes' (Introductory Quote) is less likely to provide this function, whereas the denial of pregnancy itself is an obliteration that bodes ill for neonatal life. 'Do babies think? No – they are just a bundle of reflexes' may be to some extent a self-fulfilling prophecy. In the first three cases, the mothers were patently unable to process the experience of pregnancy and provide the necessary containment for their infants. Bion's theory points to the trans-generational nature of this process, as a mother's own thinking apparatus is shaped in early interactions with her mother's mind. In that sense, the infants in this series are heirs to an earlier mother-infant interaction in which alpha-function was less than adequate.

Turning to attachment theory, the concept of 'reflective functioning' (RF) provides a scheme by which to test these ideas empirically. Reflective Functioning is described as the expression of the capacity to conceive of mental states, and involves both a self-reflective and an interpersonal component. It has been compared to Klein's notion of the acquisition of the depressive position, to Bion's alpha-function, and to Winnicott's ideas of psychological holding, as well as to ideas about mentalization in the French literature (*Reflective-Functioning Manual, Version 5*, Fonagy 1998). Thus one might argue that it does not advance us theoretically; however the difference is that this concept has been operationalized and is in the process of being tested. For example,

> mothers in a relatively high-stress (deprived) group characterized by single-parent families, parental criminality, unemployment, overcrowding and psychiatric illness were far more likely to have securely attached infants if their RF was high. This is preliminary support for the Freudian

> notion that those who do not remember and come to terms with the past are destined (are more likely) to repeat it, at least with their children (quoted in Fonagy 2001, p. 27).

Reflective Functioning was originally measured as a subscale of the Adult Attachment Interview, reflecting the narrator's capacity to mentalize about early attachment experience. More recently, it has been included as an adjunct to the Parent Development Interview (Slade *et al.* 2003), which assesses the parents' representation of his or her relationship with the child, and so is directly applicable to the field of mother-infant relations. However, there have, as yet, been no detailed longitudinal studies of the kind necessary to tease out complex clinical data.

Returning to the clinical field, some women become ill because they have a long-standing vulnerability to psychological disturbance and pregnancy acts as a stressor; for others, it is pregnancy itself and attaining the status of motherhood that is disturbing. I would like to suggest that a broadly different therapeutic focus emerges in these two groups. Pregnancy and early motherhood typically usher in a period of introspection for the woman, during which her own infantile fantasies, childhood experiences, and unresolved conflicts with her mother are awakened. In 'good-enough' circumstances, this is a period of benign regression that allows the mother to be receptive to her infant's pre-verbal needs and wishes. Where these experiences are too anxiety-provoking, however, such that the 'ghosts in the nursery' roam unchecked (Fraiberg *et al.* 1975), then the mother is at risk of psychological decompensation. Fraiberg described a series of troubled mother-infant pairs in which the mother re-enacted her own unmetabolized childhood traumas, such that her infant became a projectile vehicle for figures from her past, or for split-off aspects of herself. These women had not repressed their traumatic childhood memories, indeed they were often able to repeat their histories in chilling and explicit detail; however, the narratives were dissociated from the affective experience. The therapy consisted of encouraging them to retell their stories in the presence of their infants in order to help them unhook the projections and begin to integrate their own experiences. It seems clear that each mother in our series had her own ghosts, more or less benign. The mother in Case 1 described this rather literally: with the death of her youngest sister during therapy, she was haunted by her dead baby, seeing shadows, hearing footsteps, and dreaming of graves and babies. In this case the ghost seemed to represent her dead baby and its avengers, but it also appeared to embody aspects of the witch-mother/stepmother who dabbled in black magic and believed in demons.

What is perhaps surprising and certainly heartening in the less grossly disturbed run of mother-infant work is the rapidity with which problems in the mother-baby relationship can at least be ameliorated (Barrows 1997), although longer-term work is often necessary to address the mother's pre-existing difficulties. My clinical impression is that the mother's relationship with her

own mother figures largely in cases where the peri-natal period has been the initial trigger for difficulties, whereas this is less so in the group in which it has been one of a fairly undifferentiated continuum of stressors. Thus, in addition to immediate work with the infant, longer-term therapy in the first group would include a focus on the patient's relationship with her mother – indeed, if the hypothesis is correct, the mother would appear in a persecutory form whether invited in or not. This configuration may be overt as in the first case presented here (Ms A), or split off as in the second or third cases. At present, this is a clinical impression rather than an established finding; however, it makes theoretical sense and one could devise a research paradigm to explore it further.

Considering the effect on myself, it was as if part of these more dissociated mothers were so convincingly elsewhere as to be obliterated from my mind. It was a profoundly disturbing experience to have my normal thinking capacities so convincingly hijacked and gave me a taste of what a child would have to tolerate – if it survived. In the Infant Observation, mother did not so much dissociate as abruptly switch states; however, there was a similar sense of discontinuity that was difficult to understand and bear. The baby seemed to devise a solid kind of imperturbability that absorbed the shock of change but that was quite painful to watch. Whereas attachment theory provides a framework for thinking about the transgenerational transmission of attachment, and the empirical evidence that it occurs, it was the containment of a psychoanalytic understanding and supervision that enabled me to continue.

The mother's role has been emphasized throughout this paper; however, as emphasized above, others have an important role in containing the mother-infant pair, and it is noteworthy that none of these more disturbed women had supportive partners. Optimally, one could go on to think of a 'Russian doll' effect: the baby cocooned within mother, both supported by father, with the family as a whole nestled in a supportive network of extended family and friends; the network is then part of a society that espouses familial values. However, if the analogy is over-extended it could become stifling, with each progressive layer encasing and controlling the one below, veering towards the rigid enmeshment described as pathogenic by family therapists (Minuchin *et al.* 1978). Healthy support involves the provision of flexibility and space as well as structure, hence the opportunity for 'optimal disillusionment' as a more flexible system will inevitably fail at times. In the third vignette, the knee-jerk reaction of the authorities was imprisonment; however, I was struck by the eventual creativity of the Social Services department, who sent representatives to Ms W's country of origin to assess the risks/benefits of her returning home. This was the eventual recommendation, and she thanked the team for the humane way in which her case was handled. In the case of infanticide, however, the mother's internal world was presumably so chaotic that she was unable to function well outside a rigidly controlled environment, and invoked a wooden Russian Doll around her – a Medium Secure Unit, the Probation Service, and the Social

Services. She did not respond particularly well to a relaxation of these restrictions, being picked up for credit card fraud after her discharge from hospital. Presumably there is in all of us some gravitation towards an external environment that suits internal needs. Applying this to the mother-infant pair, one would expect the mothers to shape their shared space with the degree of freedom that can be tolerated internally. If her thought is relatively unfettered, then the mother-infant couple can explore and tolerate the contents of the baby's mind.

It has been suggested that the perinatal period is a particularly fruitful time for therapy, in that women typically have access to more primitive emotions around this time. The heightened emotions around childbirth are evidenced in everyday life, and are not really in question. As a clinician, my counter-transference bears this out, as my own more primitive fears and hopes are stirred by this kind of work. However, I would question whether this heightened emotional state necessarily indicates fruitful ground for therapy. My experience is that some women are so unsettled by it that they retreat at high speed, becoming far too busy and preoccupied to have time for therapy. By definition, we do not follow these women through; however, following the argument of this paper, one would expect the baby to become some kind of repository for persecutory thoughts that may or may not be addressed by later therapy.

In summary, I have presented a series of extreme cases to illustrate the interaction between mother's ability to think about her experiences, and her infant's development. These have mostly been considered from a post-Kleinian perspective, but I have also drawn on ideas from attachment theory. In theory, where the mother is free to contemplate her own thoughts, the infant is relatively uncontaminated by her projections and distortions, and she can be curious about its mind. She is enabled or hindered to the extent that she herself is supported, in particular by her maternal object and by the partner in her mind. Where defensive structures predominate, however, the infant becomes enmeshed by virtue of its unavoidable and persistent intrusions into mother. In attachment terms, the advent of pregnancy and motherhood can further distort impaired reflective functioning, which in turn affects the developing mind/brain of the infant; and it is at least theoretically possible to measure this empirically. Clinically, the therapist experiences something of this system, either by observing it directly and allowing it to impinge, or by interacting with the mother and noting the counter-transference. By offering a mind that can bear to think about the experience, he/she is a Bion-like mother who metabolizes and returns it in a manageable form. If she can tolerate this, mother is then is a better position to answer the question 'Do babies think?' with the knowledge that they do if she can bear to let them.

ACKNOWLEDGEMENT

I would like to thank Alessandra Lemma, Wil Pennycook-Greaves, Susan Davison, Dilys Daws and Maureen Marks for helpful readings of this paper, and to thank Dilys for

suggesting the title. I would especially like to thank Judith Elkan for her inspiring supervision.

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