Some Aspects of Infant Research and Child Psychotherapy - Their Relevance to Adult Analytic Work

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I’ve divided this paper into four sections. I hope by the end to have shown how the ideas are integrated.

A Clinical Fragment to Set the Scene

Several years ago I was asked to assess a seven year old girl I’ll call Sally. The question that was asked of me was whether psychotherapy would prevent the development of future problems given her experience of sexual abuse by an adult man, her uncle, when she was an unknown age, about 18 months old. At the age of two Sally had been adopted, together with her older brother and baby sister. All three were the children of a young woman who was a drug addict and prostitute, all had different fathers it was thought, all had been severely neglected and this little girl had been sexually abused by her maternal uncle. The adopting couple were infertile, both professionals. The request for such an assessment came from the (adoptive) mother. Initially I saw this mother alone to get a history and explore the nature of her concerns. She was worried whether this little girl’s past history of such early and severe sexual abuse would affect her later in life, specifically her relationship with a future partner. At the time of fostering all 3 children had been extremely anxious, unable to sleep in their own rooms, so that for twelve months the parents had set up mattresses for the children outside their bedroom so the children felt close enough to settle and sleep. Sally had clearly made great psychological gains in the past 4 years. For several years pervasive anxiety had been manifest in most areas of her life, in her relationship to adults, particularly her father and other men, in interaction with her peers, in learning difficulties at school and in playing. She now had a warm relationship with both her parents, was a lively girl with friends, progressing reasonably at school, though with some residual difficulties in learning. Her mother recognized that she still had areas of anxiety, mainly manifesting in these learning difficulties but that her progress was steady and demonstrable. I initially felt daunted by the question as to whether psychotherapy would have prophylactic or preventative value for her and decided the best I could do was carry out an assessment in my usual way and see what emerged.

I had a chance to observe Sally with her mother before we first met as I can see into my waiting room from the top of the stairs before I am seen. She and her mother were sitting in the separate armchairs not on the sofa, engaged in conversation. I was confirmed in my initial impression of the mother as warm hearted, sensible, and unsentimental. They were comfortable together. After introductions and a few minutes of chatting, Sally separated easily from her mother and came with me into the playroom, across the hall from the waiting room. She was also comfortable in my presence, even when I was standing behind her. I invited her to look around and play with whatever she wanted to in the room. She was interested and after a short while she went to a table with some craft material. Without exchanging words or glances, she became quite engrossed in making something with the ice-cream sticks, string and sticky tape. When she finished she scribbled a black mark on paper, carelessly cut it out, put it in the thing she had made and then said “This is a spider’s web and it’s (the black scribble) a spider but I’m not going to play with it”. She set it aside.

She moved away to another table with a dolls house on it, and a box of animals and simple dolls. She became engrossed and seemed to forget my presence, even when I was standing behind her. She constructed a farm with farm animals, with fences and trees and became lost in her play. After some time I asked her to tell me about the scene. She pointed to the big horse and the little one next to it and told me that the baby horse had been very sick, it needed a lot of care and that the mother horse had looked after it until it was better. I asked “Was the horse better now?” “Yes” she said, “But it hadn’t been for a long time.” I asked again “Do you think you could...
be that little horse that had been so sick and needed your mummy to make you better?” “Yes,” she replied “But the horse can play now”.

I felt that this little girl had a capacity to play, to symbolize her sickness and some of her pain. I was perplexed by the spider. I still am. Did it represent me, a stranger? Who can’t be trusted to play with? Did it represent some aspect of her inner world, elaborated in symbolic form into a spider? Or was it something in her experience, perhaps her sexual abuse, or severe emotional neglect, some different quality of pain that couldn’t be transformed beyond the representative sign of a spider which remained a symbolic equation. Are some atrocities of such magnitude that they paralyze the functions of fantasy and symbolization?

Part 1: Introduction - Phantasy and Play

Freud (1915), in observing his grandson Ernst, age 18 months, playing the Fort/Da (reel) game, suggested Ernst was compensating himself for the mother’s absence by re-enacting and repeating the disappearance and return of an object he could control.

Isaacs (1948) added that the child’s play “consoled” him for his mother’s absence. What is relevant in discussions about this is the Kleinian distinction between processes that are defensive against pain and depression and those that are designed to overcome it and foster growth.

Much would depend on the child’s inner state of object relations as he played the reel game. Segal (1986)’s ideas on symbol formation and Winnicott (1971)’s on transitional phenomena are very useful in thinking about this.

Was he playing it mainly in order to deny his mother’s absence, and more important, her significance (the level of symbolic equation) or was he playing it to gain some control and make her absence more bearable (playing at the level of transitional object) or did he have no doubt about either her significance or her absence, but was exploring and trying to learn more about the properties of objects in their own right that go away (playing on the level of real symbol formation)? (Alvarez 2012).

We need to take into account the state of mind of the child playing, his level of symbolic functioning as well as issues of deficit and defence.

With an already connected child functioning at a symbolic level, we interpret the content of their play and actions and talk on that level. But when it’s closer to symbolic equation (Segal 1986) the patient needs to be worked with and reminded of the interpersonal world of human beings and what could be done with them.

This is just as true in working with adults patients.

In Kleinian thinking, true symbol formation is thought to arise out of a process of mourning for the lost primary objects and to be connected with the depressive position, with an acknowledgement of loss and separateness. In these processes reality is introduced and helps to structure the human mind and emotions.

I hope I’ll be able to show work from Infant research, neurobiological research, psychoanalytical theorizing and fragments of clinical material that might help understanding when this process can go very wrong, or right.

Part 2: Neurobiological Research

Shore (2003), neuro-anatomist and psychoanalyst, suggests that many analytic concepts about the infant are supported by neurobiological research. He writes: “By regulating affect, the caregiver is also regulating the release of neurohormones in the infant brain. In the inevitable event of distress states in the infant, the comfort the infant receives reduces the level of cortisol and related stress hormones’”. When there is no interactive repair, when the caregiver is abusive, neglectful or continually mis-attuned, infants remain in chronic negative states, their corticosteroid levels chronically elevated, and dopamine activity reduced. This is thought likely to reduce the number of synapses, even the death of neurons and to undermine the capacity of the brain to regulate emotion.”

Put simply, there exists two levels of analytic work, insight versus more primary levels of understanding, such as containment, attunement, empathy, though this division is somewhat artificial because insight often comes from an experience of being understood emotionally. Some authors have suggested that these two methods of work involve different areas of the brain (Shore 2003). Neuroscience directs our attention to the differing functions of the right and left hemispheres with the left having more to do with ordinary grammatical language, linear sequencing, analytic logic while the right hemisphere uses a non verbal mode of representation, things like emotional and social processing, emotive expressive language including metaphor. The right brain has a growth spurt in the first 18 months of life and the left has its surge after 18 months. Further change occurs with the integration of right and left hemispheres.

Emotional life and cognitive development evolve and develop out of interactions with other human beings, and we now know that the effects of emotional abuse and neglect on infants’ developing brains are devastating.

Gerhardt, following Shore (reported by Alvarez 2012) tells us that when the mother smiles, the baby’s nervous system is pleasantly aroused and his heart rate increases. These processes trigger a chemical response. Endogenous opioids (which
make you feel good) and dopamine (energizing and stimulating) are released from the brainstem and make their way up to the prefrontal cortex. Both neurochemicals enhance the uptake of glucose there, helping new tissue to grow in the prefrontal brain. Dopamine is the system that allows us to operate smoothly and efficiently in day to day life. It’s suggested that intense interest, engaged curiosity and eager anticipation are the types of feelings that reflect the arousal of this system in humans. Stern (1977) suggests that the dopamine arousal system, the force that pushes sex, hunger, attachment and so on into action, that triggers the emotions, sharpens attention, starts cognitions and initiates movement. Solms (2000) has suggested that this is very close to what Freud called the life instinct.

I’ll return to these ideas later.

**Part 3: Infant Research**

Just a few ideas from this vast area of study.

There is increasing sophistication of video microanalysis of sequences of mother-infant interactions. Infant researchers can now study complex relational interactions and emotions even in newborns.

They believe that even very young babies start to make meaning, and to show reactions of shame and pride in response to how they are responded to. Within minutes of birth babies can imitate, within hours they discriminate and prefer the faces, touch and voices of their mothers and fathers (in utero they can hear). They are primed at communicate from birth. The mother influences the baby and the baby influences her (Salo 2012).

Trevarthen and Aitken (2001) wrote of baby’s “sensitive and joyful appreciation of expression in the human voice and their expressive and gestural behaviors that are adapted to ‘talk to’ their parents particularly when they are being playful... here is the baby’s need for exuberance and enthusiasm with clear anticipation of success and evident pride”. In addition to safety, babies want the fun and joy that can come from a relationship in which they are enjoyed. They are object seeking and object using from birth.

**Part 4: The Dead Mother**

But what happens when the infant’s mother is depressed?

Murray et al. (1996) is a researcher with a particular interest in the effects of perinatal depression. Her videos of the babies of postnatally depressed mothers show that when, at age 12 months, they are asked to find an object hidden openly under an inverted cup they hardly try. Hidden objects exerted no attraction for them. The babies of the normal mothers were curious, and they not only found it immediately but enjoyed it playfully for several minutes. They explored everything they could do with that object.

Green (1986)’s paper, “The Dead Mother” (published in “On Private Madness”) has been seminal to my understanding of this difficult topic of the depressed mother. In his paper he is not discussing the actual death of the mother, but to quote “the imago that has been constituted in the infant’s mind following maternal depression, brutally transforming a living object, which was a source of vitality for the child, into a distant figure, toneless, practically inanimate, and weighing on the destiny of his object relational (libidinal) and narcissistic future.”

Green shares with other authors two central ideas, which form the basis of his theoretical grounding.

“The first is that of object-loss as a fundamental moment in the structuring of the human psyche... the second idea is that of the depressive position.”

Before I discuss his central argument, and other ideas that constitute my premise, there’s a piece of developmental research, the Still-Face Studies that’s relevant to my case. This is reported in Brazelton and Cramer (1991) and I quote them here. Infant researchers define contingency as a pattern of appropriate responses to a partner’s signals, needs and emotional communications. Contingency is an expression of availability; it reveals empathy and a capacity to be affected by the inner state of the partner. In an infant, congenital diseases or abnormalities, or deviant temperamental traits, can interfere with contingent responses, and on the parental side, ambivalence, anxiety and one of the most frequent and severe is maternal depression. Experimental evidence, such as the Still-Face Studies, shows that contingency failures due to even minor forms of depression or depressive behavior can affect infants.

The experiment goes like this. The baby, after being soothed and contented, was placed in a reclining chair. The mother was asked to play with the baby in the chair, as she did at home. She could do anything but take the baby out of the chair. She played for 3 minutes, and then withdrew briefly. After a minute, the mother was asked to return for a second three minute-3-minute period. She was instructed to present a perfectly still face (absent emotion) and not to respond to the baby. She was thus violating the expectancy set up in the previous play situation. In a typical session, a three month old baby’s response might progress as follows. Before the second three-minute period, while still alone, the baby might be looking contemplatively down at her hands, fingering the fingers of one hand with the other. As the mother enters her hand movements stop. She looks up at her mother, makes eye-to-eye contact and smiles. The mother’s mask-like expression does not change. The baby looks quickly to one side and remains quiet, her facial expression serious. Her gaze remains averted for 20 sec-
Ons. Then she looks back at her mother’s face, her eyebrows and lids raised, hands and arms stretching slightly towards the mother. Finding no response, she quickly looks down again to her hands, plays with them for about 8 seconds, and then checks her mother’s face once more—finally the baby completely withdraws, her body curls over, her head falls. She looks wary, helpless and withdrawn. As her mother leaves at the end of the three minutes, she looks halfway up in her direction, but her somber facial expression and curled over body position do not change. The consistent pattern of infant behavior in the still face situation is repeated attempts to elicit mother’s response, followed by somber expression, orientation away from the mother and finally withdrawal. All this takes place in less then 3 minutes. Infants in this position are consistently disappointed by the failure in their ability to capture the mother’s interest and so vulnerable to what they see as her rejection (I want to return to the theme of disappointment later). After initial efforts and initial protest, they collapse into a self-protective state. First, they try to avoid the need they have to look at their mother. Then they try to turn off their environment completely. Finally they try their own techniques for self-comforting. These changes persist beyond the experiment. If such minor, time limited breaks in contingency can have such clear cut and relatively long lasting effects on infants, it’s not surprising that maternal depression has more complex and lasting effects, even in the first months. Bowlby and Robertson (1953) reported the case of a two-month-old baby whose mother became depressed when she learned that her husband might have cancer. The mother became withdrawn, did not respond to the child’s smiles and vocalizations and hardly talked to him. Within a week a marked setback in development was observed, with bodily activity decreased and smiles difficult to elicit. Although the diagnosis of malignancy was ruled out within a few days, the baby remained sober and unresponsive, and this setback in development remained evident for several months. He remained passive, undemanding and at twelve months, his development was still two months delayed. Research suggests that the young infant perceives even very small deficiencies in contingency in the mother’s behavior. When they are soon reversed, the infant may learn to cope with them, if they persist the effects may be long lasting.

Green (1986) (I report him directly where I can) states that the Dead-Mother complex reveals itself in the transference. At presentation for therapy, symptoms are not necessarily of a depressive kind. There are usually conflicts with people who are close, but the affect of depression doesn’t feature. Rather, problems of narcissism - high demands of an ego ideal, feelings of impotence, omnipotence, dissatisfaction.

In the transference- a sense of emptiness/depression emerges in the presence of an object which is itself absorbed by a bereavement (he lists causes for a mother’s depression - loss of a person dear to her, a deception which inflicts a narcissistic wound such as an affair of the father, loss of finances but the most serious is the death of a child at an early age). The mother’s sorrow and lessening of interest in her infant is devastating - an authentic vitality comes to a halt. The infant who previously felt loved suffers a catastrophe of a detached mother. This leads to a narcissistic traumatization. This premature disillusionment, inexplicable, carries not only loss of love, but also loss of meaning for the baby. Being at the centre of his mother’s universe, he interprets this ‘deception’ as a result of his feelings towards the mother.

An infant’s wish to give and share pleasure with the mother is an early form of reparation (Alvarez 2012, Winnicott 1971). The child’s attempts to repair the mother, who is absorbed in her bereavement, are in vain, reinforcing his impotence and despair.

Even though we are describing a two person psychology of infant and mother, each time the mother is not wholly present (at moments of contingency failure) it will be attributable in fantasy to the father. For patients such as these, the Oedipal situation or experience is not simply experienced as painful but as catastrophic (Britton 1992). Green (1986) differentiates the anxieties linked to castration-(of penis, feces, baby)- those bodily wounds associated with a bloody act, as “red” anxiety (the wound is a result of destruction) from the concept of loss - of the breast or object loss, threat of abandonment, which he calls “blank” anxiety (in this he includes black as in severe depression, or blank, as in states of emptiness). In blank anxiety hatred is a secondary product, a consequence rather than a cause and expresses loss that has been experienced on a narcissistic level.

Blankness, or emptiness, result from a withdrawal of affect, love, desire (decathexis) from the mother. This leaves traces in the unconscious in the forms of “psychical holes”- filled in by recathexis - of hatred, destructiveness, which are not balanced by love. This view modifies analytic technique because to limit oneself to interpreting hatred in structures that take on depressive characteristics never approach the primary problem. Green says this love, or desire for the mother is repressed, but I think it is also split off and projected.

This hole at the centre of being - that Green calls a cold core, and which patients call variably an emptiness, a sense of meaninglessness, a state without colour, a sense of greyness or coldness, has within it a void filled with annihilating terror. An experience of non-existence, akin to Bick (1968)’s descriptions of the infant’s primitive anxieties of falling to pieces, disintegrating or liquefying, or to quote Bion (1970), dropping into the void itself, a terror inducing, no-place filled with nameless dread.
Green (1986), using his more classical model, also talks about the terror in the void, such as falling forever, and explains the existence of the void deriving from a (decathexis) with- drawal of affect and representation - a psychical murder of the object, accomplished without hatred.

He describes unconscious identification with the “dead” mother, the deadness we feel in the transference, and that it is a mirror identification, so commonly seen in narcissism - a mimicry with the aim of continuing to possess the object by becoming the object itself.

Defences against the void and the loss of meaning

One of the most painful experiences a human can have is of longing, or desire, that is not fulfilled or met. When this desire has origins at the beginning of life - for the baby of the depressed mother, the frustration of the desire, the loss of the thing desired and the felt inability to contain the desire as an affect that can be regulated, leads I think to an experience of self-annihilation. Most commonly this desire is split off-into a desire for something concrete that can be controlled (like food) or this part of the self seeks refuge inside an object or state of mind, described by Meltzer (1992) in “The Clastrum” and Steiner (1993) in “Psychic Retreats”.

A shift occurs from living with the introjected object to living inside them in an intrusive way. Meltzer (1992) wrote: “Survival has the meaning of evading expulsion which seems to constitute the most nameless dread of mental life”. Once inside the object, the person, or part of him, becomes inaccessible to contact, and unless this is recognized these parts of the personality aren’t analyzed.

However, persecutory life inside the object can be, at least it structures existence and has the effect of fixing a sense of identity, which can be lived in with some sense of it being a known quantity. It restores psychic equilibrium as a defence against psychic change. It also means there is no separateness from the object and as such no real distance.

Other defences of this dead mother complex

Green (1986) discusses “releasing of secondary hatred” - which is neither primary nor fundamental - where sado-masochism, tyranny and submission are pervasive. The excitement of sado-masochism simulates emotion and liveliness, and being with objects. Green also cites the common defence of auto-erotic excitement where one sees search for pure sensual pleasure, organ pleasure without tenderness. There is dissociation between the body and psyche, between sensuality and tenderness, a blocking of love. Green says “secondary hatred and erotic excitement team on the edge of an abyss of emptiness”.

Grandiosity and arrogance are common and difficult defensive structures to both access and change. From Steiner (1993) we get another clinical useful description of retreat, one characterized by the world of grievance and resentment. Alcohol, promiscuity, drugs, workaholism are common ways of avoiding contact with anxiety and often used as a defence against feelings of anxiety engendered by the void. Bick and Meltzer describe second skin defences, which include hyperactivity, muscularity and adhesive identification (Emanuel 2001).

Without hope there is no life. Hope is isolated in the hidden desire, in fusion with the dead mother. With the fantasy of fusion (or intrusion inside) one can avoid the catastrophe of loss and separation, because it’s not just loss but annihilation of the self. Green (1986) said “Behind the dead mother complex, behind the mourning for the mother, one catches a glimpse of the mad passion, the intense desire, of which she remains the object”.

If we listen carefully to patients such as these the theme of disappointment is a recurring one, either explicitly or implicitly expressed. A patient of mine, who was conceived as a replacement baby after the death of a sibling at age 6 months, was for many years a patient who was difficult to reach. He said “I always thought my sense of disappointment was about all the things I spoke about that weren’t going right in my life. Those things are OK now, and I’m still left with a sense of disappointment that I can’t understand”.

Before I discuss some technical issues in working with avoiding patients, I want to make a few general points.

Green (1986)’s description is of a mother who had periods of aliveness that preceded the depression. But often the mother is perceived by patients as someone who is permanently depressed, and I have supposed that most mothers have periods or moments of responsiveness even if they are depressed. Some patients don’t necessarily reconstruct the mother as depressed and emotionally absent but rather see the mother who turned away from them as intrinsically defective or bad. In other instances it would appear as if the mother was unable to recognize that her child had an inner life that was separate and distinct from her own. Recognizing the uniqueness of the child’s inner life is equivalent to recognizing that the child is psychologically alive. The alternative is devastating.

Technical issues in working with avoiding patients

There’s no pattern or guide, every patient brings his own history, personality and constellation of anxieties and defences against them even if one identifies this dead mother complex at the core, and every stage of an analysis allows for a different quality of interaction. Therefore, there are a few pertinent issues in working with this type of patient.

Characteristics of the transference

Generally, but not always, the patient is strongly attached to
the analysis, the analysis more than the analyst. The patient does not know how to be with the analyst—any feeling of love for the analyst is felt to be dangerous and potentially destructive. Patients become dead and lifeless in the analytic setting, often showing little movement and speaking in a voice drained of affective modulation.

There are serious technical difficulties in reaching patients in this avoiding state. Either they are so panic-stricken by potential contact with the persecutory object of non-existence or space, or they are so defended against it that they are difficult to reach.

The key issue is survival of the mind and interest of the therapist in working with unreachable patients.

Green (1986) says that the therapist who is too silent only perpetuates the transference of blank mourning for the mother. The analysis for these people induces a sense of emptiness. The patient’s sense of deadness cannot be symbolized, it’s a thing rather then a feeling, and is enacted (entombed) in the lifelessness of the analytic experience itself. The passion and the pain are without representation.

This passion, desire that the patient dissociates from needs to be contained and kept alive in the therapist until the patient can, bit by bit, accept it back, and re-experience the disappointment, in portions that do not lead to disintegration. The therapist needs to stay, as Alvarez (1992, 2012) calls it, “live company” for her patient. Alvarez says: “too much distress in an infant evokes reverie and containment (Bion 1970), and too much withdrawal evokes sensitive drawing into contact (Brazelton and Cramer 1991, Stern 1998, Trevarthen and Aitken 2001)”.

Bromberg (2001), an American analyst in his paper “Treating patients with symptoms and symptoms with patience” discussing this sort of patient, warns against the analyst also dissociating, or cutting off from, the difficult experiences in the therapeutic relationship. He says: “the analyst has to get fed up. It’s important he get fed up, he should get fed up. But he shouldn’t get so detached from his own fed-up-ness that he cannot perceive the retaliatory component of his behavior”.

I’ll discuss just one moment with two patients of mine, though I could discuss many who fit the topic of this paper.

**JAMES**

He was a 5 year old boy who was in therapy with me. His mother was a heroin addict for the first few years of his life, though in the last two years she had had dry spells during which she was very anxious and depressed. They were reasonably well to do as the father, a wealthy business man from Asia now divorced from the mother, gives them financial support. Although he is involved with James, he’s a withdrawn, rather schizoid man who was only intermittently in contact until the last few months when he moved from another state in Australia to live in Sydney. He then moved into the same street and sees James more often. The mother is very involved with James, but not very emotionally available. James seemed like jelly to me, as though he didn’t have a backbone, or a structure to hold him together. Saliva constantly dribbled out of his mouth and he couldn’t articulate sounds that involved the pressure of his tongue against his palate. He was very omnipotent and controlling of his mother but rather submissive with me. Early in the therapy, for no external reason that I ever came to know, he sobbed for two whole sessions, and all I could do was hold him physically through this. He owned every expensive toy manufactured but he didn’t know how to play. He would want me to play, to show him what play was, but any game I initiated he copied and I could see it was a mimetic transference. Breaks, holidays were understandably difficult and he returned either manic or cut off or just detached and unreachable. As the therapy progressed this unreachable quality was more and more a feature even without holidays, and with that he was listless, disinterested. In these states not much of what I said had much impact nor could I really bring him back into contact. One day after much talk on my part about his being angry with me and turned away, about his sadness and hurt, perhaps he couldn’t look at me because I’d turned into something ugly for him, like a witch - all to no avail. Most of the session had passed and I said: ‘do you want to play with me now?’ He looked, looked again, came closer and nodded yes, and after a little playing when there seemed to be more contact, I was able to talk to him about how unbearable it had been to want me so much when I wasn’t there for him. He understood when I said the wanting and not getting me had hurt so much that it was as if he broke into a million pieces and that he had to stop wanting altogether.

**JODIE**

A couple of days later, it was after a break, I saw another patient Jodie, a woman in her 30’s, who’d been referred when pregnant with her first child. Although she and her husband had planned this pregnancy, she had split off from awareness (not totally) her interest in the fact of this baby coming... She clung tenaciously to her treasured identity as a scientist. She had dreams where the baby was forgotten and left behind, and this would make her feel variably guilty and panicky. She was a likable woman but rather detached and distant. She could truthfully but with some shame articulate her concerns that the baby wouldn’t be as attractive as she hoped. We knew her mother had been preoccupied and probably depressed when she was born and for several years after. My patient is...
married to a man who expresses a part of herself she cannot, he is passionate in his engagement with life though he too is narcissistically vulnerable to hurt.

After this break from therapy she is co-operative, tries to please, to impress me and tries to engage with interesting talk but she’s distant, more so than usual. No matter what say, when I try to interpret her disappointment, anger, hurt, all of which she agrees with, she remains cut off from me and from her feelings. She returns next session and I think, from my past experience with her, that this will continue for a long time. I thought of my little patient James. I can’t say to her “Do you want to play now” but I told her the story, and when I said “I asked him, do you want to play with me now and he came over to me” she started to cry painfully. I could then speak to her about my needing to carry her desire, the wish to be together and the painful longing. Because if she did it grew and grew until she couldn’t bear it and cut it off.

Months later this patient told me a dream she had on the night of our first session after a break of three missed sessions. She was aware that 4 men had forced their way into their house and were attacking Steve (her husband). She had her mobile phone and tried to ring 000 (emergency) but she couldn’t get through. She felt utterly hopeless and despairing that he was dead. Then she remembered she was in America and it was a different emergency number - she tried this- still delay. She went in next door to a neighbor, still phoning and eventually got though. Emergency said - we knew someone was trying to get through - they were sending someone but she felt helpless and despair that Steve was dead.

Green (1986) said “By using the setting as a transitional space makes an ever-living object of the analyst, who is interested, awakened by his patient, giving proof of his vitality by the associative links he communicates to him, without ever leaving his neutrality. For the capacity to support disillusion will depend on the way the patient feels himself to be narcissistically invested by the analyst. It is thus essential that the latter remains constantly awake to what the patient is saying, without falling into intrusive interpretation. For passivity is at the heart of the conflict common to the mother and infant”.

I would also say that an equally important component of the transference enactment is the split off fantasy of the ideal baby fused with, or inside, the ideal mother. If this is not brought in and worked with, the work of the analysis is never complete. I think Green would say that the baby will stay enshrined with the idealized dead mother and so will be unable to mourn her and establish meaningful relationships with anyone else. This is quite different from an internal relationship based on an object who has been experienced as real, valued, loved and hated.

In discussing this, Joseph (1989), in her paper “The Patient who is Difficult to Reach” says: “Sometimes it is difficult to see this split off structure since the patient may appear to be working and co-operating with you. There seems to be understanding, apparent contact and appreciation, even reported improvement, and yet there’s eventually a feeling of flatness or hollowness. Sometimes you get a feeling in the session that nothing will happen unless you say something, or that you need to pressure the patient to talk or respond. If one talks because of this silent pressure without realizing what is going on, the session will go on but becomes superficial or repetitive. Often the patient has projected the active, interested or concerned part of the self into the analyst. I think in some patients and in some stages of analyses this has to occur, even for quite a long time, but the analyst needs to be aware of the projective identification taking place and be willing to carry it long enough until it becomes possible to interpret about the process being enacted rather than about the content under discussion”. Joseph (1989) adds, and I agree with her experience “at other times what you offer may not seem adequate or come quickly enough, so it seems to leave a terrible feeling of emptiness or hunger so that the patient can never get a sense of relief… one hears ‘Yes, but…’ as if chewing at me or into me, holding me concretely with her anxiety and demands”.

This secret internal euphoric relationship with the analyst/mother precludes and excludes the separateness of the other, and when this structure starts to collapse, first anxiety then terrible pain emerges.

The infant researchers confirm Green (1986)’s view, and clinical experience, that unresponsive, or non-contingent behavior, from the mother precipitated well organized negative emotional reactions of frustration, depression or shame and humiliation. Green emphasizes the presentation of narcissism in this situation. It’s my experience with patients such as this that after separations the material I often hear is about rejection, feeling unwanted (usually by other people not me), shame and humiliation.

The depression is manifest in the lifeless transference.

I’ll finish with a quote from Ogden (1999), in his chapter from the book edited by Gregorio Kohon “The Dead Mother - the work of Andre Green”, which is a festschrift to Green’s paper. Ogden wrote:

“I have become increasingly aware over the past several years that the sense of aliveness and deadness in the transference-countertransference is, for me, perhaps the single most important measure of the moment-to-moment status of the analytic process.”

He further writes in this chapter:

“The goal of analysis from this point of view is larger than that of the resolution of the unconscious intrapsychic conflict, the diminution of symptomatology, the enhancement of re-
reflective subjectivity and self understanding, and the increase of sense of personal agency. Although one’s sense of being alive is intimately intertwined with each of the above-mentioned capacities, I believe that the experience of aliveness is a quality that is superordinate to these capacities and must be considered as an aspect of the analytic experience in it’s own terms.”

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Conflicts of Interest

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REFERENCES


