When a Mother Brings Her Baby to Psychoanalytic Sessions

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In this review paper, the clinical importance of being open to why a mother wishes to bring her baby to analysis is considered as a spectrum of views about the frame and transference aspects of why a mother shares her sessions are explored. The concept of motherhood as a developmental stage is first outlined, as well as difficulties on the path to motherhood. In discussing the centrality of attending closely to countertransference in following the meanings of the request and the evolving analytic process, the analytic potential of a baby’s presence in a mother’s working through is exquisitely perceptible, highlighting gains in integrating projections and facilitating introjections so that a maternal good object may be more securely internalised and consolidated. A baby’s presence may contribute to a more layered presentation with a mother bringing material that might otherwise be ‘beyond words’. Taken together this suggests that a more traditional view of the frame that a baby should not come to sessions may slow therapeutic gains, and that technique would be informed by viewing the request as developmentally appropriate.

KEY WORDS: Psychoanalytic session · Baby · Frame · Countertransference · Infant transference.

Introduction

This paper draws on material from four to five times a week psychoanalytic sessions with mothers whose baby is present, touching on important questions about the frame, countertransference aspects and the real relationship, to give an overview of clinical and technical issues. While bringing the baby occurs more often in psychotherapy (Loewald 1982), the focus here is on mothers in analysis whose babies accompany them without the expressed purpose of having the mother-infant dyad analysed or the baby helped, in order to explore how the presence of the baby in the analysis affects the analytic process (Anderson 1995; Friedman 1996). Addressing the mother-baby relationship as in infant-parent psychotherapy is not discussed, nor is therapeutic intervention with a baby, described by Salomonsson (2007) as ‘analyzing’ the baby. There has until recently been a relative paucity of literature on mothers bringing their babies to analysis and in a brief literature search, the early 1990s emerges as the time that British and American women psychoanalysts such as Raphael-Leff (1993), Anderson (1995) and Balsam (1996) began to describe mothers bringing their babies to sessions. While working with a baby present changes the session, these analysts concur that it seems possible to hold the frame. Current concepts about mothering have the potential to tilt psychoanalytic theory and practice: becoming a mother is in particular recognised as a therapeutic experience for most mothers (Friedman 1996; Mendell and Turrini 2003). Changes in analytic practice with mothers and babies have led to therapeutic effects of a baby’s presence on a mother’s analytic process being illuminated, such as facilitating mourning the loss of the internalised good maternal object and the possibility of feelings previously unknown to the patient becoming known by the analyst (Anderson 1995; Hollman 2003; Imber 2010). Recently Kite (2012) suggested that the presence of a mother’s baby son in the consulting room and the new object relationships which he engendered made his mother’s analysis possible.

Many women having their first baby, particularly those without available mothers, wish to bring their baby to sessions when they want to be a better mother, viewing the analyst in a benign (grand) mother transference. From the literature search and clinical experience what emerges is that a stance of accepting and exploring why a patient wishes to bring her baby is generally enabling of development, underlining the importance of attending closely to countertransference. While there are cultural differences worldwide in views on motherhood and mothering, and this paper is written and illustrated with brief vignettes mainly in the context of analytic practice in Western countries, the ideas are thought to be relevant generally.
Motherhood as a Developmental Stage and Difficulties on the Path to Motherhood

For the mother of a new baby, a cascade of change takes place emotionally. In Stern’s (2000) motherhood constellation (a psychic re-organisation with its own fantasies), there is a shift in a woman’s psyche so that her thinking of herself as a mother becomes part of her identity; the couple relationship, of which she is part, changes to become that of a parental couple. Experiences of how she was cared for as a baby are revived, and her intra-psychic representations change from viewing herself as childless, to that of being the mother of a dependent baby, and then to being the mother of a toddler. Studies of the neurobiology of mothering and attachment confirm that a mother’s neural circuits are shaped by this experience enabling her to become more lovingly attached and sensitive (Schore 1994; Strathearn 2007; Bartels and Zeki 2004). Many resilient mothers try, in the face of enormous difficulties, to protect their babies from an intergenerational transmission of family problems, by their choice of partner or adaptive coping mechanisms, or through psychotherapy (Sroufe et al. 2005; Berlin and Cassidy 1999). Infant studies and object relations theories, in describing how a mother’s mental functioning scaffolds her baby’s experiences from birth with meaning, have nudged Freud’s view of a mother as her baby’s object of libido to include a view of her as a person who contributes vitally to the development of her baby’s mind (Tronick et al. 1998; Gerhardt 2006; Meins et al. 2002). For this, a baby needs to be kept in mind and enjoyed. A mother integrates her sexuality with motherhood by modulating the sensuality of interacting with her baby’s body (particularly in breastfeeding), and aims for her baby to develop a representation of a father who is ‘good enough’ (Winnicott 1953).

Becoming the mother of a baby may evoke anxiety strongly and continuously, and many difficulties on the path to motherhood compound this, such as experiences of sexual abuse, trauma, infertility, mental illness, drug dependence and lack of support (Fraiberg et al. 1975; Kirkman et al. 2002; Waterman 2003). What has often seemed insufficiently emphasised in psychoanalytic literature, partly with an emphasis on the negative and on maternal hate, is the primacy of the creative act in giving birth and a mother’s positive loving feelings for her baby. While mothers may be resentful about the demands and deprivations, the rewards of motherhood have had a relatively small voice in much psychoanalytic writing. One way that the perspective of the mother is tilting psychoanalytic theory and practice is around the universal maternal fantasies of omnipotent perfection, which used to be viewed negatively as regressive pathological fantasies, and their contribution to the maternal ideal and caring, ignored (Mendell and Turrini 2003). They are now seen as also having creative and transformational aspects, so that the concept of continued psychic development, not just a reworking of older conflicts, is more prevalent in the field (Mendell and Turrini 2003). With these developments, the depth of a mother’s guilt which is often felt to be almost unbearably painful modulates, I suggest, the psychoanalytic view of the baby who is viewed primarily as a narcissistic extension of the mother. Parenthood, Shuttleworth (1985) writes, is the central stage of life and when something goes wrong with the link to the baby, a mother feels that this has disastrous consequences for her own development, with the central hopefulness of her life irreparably damaged. If a woman’s own mother had experienced postnatal depression or unresolved difficulties, these ‘ghosts in the nursery’ (Fraiberg et al. 1975) are likely to become active when she has her own baby. Winnicott poignantly explored a mother’s hate: ‘The most remarkable thing about a mother is her ability to be hurt so much by her baby and to hate so much without paying the child out’ (1949, p.72). The fundamental changes of motherhood compound her guilt about hating her baby and feeling herself to be a bad mother. Enabling her to work with this feeling of hate in the presence of her baby may offer her a greater chance of developing self compassion.

Spectrum of Views on the Frame

A mother bringing her baby to sessions has been viewed by many analysts as a break in the frame; from the viewpoint of the analyst’s stance and responsibilities, it is taken as a given that to facilitate the analytic process a mother would resume analysis soon after her baby’s birth and arrange for the baby to be cared for. Bringing the baby has been viewed as ‘acting in’ behaviour, which may not be exclusively transferential and is without insight but does have meaning that can be explored (Paniagua 1998).

With a shift in cultural mores it has become more acceptable that a mother should not be expected to leave her baby if she does not wish to. Winnicott’s (1956) concept of the primary maternal preoccupation of the early months as a developmental state points to the importance of not asking a mother to separate too early. In 1993 Raphael-Leff wrote that when a mother’s problems are related to interaction with her baby, or when she is reluctant to separate or does not have the facilities to do so, it is the therapist’s responsibility to make suitable provision. Since then a number of analysts have supported a mother’s wish to bring her baby to sessions, prioritising a psychic space for her to explore the many meanings that her baby has for her (Anderson 1995; Balsam 2000; Zeavin 2012). An analyst who was in analysis as a candidate with Esther
Bick [who pioneered psychoanalytic infant observation, (1964)] did not take her baby to her own analytic sessions, responding to an unspoken taboo, yet found it completely natural a number of years later for a patient of hers to bring her baby to sessions. This modified view of the frame points to a shift in intergenerational patterns among analysts.

Parsons (2007) suggests that when an analyst has developed an internal analytic framework, whatever happens in the external setting including the presence of a baby can still be considered in symbolic terms (He notes that some French analysts do not permit bringing the baby, viewing this as an interference with exploring the patient’s fantasies about the baby). There has been, in the clinical infant mental health field, a move towards viewing the baby as a subject in his or her own right, away from viewing a baby as representing only the mother’s unconscious (Paul 2008), which might be considered at times as the analyst colluding with a mother obliterating the baby from her mind.

How a patient broaches the issue with her analyst varies considerably. She may when pregnant raise the question of bringing her baby or she may arrive with her baby citing babysitter difficulties. How frequently she brings her baby varies considerably. Some mothers never do, some once, some bring their baby every session, some may bring a second baby only once every four sessions and use that session differently. Zalusky Blum (2012) found that it was rare for a patient who is a new parent (female or male), to not bring their baby at least once for her to meet. There are practical issues to be negotiated for analyst and patient: where the patient places her baby, such as beside the couch, or on her body - and how to conduct the session so that the analytic process can continue if, for example, she moves off the couch to a chair or the floor. Or a mother may make an unusual request which necessitates the analyst’s clinical judgment. The patient of an analytic candidate, for example, asked on resuming sessions after her baby’s birth if the first session could be in the nearby park, perhaps out of a fantasy that the office might contain germs (Imber 2010). The analyst judging that this patient who was vulnerable to depression needed this, agreed to meet her there and spent the session time talking about the baby and the patient’s adjustment to motherhood. She felt that this more ‘elastic’ frame allowed the patient to ‘almost concretely play out the good grandmother transference’ (p.508), and identify with a new maternal object which, in the light of her history, she needed in order to support her move into motherhood. The analyst felt that to interpret the negative transference of herself as a bad, envious mother might have destabilized the patient and only subsequently, when the patient did not succumb to depression, did she interpret it.

If an analyst approaches a mother’s wish to bring her baby with a stance of exploring the meaning of the wish, the frame can hold even with the analyst being seen at times as a new object in a real relationship as they negotiate situations which bring them face-to-face more than previously. The variation of the frame may not only allow the analytic process to continue but may facilitate outcomes that might otherwise be harder to achieve, so that bringing the baby is seen less as an attack on the analysis and more as a developmentally appropriate stage.

**Transferral Aspects of a Mother Sharing Her Session**

The reasons why a baby accompanies the mother to analysis and how long he or she is brought stem from the meaning(s) of the baby for the mother, and whom the analyst represents for her. They range from developmentally appropriate wishes such as her pride and wish for admiration to unconscionable ones such as the desire to integrate and/or mourn the internal maternal object.

Several psychoanalysts concur in viewing the early transference as mainly that of a benign and protective grandmother or idealised mother (Balsam 2000; Raphael-Leff 1993). A mother bringing her baby with her, while at times a resistance, may help to connect her back to her analysis. Raphael-Leff has suggested that bringing a baby ‘may serve a healthy function (for the mother), sharing her pride or sorrows, showing the therapist what she produced, asking for help with difficulties, gratified by ‘grandparental’ admiration, seeking experience of a rejected baby or aspect of her own baby self’ (1993, p.185). The analyst may become involved in working out practical management issues in the session as if in the place of a helpful person, predisposing to a transference to a ‘good’ mother. With pregnancy and birth being times of significant psychosocial change for women, patients may unconsciously choose an analyst who is open to being flexible about this.

A main early reason a mother brings her baby to analysis is her developmentally appropriate pride and wish to share admiration of her baby, and to show her competence. Aspects of the good (grand) father transference might also be relevant. The pace of the work I have found is slower as the ‘sheer (appropriate) vitality’ (Balsam 2000, p.470) of the mother’s experience of her baby may delay the exploration of projections and ambivalence. If a mother’s need to get to know her baby through her reverie (Bion 1963) is accepted, following her lead seems an appropriate analytic stance at this time. There are links with Winnicott’s (1956) view that primary maternal preoccupation would, if not for pregnancy, be regarded as an illness. Breast-feeding mothers usually seem less interested in self reflection, not wanting to distance themselves from their
baby, and the time to start working in the transference may appropriately be later (Balsam 2000).

The analyst’s face and gaze may become more important at this time, a reflection of the significance of a mother’s face for her baby, as Wright (1991) highlighted. Some patients are described as needing to experience the analyst’s full face-to-face attention to their distress and sense of depletion before they can begin to be open emotionally to their baby. In identifying with their analyst’s empathy, they become more able to ‘read’ their baby’s cues, and feel satisfaction in the relationship. For many women having their first baby, who do not have mothers who are available externally or internally particularly those who have lost their mother through death or feel her to be unavailable, the responsive presence of an analyst usually facilitates mourning the loss of the internal maternal object (Hollman 2003).

Deeply unconscious wishes include the wish to prevent profound regression and simultaneously the wish for previously unknown feelings to become known by the analyst. Friedman (1996) suggests this in a patient who ‘accidentally’ became pregnant in her first year of analysis and decided against an abortion. She was the daughter of Holocaust survivors, and had a childhood history of traumatic sexual abuse with severe parental neglect. Two weeks after a caesarean section she returned to analysis, unexpectedly bringing her son and she lay on the couch fully dressed, placing him gently on her breasts, quietly breast feeding and rocking him when needed. She could not verbalize much about her inner experience, but it gradually became clear that this behaviour, which continued for several weeks, arose unconsciously to show her attunement with her baby whom she had felt during pregnancy to be conceived as an ‘analytic baby’ (p.485). But she struggled to breastfeed her crying, miserable baby who did not gain weight. Her analyst saw her bringing him as a plea for help and the patient’s capacity to be more maternal and accepting of her own infantile vulnerability increased slightly. A baby’s birth leads to developments in female sexuality; in Western cultures turning back more fully psychically to the partner may be felt as giving up some of the pleasure of breastfeeding, and mothers who bring their babies to analysis may want help with this.

Mrs A

Mrs A who had been in five times a week analysis took some time to return after the birth of her baby, bringing her much longed-for baby. Returning after some time was a protection for the baby, with the analyst seen in the transference at that time as the bad mother. Mrs A’s parents were overseas and felt to be unavailable physically and emotionally, her mother often seeming out-of-touch with reality. Mrs A said that she would have been crazy if I had told her to return to analysis within the first month. Initially in the countertransference it had felt as though I had to work in a narrow register, as the patient had also felt helplessly constrained, selecting minimal interventions in the field for their probable resonance with transference and unconscious affects and phantasies (Ferro 1999).

In sessions she spontaneously tried to keep what she considered to be an analytic stance when breastfeeding or playing with her baby by looking downward when speaking to me. The baby would swivel round quickly even when I spoke quietly; I was definitely a ‘third’ but not a negative one. In hoping to find happiness with her baby, Mrs A began unconsciously to hope, in the apparent absence of a good internal and external maternal object, that she would feel her delight mirrored in me. In time, there was a sense of my representing a benign safeguarding father in the couple, who could witness her growing independence and courage.

With my accepting her return to analysis in her own way, with the baby present, although the pace of the work was initially slower, Mrs A came to work at a deeper level in the analysis. As the baby became more involved in sessions, there was a greater see-sawing between transference and real relationship. Mrs A said, when I had been trying to respond to the 7-month-old baby only in ways that would have a resonance for Mrs A, that I had not responded enthusiastically enough. While I was considering how best to take up the transferential elements, the baby reached out to me, which Mrs A, while initially repudiating interpretation of her jealousy, seemed to resent slightly and the baby became transitorily more muted and avoided me with my lack of response. This could later be seen as the beginning of Mrs A’s approaching painful feelings of separation, when her baby would begin to leave her. There was an element of using me as the oedipal third coming between baby and mother to dilute what could be felt to become too close a relationship. Bringing the baby allowed this register to open more and helped Mrs A begin to face separation, seeing how her baby managed it for forward growth.

Some Countertransference Aspects

In attending closely to countertransference, of central importance in working through a mother’s profound anxieties when she brings her baby to analysis, it may have a clamorous internal voice as the analyst is also feeling their way how to ‘be’ in the presence of the dyad. As a backdrop to a re-invigorated oedipus complex in sessions, countertransference would in part be affected by where an analyst is in their lifecycle in
terms of gender, life history, parenthood and analytic experience. An analyst’s maturity and aging may be important in helping patients become the mother whom they hope to be (Abrevaya, pers. comm. 29.11.2009). A female analyst working with a patient who is a mother may experience different or more pressing transference/countertransference responses than a male analyst, may feel more critical in the maternal transference or may identify more (Nadelson et al. 2005).

A mother may unconsciously feel that bringing her baby to sessions would be the only way possible for her analyst to understand aspects of very early self-experience that are ‘beyond words’. Anderson (1995) recounted how despite feeling that the baby being present was contraindicated by both her Kleinian and ego-psychological trainings she decided to accede to three of her patients’ insistent requests. She describes how with one mother, her countertransference illuminated primitive issues such as feelings of being an ‘abandoner’, as well as of being impoverished, overwhelmed and paralysed. Her countertransference also revealed how endangered the mother’s two babies were, as though there was a deadened chasm between mother and her son, and when he came ‘alive’ he felt like a baby who tyrannically destroyed the space of his mother and her analyst. It was particularly important that the second baby, a girl, was present: she was violently hated by her mother who felt that she was intrusive and demanding in a very intense and negative way. The analyst came to understand the deathly primitive anxieties that the mother was trying to know about and face; she also viewed it as prophylactic for the baby. Containing in the countertransference was what led to greater therapeutic change, Anderson thought, than interpretation would have done (Lax 2003).

More importantly than ameliorating separation anxiety, Mrs A was searching in the analysis for how to integrate what were felt to be parts of the self that had been closed off and not known about and therefore felt to be mad as they threatened the self with disintegration during integration of experiences of separation anxiety and anger around the beloved mother who then had to be distanced from, as well as an unavailable father. A few months after the incident described above, Mrs A recounted that a male colleague had unprofessionally criticised another colleague. She brought a dream that I had conducted a session not only for her and her baby but I had also included her husband. In telling this, she sounded anxiously puzzled that I had done something not quite right. I interpreted her anxiety that in my having agreed that she could bring her baby to analysis I was breaking boundaries. There had been previous hints in the material that she was anxious that I had a mad mind that leaked stuff, and she had had a dream of carelessly feeding her baby bad food. She could now begin to face her anxiety that by permitting the baby to come I was mad, that my mind was “contaminated” and my madness would leak out and contaminate her and her baby. She could bring her anxiety about whether I would be able to contain what she felt were mad parts of herself, so that they would not overwhelm her baby, as she had felt overwhelmed and fed bad stuff as a baby. As we pieced this together she could reconnect much more to the devotedly loved mother of infancy who had been lost.

A baby’s crying in sessions may evoke a countertransference response so that the analyst comes to feel and know the mother’s irritability (Anderson 1995). When Mrs A’s baby investigated my office this exerted a pull to cope, not unlike a mother feels with a high-needs child, making it challenging to hold on to understanding symbolically this as the mother investigating the analyst’s body. In the countertransference the feeling continued that the infant should not be there and gradually what was evoked were feelings that Mrs A’s time in sessions was crowded. But I also had a concern that limiting some of the infant’s exploration for practical reasons could become a negative experience, resonating in the transference the mother’s experience as an infant but possibly bringing this into the transference in a new way. It seemed important to follow her timing despite feeling through projective identification that she was at times lost sight of by her analyst. As this was processed in the countertransference what emerged was that Mrs A was at the same time unconsciously beginning to explore feelings about having another baby. When Mrs A was at times aware of the loss for herself in not reclaiming her sessions, this confronted me with whether to not interpret more vigorously this as collusion. Bringing the baby to sessions to be known through the countertransference seemed to be the only way Mrs A could bring these aspects of self-experience that were ‘beyond words’, to begin to be known about.

Provided that a baby’s presence does not increase a mother’s idealisations and those of the analyst, and while the pressures that a baby exerts may lead to countertransference responses which may be used defensively, the attempt to understand these can deepen the analysis; potential countertransference enactments may be worked through, with the possibility for the analyst to confront the negative in themselves simultaneously with an important opportunity to explore destructive, frightening aspects of the patient’s experience (Zevin 2011, 2012).

The Baby’s Experience

I am not aware of an account of an analyst who regretted having a baby present in sessions: a number privately say that they enjoy it. Swinging the lens to consider the baby’s perspective raises a number of questions. When a baby is present,
it becomes a 3-person process as even a tiny baby will reach out to an analyst, so does an analyst need to consider how to not reject the baby’s overtures? How much does a baby understand of what mother and analyst are talking about, and how much does the baby have to be shielded (perhaps slowing down the process)? Do the gains for the mother-baby dyad outweigh any distress for the baby? Should one think in terms of an analytic triad? In an analyst’s response to a mother and her baby girl or boy, which countertransference is privileged? [Stuart (2012) raises further questions] Even if an analyst tries not to initiate interaction, the baby does not know the ‘rules’, as when a 4-month-old baby spontaneously held out her arms to the analyst when her mother returned to her sessions, recognising his voice from in utero (Christie, pers. comm.). The response of Mrs A’s baby swivelling round to me suggests that an infant transference existed, which while not working with it, one would need to be mindful of it.

The therapeutic results for mother and the dyad’s relationship can be striking, particularly for a mother in the extent to which there is positive change. Having the baby present seems likely to have a preventive aspect, as with a mother who had not brought to sessions her two older boy babies who had feeding difficulties; the third baby who came to sessions did not have feeding difficulties as though the mother in having her present had been able to think more reflectively (Elton, pers. comm.). Nevertheless, a baby may at times in sessions become distressed, experiencing feelings which the mother finds indigestible and cannot experience: the baby carrying them for the mother may enable her to become aware of them (Safier 2000). Van Buren (2007) described working with a baby, Anika, who had accompanied her mother to analysis since her birth. Van Buren thought that when Anika was 2.5 months old, she carried her mother’s feelings of nameless dread and in initiating interactions with Van Buren she wanted help with some contradictions that she experienced in her relationship with her mother. To attend to the distress that a baby carries for and in response to the mother would be an ethical stance on the analyst’s part.

**When the Baby Stops Attending Sessions**

Many mothers cease bringing their baby within the first year, which would seem to be when mothers feel that their need for understanding or attunement (Stern 1985) has been met. When patients who initially want their analyst to see and share their baby, feel driven to bring jealous, infantile aspects under the sway of the regressive aspects of the analytic process, they no longer wish to share their analyst with their baby. When a mother has extreme difficulties around separation the baby may come to sessions as these issues are worked through. Mrs A’s baby’s departure from the analysis was protracted, mirroring her difficulties with separation but allowing her to process and integrate fearful phantasies as the infant had developed so well. One analyst found that once his patient’s son started to look directly at him from the couch, the mother’s competitive feelings were aroused and she immediately arranged for him to be cared for during sessions. If a mother gives birth to a second child while in analysis attendance with this baby may be more varied. Some male analysts describe telling their patients that when the baby is a year old it is no longer appropriate for the baby to attend sessions: when an older infant would look upwards from his mother’s chest into the analyst’s face, he described feeling that this had become a distortion of the analysis and his mother should be discouraged from bringing him.

**Return after termination of analysis**

A mother may request after her analysis has terminated to return for sessions with her baby to both show off the baby and seek help, while being ambivalent about exploring the need for therapeutic input. For one young mother, to bring her 5-month-old son once to a session was particularly important: she had in analysis worked through her sadness that she had felt that her own mother could not allow her gaze to rest on her as a child, and she brought her baby so that I could ‘see’ him as she had felt ‘seen’ in her analysis. Another patient previously in analysis for eating difficulties returned with her first baby whose cues she had found hard to read and to whom she did not feel bonded; her second baby with whom she felt more confident only accompanied her briefly.

**Concluding Discussion**

Bringing a baby to analytic sessions is a clinically and theoretically important topic and the analytic potential of a baby’s presence is often considerable. Acceding to a mother’s wish to bring her baby can bring rich material - analysts who have worked with the baby present concur that this provides considerable transference/countertransference material (Anderson 1995; Friedman 1996) and the early gains for a mother in bringing her baby are often clear. While a baby’s presence may initially appear to counteract the depth of analytic work, a mother who is aware at some level of her need for help, as with Friedman’s patient, may be more ready to explore her inner world. Having the baby present may function as a kind of transitional space as when in sessions, a baby boy lay on the couch in a reverie beside his mother, stroking her long hair as if it was a transitional object and he was a transitional object for her (Glickfeld, pers. comm). In the mother-baby inter-
action the analyst can see how unconscious material is acted out or split off, and combined with dream analysis this enriches interpretations and helps the mother link perceptions of her relationship with her baby with inner states of hostility (Trad 1991). A baby’s cries could, for example, be a channel for a depressed mother to express her hate and aggression (Zachary 1985).

Viewing motherhood as a fundamentally new developmental stage would mean that rather than interpretation of primitive fantasy being privileged, motherhood issues around identity and mothering a tiny dependent baby with the deep anxieties and primitive feelings that this arouses in the transference and countertransference could also be worked with. A patient with considerable conflicts around dependency and separation anxiety usually reworks these with the birth of a baby; working through them with the baby present may take on a heightened valence in that how the baby manages micro separations from the mother can be explored in analysis. When an analyst ‘recognises’ a baby as a person in the mother’s presence, this can function as a re-presentation and may help the mother feel that she has not damaged her baby who is at one level hated because she does not feel herself to be a good enough mother (Paul 2008). Seeing her baby differently may aid the development of her reflective thinking (Fonagy and Target 1997). When appropriate, material about a baby as standing for the mother’s internal baby needs to be interpreted as well as her competitiveness, envy and death wishes toward her ‘real’ baby. But, with the shift in theory towards object relations, the mother-baby dyad and a focus on the infantile transference, it may be questioned whether the ‘inner’ baby has sometimes been interpreted at the expense of the ‘real’ baby.

The baby being present may facilitate the ‘ghosts’ becoming almost a lived experience for mother and analyst heightening a sense of conviction in the working through. This can aid integration when there is an unstable oscillation in the transference between the idealised mother and feelings about a toxic mother, which while mainly split off, may reappear infused with paranoid feelings. A mother with issues around male imposition of power may be very anxious about having a male baby and the baby’s presence in sessions may facilitate working through some of these difficulties. Some patients with a profound need to have unbearable states of mind contained (Bion 1962) may unconsciously feel that the only way they can have an early experience understood is to conceive a baby to take to sessions so that the analyst could know and understand something that had been unable to be represented (Anderson 1995).

The literature about the baby’s presence in sessions is almost entirely by female analysts and seems mostly positive about the effects of doing so. Hints of gendered perspectives issues emerge in clinical discussion in a relative resistance on the part of some male analysts to the baby being present. One stated that it was a perversion of the process to continue longer than a year, but equally, another male analyst advocated that a mother recommence analysis as soon as possible after birth and bring her newborn to facilitate defended-against infantile vulnerability coming into the analysis. It is, therefore, too early to comment further about these gender effects. Male and female analysts may evoke differently emphasised transference and countertransference reactions that bear on feelings of acceptance and safety when mothers bring their babies to analysis. Some patients feel that female analysts respond more contingently to regressive trends. These may be exacerbated by the comparisons a patient makes between her own and her female analyst’s body (that can give birth to and suckle a baby), which would resonate the comparisons that a girl makes with her mother, and may be inescapable in a female-female analytic dyad (Balsam 1996; Conte 2012). If a woman has been sexually abused in childhood it may be easier to bring her baby to sessions with a female than a male analyst. One patient, who had been sexually abused, brought her two baby girls to analysis for a short time but felt too jealous to bring her third baby, a son; not having at that point sufficiently worked through the experience of the abuse she felt too ambivalent about a male child having a good experience which she lacked.

What seems needed in clinical work and research from here onwards is further dissemination in the literature to increase the sharing of accounts around the topic of a mother bringing her baby to analytic sessions.

**Conflicts of Interest**

The author has no financial conflicts of interest.

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