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An Object Relations Approach to Therapeutic Work with Children in Clinical Settings

Dissertation submitted in partial fulfilment of the requirements for the Degree of Master in Clinical Social Work

by

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It has become my belief that the psychopathology of all disorders can be looked at from the vantage point of the success or failure to achieve bonding or attachment between the infant and its mother and that a more convenient paradigm for gauging normalcy and psychopathology is the nature of the interrelationship with the other rather than of the individual self.

J.S. Grotstein *

* J.S. Grotstein, 1983. Proposed revision of the psychoanalytic concept of primitive mental states, Part II, Contemporary Psychoanalysis, 19 : 570 – 604.

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ABSTRACT

The aim of this paper is to elucidate an object relations approach to therapeutic work with children. The study is conducted by means of a critical theoretical evaluation of psychoanalytic and object relations conceptualisations of the nature of the primary biological mother-child relationship; an in depth theoretical exploration of the mother's involvement in and contribution to both optimal and pathological development in the child, and of her role in the child's treatment. The theoretical exposition is supplemented by the presentation and examination of clinical material derived from a child treatment case in clinical practice.

Child treatment is located within an historical context; the role of parents in child treatment is addressed and divergencies in technical approaches to their inclusion in child treatment are reviewed. The nature of the primary biological mother-child relationship - its evolution, unconscious interrelational processes, optimal and pathological vicissitudes and its implications for child treatment - is explored. Simultaneous treatment of mother and child is offered for consideration, as an object relations approach which addresses the operation of both conscious and unconscious processes within the mother-child relationship, the vicissitudes of developmental disturbances and how these manifest in the therapeutic situation.

The conclusion drawn is that an in-depth understanding of the primary relationship and its unconscious processes is of crucial importance in the assessment, diagnosis and treatment of children and that in many instances the mother needs to be directly involved in the treatment endeavour. It is further concluded that ***simultaneous*** treatment of mother and child is valuable in highlighting points of interaction between the disturbances of mother and child, and facilitates an understanding of the unconscious meanings and associations held by the mother in connection with her child, as well as the ways in which her unconscious expectations are fulfilled by the symptomatic child.

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CHAPTER ONE: INTRODUCTION

The aim of this dissertation is to elucidate an object relations approach to therapeutic work with disturbed children. The study is informed throughout by the fundamental premises posited by classical psychoanalytic and object relations theory. The arguments developed are therefore presented from within the limited confines of these theoretical perspectives, and reflect the writer's psychoanalytic-object relations orientation. The study is approached by means of a critical theoretical evaluation of psychoanalytic and object relations conceptualisations of the primary biological mother-child relationship, and of the mother's involvement in and contribution to both optimal and pathological development in the child. This theoretical exposition is supplemented by the presentation and examination of clinical material derived from a mother-child treatment case in clinical practice.

Although it has been widely acknowledged that there is often more than one participant in the disturbance with which a child presents for treatment, and that the psychogenic origins of the disturbance may not reside with the child himself,[1] this has not always led to an examination of the question of how to take these factors into account in the therapeutic endeavour. Traditionally, classical psychoanalytically-oriented approaches have maintained as their hallmark the assumption that the focus of therapeutic action should be primarily with the child, while the parents have been relegated to some position more or less extraneous to the main therapeutic effort.

In contrast, in this paper precedence is given to the reality of the inevitable presence and involvement of parents in the lives and hence in the treatment of their children. Lack of parental involvement, support and co-operation during therapeutic treatment of the child - especially on the part of the mother - are viewed as the factors that most often bring about the demise of the child's treatment. Hence the nature of the early biological mother-child relationship, and how

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[1]For ease of reading, the writer will use the masculine 'he' when referring to the child subject, and 'she' when referring to the clinician, other than in instances in which direct quotes are used, in which case gender is retained as in the original.

this may be implicated as one of the most confounding features encountered in child treatment, is granted paramount importance in this paper and forms a cental focus of the discussion throughout. The writer offers for consideration an object relations approach as a possible means whereby this confounding feature may be understood and whereby parents may be drawn into the therapeutic effort in a way that furthers, rather than hinders, the child's treatment progress.

Although object relations theory is indelibly rooted in classical psychoanalytic theory, it is fundamentally a theory concerned with the dynamic ***interplay*** of unconscious internal object relations and current interpersonal experience (Ogden, 1983 : 227). In its broadest sense, object relations theory refers to attempts within the psychoanalytic tradition to confront the potentially confounding observation that people live simultaneously in an external and internal world, and that the relationship between the two ranges from the most fluid intermingling to the most rigid separation. The term therefore designates theories, or aspects of theories, concerned with exploring the relationship between real, external people and internal images and residues of relations with them, and the significance of these residues for psychic functioning (Greenberg and Mitchell, 1983 : 11-12).

Hence, the individual psyche may be viewed as a system of internalised images of self and others. Of central import to this paper are the notions that these internalised images are initially formed in the infant's primary relationship with the mother, and that the child's mother remains the most powerful shaper of the internalised object relations of her child - ***even though these images are influenced and altered by relations with other persons***(cf Joffe, 1989).

Central to the argument developed in this paper is the writer's belief that therapeutic work with children requires an in-depth understanding of the mother-child relationship and of the ***interplay*** between phenomena in the intra-psychic sphere, and phenomena in the sphere of external reality and interpersonal relations. The writer postulates an object relations treatment approach, informed by object-relations theory, which as a "non-linear, circular, interactional theory" (Slipp, 1984 : 41) provides the bridge which connects the intra-psychic and interpersonal spheres.

Specifically, the paper addresses the question of how to understand and manage the mother's often intrusive involvement in the child's treatment and offers for consideration simultaneous treatment of mother and child as an alternative approach to the classical stance of individual treatment of the child.

As object relations theory is firmly rooted in psychoanalytic theory, classical theory is taken as the point of departure in this paper. Chapter two demonstrates how, as a result of the pioneering work of Sigmund Freud towards the end of the 19th Century, individual treatment of emotionally disturbed adults began (cf Freud 1893, 1895, 1900, 1901, 1905, 1916). Treatment of disturbed children emerged out of the principles of adult analytic work and thus also traditionally focused on the individual child (Glenn, 1978; Marks-Mishne, 1983). A brief overview of the development of child psychoanalysis and child psychotherapy is then presented in order to locate therapeutic work with disturbed children within an historical context. In the course of exploring the literature on child treatment, the central dilemma of the role of the parents in the treatment of children emerges. The divergencies in technical approaches to the question of parents is discussed and it is shown that despite the different approaches utilised, parents (particularly the mother) remained a most confounding problem in child treatment.

The literature on treatment approaches frequently alludes to the universal existence of a seemingly unique bond between mother and child, and this the writer considers to be of considerable import to the central thrust of this paper. The nature of this mother-infant relationship, and its nuances, is explored in chapter three by means of presentation and evaluation of the more influential psychoanalytic and object relations theorists, inter alia Freud (1920 - 1938); Klein (1930 - 1959); Michael Balint (1937, 1968); Alice Balint (1939); Benedek (1938 - 1960); Fairbairn (1952); Bowlby (1940 -1988); Winnicott (1945 - 1962) and Mahler (1974, 1975). These theoretical perspectives appear to provide substantiation for the existence of a unique emotional bond between mother and infant that develops as the result of the many daily interactions which occur between them during the early weeks and months. It is shown that disruptions in this early bond are potentially pathogenic, and may impede the child's emotional

development. The nature of the child's tie to the father, to siblings and to the family group are also briefly alluded to.

The writer then argues that in addition to the ***conscious*** interactions that occur between mother and infant, there are also in existence ***unconscious*** interactions. Chapter four is specifically concerned with these unconscious aspects of the primary mother-infant/child relationship and with the operation of processes such as projection, introjection, identification, projective identification and internalisation within the mother-child relationship - how these affect the mother's functioning and facilitate or hinder the emotional development of the infant. It is argued that it is important for clinicians to explore not only the nature of the 'conscious' mother-child relationship, but that a central consideration should be to evaluate the persistence of unconscious interconnections of a primitive nature between mother and child that may be impeding the child's optimal functioning.

The writer hopes, in the course of the in-depth exploration of both the nature of the child's tie to the mother, and of the unconscious links between mother and child, to demonstrate the central importance which these have in the treatment of disturbed children. It is asserted that parents, especially mothers, have remained one of the most confounding factors in child treatment precisely because clinicians have failed to accord crucial importance to the primary relationship, and have failed to evaluate the residues of primitive ties between mother and child.

The writer stresses that it is necessary to evaluate the history of the development of the infant. This history begins with the weaving of an intersubjective mother-infant context; in some instances this context becomes the background support on which a new psychological life takes shape. In other circumstances, this intersubjective context becomes a web that entangles the child and impedes his development towards becoming a separate psychological being. In such instances the writer advocates, as an alternative to traditional individual treatment, simultaneous treatment of mother and child. The literature pertaining to simultaneous treatment which is reviewed in chapter five demonstrates, by means of the case examples presented, the operation

of the conscious and unconscious intersubjective developmental processes within the mother-child relationship, the vicissitudes of such developmental disturbances, and how these manifest in the clinical situation.

Chapter six constitutes a clinical case illustration of a simultaneous treatment of a mother and child from clinical practice, the purpose of which is to illustrate the theoretical aspects addressed in this paper. Both the theoretical considerations and clinical material presented suggest that greater therapeutic involvement on the part of the mother is required in instances where the child has not moved away from an intersubjective entanglement with the mother and towards separation-individuation.

Final concluding comments and clinical implications are presented in chapter seven. Essentially, an in-depth understanding of the primary relationship and its unconscious processes is seen to be of crucial importance in the assessment, diagnosis and treatment of children. It is concluded that in instances in which primitive interconnections within the mother-child relationship persist, and impede psychological development of the child, the mother needs to be directly involved in the treatment endeavour. Simultaneous treatment of mother and child is shown to be valuable in highlighting points of interaction between the disturbances of mother and child and in faciltating an understanding of the unconscious meanings and associations held by the mother in connection with her child, as well as the ways in which her unconscious expectations are fulfilled by the symptomatic child.

CHAPTER TWO : CHILD PSYCHOANALYSIS AND CHILD PSYCHOTHERAPY IN CONTEXT

2.1. Introduction

In this chapter, therapeutic work with disturbed children is located within an historical context. The classical psychoanalytic orientation, pioneered by Sigmund Freud (1893, 1895, 1900, 1901, 1905, 1916) is taken as the point of departure and it is shown that many later developments in the treatment of children evolved from these early principles and techniques.

The work of early child psychoanalysts is briefly reviewed, and the development of child psychotherapy as a sub-speciality of child psychoanalysis is traced. In the course of the review, a central dilemma is seen to emerge: that of the role of the child's parents in treatment. Various ways in which parents have been included in the treatment process, as well as the difficulties inherent in different approaches to working with parents, are highlighted.

On the basis of the literature reviewed, it is suggested that the role played by parents in the child's treatment is likely to be crucial to the success or failure of the child's treatment.

2.2. Classical Psychoanalysis : The Influence of Sigmund Freud on Child Psychiatry

Psychoanalysis is, for all intents and purposes, the creation of one person: Sigmund Freud (Jones, 1953 - 1957). Freud developed psychoanalysis by working essentially alone for several years. By the time he was 'discovered', around 1900, and had acquired co-workers, he had evolved a fully-articulated (although not final) vision of the psychic development of the human mind (ibid, 311).

Freud's early ideas on development were arrived at mainly from his analytic work with adult patients: his theories were inferred from their recollections, dreams and reconstructions. Freud later turned to the direct observation of children in an attempt to

confirm and extend his initial findings. As early as 1908, he undertook the indirect individual treatment of five year old Hans, via Hans' father (Freud, 1908).

This was the first application of the technical principles of adult analysis to a child. Child psychoanalysis, as a therapeutic mode of intervention in treating childhood disturbances was soon to develop out of these early ideas and formulations. In addition, the many inferences and rudimentary ideas on early development, and parent-child relationships, which are scattered throughout Freud's writings, provided the impetus for others to explore the area and to enlarge upon Freud's ideas.

2.3. The Emergence of Child Analysis

Child analysis emerged in the early 1920's as part of the "widening scope of [adult] psychoanalysis" (A. Freud, 1966 : 49). Analytic therapy had been confined largely to neurotic young adults; from the 1920's onwards, other ages as well as other categories of disturbance were included in its field of application.

Child analysis was represented almost simultaneously by Hug-Hellmuth (1921) and after her by A. Freud (1926 -1928) in Vienna, and by Klein (1919, 1932) in Berlin. Other significant figures included Berta Bornstein (1935) in Berlin, Steff Bornstein (1935) in Prague and Alice Balint (1939) in Budapest (cf A. Freud, 1966 : 49).

Hug-Hellmuth (1921) was one of the first analysts to attempt to work directly with children, and who from early on stressed the need for techniques appropriate to children, such as the use of the child's play and drawings. Although she outlined differences between child and adult analytic work, she did not develop a specific child analytic technique; she did not undertake the analysis of children under six, and was of the opinion that a proper analysis according to psychoanalytic principles could only be carried out after the seventh or eighth year (cf Klein, 1979). In her classic paper of 1921, Hug-Hellmuth alludes to three of the most central dilemmas which have permeated child

psychiatry since its inception. Namely: the nature of the analyst's relationship to the child patient's parents; the relationship between the child's disturbance and parental management of the child; and the implication that it is often a parent, rather than a child, who is in need of treatment. She states : "If the parents themselves were analysed, in all probability fewer children would be in need of analysis" (p 305).

By the mid-1920's, Anna Freud had already begun what was to become her life-work : the psychoanalytic study of the developing child (cf A. Freud, 1922 - 1935, 1926, 1929, 1945, for an elaboration of her early ideas). Melanie Klein undertook her first child analysis in 1919, and after working with children for five and a half years in Berlin , she settled in London in 1926, and continued her work there. Klein's contributions to general psychoanalytic theory, and her development of the psychoanalytic play technique, stand out as monumental achievements (cf Pick and Segal, 1978; Klein 1921 - 1945; 1932; 1955a; 1961).

Differences in theoretical underpinnings and analytic technique between Anna Freud and Melanie Klein emerged early on and later evolved into two predominant analytic streams in Britain - the Viennese or Freudian, and the English or Kleinian schools - and into a life-long controversy between the two women (cf A. Freud, 1926, 1929, 1966; Klein, 1927, 1955a; and Rangell, 1984; for an elaboration of the controversy).

Throughout the early period of the 1920's and beyond, Anna Freud and Klein continued to treat children and to refine their ideas and techniques (cf A Freud, 1965, 1968, 1971; Klein, 1952, 1955a, 1961). Bick (1962 : 168) observed: "... progress [during the last 34 years] has been deeply and variously influenced by the work of Melanie Klein and Anna Freud ... the range of children felt suitable for treatment has been extended; play technique is now in general use; the importance of interpretations has been widely accepted".

Child psychoanalysis continued to grow in importance, as was evidenced by the increasing number of child analysis publications, which emerged in addition to the work of A. Freud and Klein (cf inter alia Bick, 1962; Berta Bornstein, 1935, 1945, 1948; Steff Bornstein, 1935; Sterba 1949).

Out of this period of progressive development in the field of child analysis, fundamental practice principles emerged. Four to five analytic hours per week were found to be necessary to promote an intense relationship between analyst and patient, and to maintain a continuous flow of analytic material. The child patient required substantial ego strengths to tolerate the anxiety aroused in uncovering conflictual material. In addition to speech, play, drawings and dreams were used as vehicles to facilitate treatment. The goal of child analysis was defined as an attempt "to undo the various repressions, distortions, displacements, condensations etc., which have been brought about by the neurotic defence mechanisms, until, with the active help of the child, the unconscious content of the material is laid bare" (A Freud, 1946 : 71). Together with these principles, there emerged an increasing controversy concerning the analyst's relationship to the child's parents, the role of parents in the child's treatment and their part in the child's difficulties (Szurek, 1944; 1950; 1952).

Largely due to the intense emotional demands, time and financial commitments involved, classical child analysis became the treatment of choice for only a relatively small number of children. It may, however, be viewed as the foundation from which other psychoanalytic approaches emerged and out of which child psychotherapy – which is briefly outlined below – developed.

2.4. The Development of Child Psychotherapy

From the 1920's to the mid-1940's, child psychoanalysis predominated in Britain, in major psychoanalytic centres in central Europe (such as Austria and Hungary) and in the United States, and was the exclusive domain of a relatively small group of child analysts.

After 1945, various forms of psychotherapy began to emerge : many approaches evolved as a modification of child analysis; most were time limited, focused play therapies; some involved direct environmental manipulation (Marks - Mishne, 1983; Sours in Glenn, 1978). Only psychoanalytically-oriented child psychotherapy will be briefly outlined below. The reader is referred to Adams (1974) and Haworth (1964), for fuller expositions of different child psychotherapy approaches.

Child psychoanalytic psychotherapy is derived from classical child psychoanalysis, but differs in terms of frequency (two to three sessions per week); in having more limited objectives viz. symptom resolution, behaviour modification, and some degree of personality change; as well as technical differences in that more focal exploration and interpretation with a greater emphasis on understanding current interactions and current inner conflicts is advocated. Interpretation is directed to themes reflected by the child's play activity; defences are interpreted; the child uses the therapist as an auxiliary ego, helping to modulate emotional responses (Marks-Mishne, 1983 : 175 - 180).

The objectives of child psychotherapy are based on comprehensive and accurate assessment and diagnostic procedures, which reveal the complexity, structure and genetic roots of the child's disturbance, as well as ego-strengths and levels of development (A. Freud, 1965, 1981; Marks-Mishne, 1983; Sours in Glenn, 1978). Insight-oriented psychotherapy (such as psychoanalytically-oriented psychotherapy), requires specific ego-strengths in a child similar to those required for more intensive analytic work.

Hence, child psychotherapy appears to be largely the result of an amalgam of psychoanalytic principles, and the influence of early leaders in Britain, several European centres (particularly Austria and Hungary) and in the United States, who concerned themselves with direct work with children (cf Allen, 1942; Axline, 1947; Taft, 1933; and Moustakis, 1959; amongst others). With greater utilisation of psychotherapy in treating

childhood disturbances, it became increasingly apparent that the parents of child patients had to be taken into account as part of the treatment process, and they were subsequently accorded greater attention.

2.5. The Role and Importance of Parents in the Treatment of Disturbed Children

While child psychoanalysis and child psychotherapy were evolving in Britain, Central Europe and the United States, a number of Child Guidance Clinics were established during the 1920's and 1930's in major centres in these countries. A team approach to assessment, diagnosis and treatment of the child's problems was employed. Initially, treatment consisted largely of recommendations to parents, advising on the management of particular symptoms or specific behaviours. Where the child was seen in individual therapy, contact between parents and the child's therapist was initially not encouraged (Szurek, 1944 : 119).

Gradually, as clinicians began to realise the importance of the parents in the child's difficulties, a new pattern of treatment emerged : weekly therapy sessions with the child, as well as regular case work with one or other parent. This constituted the standard approach until the 1950's, when an interest in the family as a group began to emerge (cf Bentovim, 1979). However, technical problems became obvious early on in the history of child treatment, and compelled clinicians to draw parents into the therapeutic endeavour as systematic reporters, as supervised therapists, as therapists and as simultaneous patients. A brief historical review of some of the main approaches which were utilised is presented below.

2.5.1. Inclusion of Parents in Child Treatment : Literature Review

The presence of parents in the treatment of children was often regarded as a necessary evil by clinicians. On the one hand, their co-operation was considered necessary, as their assistance was required in setting up and maintaining the practical arrangements of the treatment, and because they were regarded as useful informants by the clinicians.

On the other hand, clinicians repeatedly encountered the disruptive effects which parents created through their antagonism, ambivalence and unwillingness to co-operate, and hence regarded their inclusion in the treatment process with some trepidation (Glenn et al, in Glenn, 1978 : 392 ff).

As early as 1932, Burlingham drew attention to the difficulties posed by parents during child treatment: "The child's dependence upon his parents forces the analyst to keep parents in a favourable attitude towards the analysis .. [otherwise] ... analysis may be prematurely interrupted or terminated ..." (p 69). Burlingham draws attention to the various feelings which the mother, in particular, usually has on having to bring her child for treatment and that because of this gaining her co-operation is often difficult. In advocating contact between the child's analyst and parent, Burlingham is not unaware of the possible pitfalls of what she terms the "double transference situation" (p 92) ie. transferences of both parent and child onto the analyst, which may create difficulties in the treatment. Despite this limitation she regards gaining the mother's co-operation as essential if the child's treatment is to succeed.

Jacobs (1949) espouses an 'educational approach' - the general education of parents as a prophylactic measure. The therapist aims to provide the mother with greater knowledge of the child's developmental phases, and more appropriate or effective ways in which to manage the difficulties involved in each developmental phase. It was expected that the child would then respond to the more understanding approach adopted by the mother as a result of her attending the educational sessions.

Schwartz (1950) draws attention to the need for co-operation between analyst and the child's parents, and focuses specifically on the problem of the attitude of mothers of very young children towards the analyst. In agreement with Jacobs (1949) Schwartz suggests that the intimate relationship between the mother and a pre-latency child makes 'advisory work' with mothers successful, and preferable, to individual treatment of the child -

"which interferes so radically with the bond between mother and child" (Schwartz, 1950 : 344). In instances where advisory work does not suffice, Schwartz advocates that the mother attends treatment sessions ***with*** her child. In this indirect way, she gains 'analytic knowledge' to assist her in handling her child, via observing the analyst.

Bonnard (1950 : 391) discusses an approach in which the mother was used as a "therapeutic intermediary" between the therapist and the child. The child's problematic behaviour was related by the mother to the therapist, who interpreted it to her. Mother, in turn, re-interpreted the behaviour to her child, who then reacted and behaved more appropriately, following the interpretations.

From the literature reviewed thus far, it becomes apparent that between the 1930's and 1950, various treatment approaches were advocated, in which inclusion of the parent – usually the mother – in the child's treatment became increasingly common. The general rationale appeared to be one of attempting to assist the child via the parent. What was highlighted by the various modalities was that the relationship of the mother to the analyst or therapist remained a most difficult and crucial problem. Where the mother could not be positively engaged, the child's treatment and progress generally floundered.

In addition, it became increasingly apparent that frequently mothers themselves (and sometimes fathers) required treatment, as their own difficulties were found to affect the child's development, appeared to play a role in the child's difficulties, and to affect treatment progress. As this became more apparent, there was a move towards separating the mother out of the child's treatment, to be 'advised' by someone not personally concerned with the child's analysis. This, to some degree, also appeared to ameliorate the difficulties created by the 'double transference' and provided the opening for the mother to address her own issues.

In discussing treatment of the mother, Burlingham (1951) raises the important question of the different 'levels' to which treatment should be directed, viz conscious, pre-conscious or unconscious levels. In 'advisory' and 'educational' approaches, only conscious and pre-conscious material is addressed. Hence, where the conflicts are of a deeper nature, such approaches will be largely ineffective. In contrast, when unconscious conflicts are raised to consciousness and worked through, the mother is 'freed' and enabled to deal differently with her child – on the basis of a beneficial change in her ***own*** personality.

Furman (1957 : 252) presents a variation of Jacobs' (1949) 'educational approach', and Schwartz's (1950) 'advisory approach', which she terms 'mother guidance'. She demonstrates the efficacy of such an approach when utilised at a therapeutic nursery school, where therapist, mother and teaching staff all work together, to develop the most appropriate ways to manage the child. The expectation inherent in such an approach is that a mother of relative emotional health can use advice effectively. It presupposes that a close bond exists between the mother and a young child, which enables her to recognise the child's feelings, thoughts and defences, and with insights gained from the therapist, can help her child. The approach highlights the need for accurate assessment of both the child and the significant parent, and Furman (ibid; pp 254 – 261) stresses that case selection is of the utmost importance. Of particular note is her observation that it is often only possible to assess a mother's capacity for treatment ***after*** a period of working with her, and hence a fairly lengthy assessment period may be required, prior to treatment proper.

In later publications, Alpert (1967); Furman (1966, 1969); and Mody and Buchholz (1988) elaborate upon and address the indications and contraindications for therapeutic intervention via the mother. Also highlighted are the complexities of childhood disturbances; the inter-relationship between mother and child, and the need for detailed and accurate assessment procedures.

Chethik (1976 : 454 ff) advocates what he terms a 'middle-range intervention technique'- treatment of the parent-child relationship, which focuses on the interlocking struggle between the parent and child. Parents learn, through insight in therapy, that their inappropriate affective responses to their children are not reality based, but come from their own earlier childhood contexts. By recreating and reliving them within an historical context, it becomes possible to remove the child as the source of pathology.

Brinich (1984) suggests joint treatment of parent and child. Joint sessions in which mother and child are seen together were found to unveil the 'transference relationships' that were already alive and operative in the mother-child relationship, and precipitated a re-enactment of the unresolved parental past, in the present, with their children. (cf also Fraiberg et al, 1975, 1980).

This concludes the brief overview of the literature on the inclusion and role of parents in the treatment of disturbed children. Despite the different approaches utilised, the inevitable presence and involvement of the parents (particularly the mother) nevertheless remained one of the confounding factors in child treatment as a result of their lack of co-operation and support for the treatment. In the 1950's an interest in the treatment of the family as a group began to emerge, and clinicians began to examine the role of family factors in the genesis of various psychiatric disorders of childhood.

2.5.2. Inclusion of the Family in Child Treatment

The work of Ackerman (1958) based on psychoanalytic concepts, provided the first systematic description of psychotherapy of the family as a group. Other approaches to family therapy evolved over the next decade, some remaining in the analytic tradition, and others offering new theorectical models (cf Haley, 1971; Minuchin, 1974). However, professionals working with children were slow to shift to these new treatment methods, and in many instances were vehemently opposed to consideration of family treatment (which involved both parents and/or siblings) in place of, or as an adjunct to, individual

treatment. For a further exposition on the development of family therapy and controversial views with respect to individual and family treatment, the reader is referred to Fouché (1985), Malone (1974, 1979), McDermott (1979), McDermott and Char (1974) and Strean (1967).

During the 1970's there was a move towards greater acceptance of the family as a legitimate focus of treatment when the child was the referred patient. This was in part due to the development of theoretical models about family life and psychopathology, which in turn led to the development of specific methods of intervention (cf also Barker, 1981; Bloch, 1978, Will and Wrate, 1985). In general, the family approach was used when the referred child patient presented with problems which were so clearly bound up with faulty family functioning that individual treatment was no longer considered appropriate. In many instances however, parents sabotaged the treatment process, or treatment failed to 'cure' the identified patient. Essentially, treatment of the family system – either prior to, simultaneous with or following the child's treatment – was a procedure considered somewhat reprehensible to orthodox child therapists; most remained, by persuasion and training, oriented to individual approaches.

2.6. Conclusion

In this chapter, therapeutic work with disturbed children was located within an historical context. An overview of the evolvement of child psychoanalysis and child psychotherapy out of the classical Freudian psychoanalytic tradition revealed the need to examine the development of various therapeutic approaches in which the inclusion of and role of parents in the treatment of the child, were addressed. The literature reviewed argued that for the child's treatment to be successful, some form of contact between therapist and parents needs to be maintained throughout the course of treatment. In many instances, parent–therapist contact of a ***general*** nature proved to be inadequate: one or both parents needed to be directly invovled in the treatment process. Where a parent

was found to have his or her own unresolved intrapsychic difficulties, individual treatment of the parent was indicated.

Much of the literature reviewed referred to the existence of a unique relationship between the young child and the mother – an interaction which is so intense it appears to be characterised by an unusual mutual closeness. It is this specific bond which seems to be implicated in both the normal and the disturbed developmental progression of the child, and which may account for the necessity to include the ***mother*** in the child's treatment, or to be in treatment herself. This observation suggests that not only is a comprehensive initial family assessment essential, but that a further assessment focusing specifically on the ***interrelationship*** between the disturbed child and the more emotionally significant parent – which is usually the mother – is required. Hence, the child's need for treatment, the potential of the more significant parent as an instrument in the treatment of the child, and this parent's possible need for individual treatment, all need to be established. It is the writer's opinion that such a process facilitates recognition and localisation of the child's problem, and ensures a greater possibility of therapeutic interventions being applied as close to the developmental level affected as possible.

On the basis of the observations revealed in the literature reviewed thus far, the area of primary relationships, that is, of the first relationship formed by the infant with another person in infancy, was shown to be of crucial importance and is therefore explored in greater depth in the following chapter.

CHAPTER THREE : PRIMARY RELATIONSHIPS : THE NATURE OF THE CHILD'S TIE TO THE MOTHER

3.1. Introduction

The literature reviewed in the previous chapter revealed the existence of a seemingly unique bond between parent, usually the mother, and child. On the basis of the literature reviewed, the writer tentatively asserted that this very early unique mother-child bond - its formation, development, and resolution - is of crucial importance in the understanding, assessment, diagnosis and treatment of disturbed children.

In an attempt to substantiate the above assertion, this chapter explores a number of different theoretical views on primary relationships. In keeping within the scope of this paper, only the work of the more influential psychoanalytic and object-relations theorists is presented, encompassing the ideas of Freud (1920 - 1938); Klein (1930 - 1959); Michael Balint (1937, 1968); Alice Balint (1939); Benedek (1938 - 1970); Fairbairn (1952); Bowlby (1940 - 1988); Winnicott (1945 - 1962) and Mahler (1974 - 1979). The ideas of these writers are not considered exhaustive. However, they do appear to provide powerful theoretical argument for the assertion that the primary mother-child relationship is of special importance, and crucial to the emotional development of the child.

The various views presented also appear to provide substantiation for the writer's suggestion that an in depth exploration of the primary mother-child relationship should be a key aspect of the assessment, diagnosis and intervention processes when treating childhood disturbances.

Considerations concerning the nature of the child's tie to the father, to siblings and to the family group are briefly introduced and targeted as areas for further exploration and debate.

3.2. Parent and Child : An Overview of Primary Relationships

The importance of the mother in the psychological development of the child has been a fundamental tenet of classical psychoanalysis, and has been further developed by ego psychologists (such as Anna Freud, 1965; Hartman, 1964; Spitz, 1965); the Kleinian and Winnicottian 'schools' or object-relations theorists, and Mahler et al (1975). An exploration of some of the most pertinent contributions concerning primary relationships is presented below, beginning with Freud.

3.2.1. The Ideas of Sigmund Freud

Perusal of Freud writings reveals that it was only during the last phase of his work (around 1923-1933) that he began to appreciate the existence of a close tie between mother and child. Up to the 1920's, Freud held the view that there is but a brief period during which the infant finds satisfaction by attaching itself to the mother's breast. It then detaches itself, becomes independent, and at the same time, auto-erotic (cf also Greenberg and Mitchell, 1983 : 67 - 78). Although there are allusions at various points in Freud's early writings (1920, 1926) which suggest that the infant is not exclusively auto-erotic, and that the mother ***is*** important in the infant's early experiences, Freud generally seems to imply that the infant's needs of the mother are predominantly physiological, not psychological or socially-oriented.

By 1931 however, Freud appears to recognise a phase in which the mother is psychologically important to the infant and attributes it some significance. He states:-

> "Everything in the sphere of this first [pre-Oedipal] attachment to the mother seemed to me so difficult to grasp ... so grey with age and shadowy and almost impossible to revivify ... two facts have struck me as new: that a woman's strong dependence on her father merely takes over the heritage of an equally strong attachment to her mother and that this earlier phase has lasted for an unexpectedly long period of time..." (p 373).

Having acknowledged the existence of this early tie between child and mother, Freud does not then attempt to provide an account of ***how*** this relationship develops. In what seems to be a final synthesis of his ideas on the subject, he wrote the following:-

> "... There is no doubt that to begin with, the child does not distinguish between the breast and its own body ... This first object is later completed into the person of the child's mother, who not only nourishes it, but also looks after it ... By her care of the child's body, she [also] becomes its first seducer. ***In these two relations lie the root of a mother's importance, unique, without parallel, established unilaterally for a whole lifetime as the first and strongest love object, and as the prototype of all later love relations ...***"(1938 : 423; emphasis added).

Hence, it appears that towards the end of his life, Freud was imbued with an appreciation of the central importance of the mother – child tie. He did not, however, leave a fully articulated vision of primary object relations, and it was left to his followers to build upon the framework which he had sketched. Klein's ideas, in many ways an extension of Freud's, provide innovative, broadened insights into the earliest experiences of the infant.

3.2.2. Melanie Klein

Klein's early thoughts on primary relationships appear in 1930, in a paper in which she asserts that symbolism comes to be the foundation of all phantasy and sublimation and is the basis of the child's relation to the external world: "The child's earliest reality is wholly phantastic" (p 221). She has little to say, at this stage, about an actual, real relationship between the child and the mother. A further detailed account of development appeared in 1932; her final exposition of early development is found in two papers, written in 1952 (cf Klein, 1952a and 1952b).

According to Klein (1952a : 61 – 93) the infant's experiences immediately following birth are those of pain and discomfort and loss of the intra-uterine environment. The infant's primary relationship during the first three to four months (the paranoid-schizoid position) is seen by Klein to be primarily with the mother's breast, ie. with a part-object. The relation to her as a ***person*** is only gradually built up, particularly from four to six months during the depressive position, when many changes in the infant's cognitive and emotional development occur. Klein (1952a : 72) notes:- "All these developments are reflected in the infant's relation to his mother ... The relation to the mother as a person,

which has been gradually developing while the breast still figured as the main object, becomes more fully established, and the identification of her gains in strength". However, although Klein does appear to recognise the existence of an especially close bond between the young child and the mother, the child's attachment to the mother as a whole person is never fully articulated by her. Her ideas on this early period were largely dominated by the themes of food, orality, and the mother's breast (cf also Bowlby, 1958 : 350 – 373, and Winnicott, 1962 : 177 in substantiation of this contention).

Klein appears to have assumed all the basic elements in her theory to be 'in place' at birth, leaving little need to assign much importance to the ***actual*** experiences of the infant in interrelationship with the mother and the environment. In Klein's schema, ***real*** experiences and real people simply modify innate processes rather than determine or generate them. Although Klein's later papers (for example 1959) do appear to reflect a shift from the constitutional/internal to the environmental/external, and greater influence is attributed to the role of the actual parents in shaping development, she remained to the end more interested in the workings of the child's internal world (cf also Burch, 1988; Greenberg and Mitchell, 1983; Pick in Glenn, 1978).

Despite these limitations however, Klein's ideas on early development provided for others an entrée into the complexities of the hitherto relatively unexplored area of the infant's experiences in the first few months of life, and their significance in the development of primary relationships. Perhaps somewhat more explicit than Klein about the actual emotional bond between mother and child are members of the Hungarian or Budapest School.

3.2.3. <u>The Hungarian School</u> : <u>Alice and Michael Balint, and Therése Benedek</u>

Adherents to the Hungarian School postulate an early, intense, intimate relationship between mother and child which is, initially, a continuation of the state of 'oneness' which exists between mother and child during pregnancy. Instinctual interdependence between

mother and child is seen to be the biological basis of an unavoidable and necessary phase of primary or primitive object-love which occurs very early in life and to which all later object-relations can be traced (M. Balint, 1937 : 74 - 90).

A. Balint (1939 : 95) sees pregnancy , giving birth, suckling and fondling as instinctual urges to a woman - "maternal love" - which she satisfies with the help of her baby. In turn, the infant's "archaic egoistic way of living" is originally directed exclusively to the mother. Just as the child does not recognise the separate identity of the mother, so the mother looks upon her child as part of herself: "The relationship between mother and child is built upon the interdependence of the reciprocal instinctual aims ... Maternal love is the almost perfect counterpart to the [child's] love for the mother" (p 101). From this early, archaic, mutually egoistic mother-child relationship, this primary phase lacking any sense of reality, the child is faced with the task of adapting to reality.

Michael Balint (1968 : 64 - 72) in an elaboration of his and Alice Balint's early ideas, postulates a theory of "primary love". He suggests that the foetus' dependence on its environment (mother) is extreme. The foetal environment is undifferentiated, unstructured: the environment-mother and foetus penetrate into each other - foetus, amniotic fluid and placenta exist together in a "harmonious, interpenetrating mix-up" (p 66). By implication, therefore, the infant is ***born*** in a state of intense relatedness to its environment-mother. However, birth is a trauma that upsets the equilibrium by changing the environment radically and by enforcing a new form of adaption. Objects begin to emerge out of the harmonious mix-up, and out of this is formed the primary relationship between infant and mother. This primary love relationship represents the first and most basic form of object relations and underlies all others.

In a series of papers Benedek (1938, 1949, 1956, 1959, 1960, 1970a, 1970b) presents her ideas on the primary unit of mother and child and the existence of what she terms 'emotional symbiosis' between mother and child. Benedek (1949; 642 - 654) suggests

that it is the biological unpreparedness of the infant to maintain his life separately that is the source of the infant's prolonged absolute dependence on the mother and which facilitates the mother-infant symbiosis. This symbiosis exists throughout pregnancy, and although interrupted at birth, remains a functioning force directing and motivating the emotional and physiological interaction between mother and child throughout early development.

> "The physiologic and mental apparatus of the infant represents a system which communicates broadly and fluently with the system of the mother, - with all aspects of the mother's personality... Through the process of identification with the mother, the infant develops from the undifferentiated state of the newborn to an individual with structuralised mental apparatus which is in control of psychic and somatic processes" (Benedek, 1949 : 653).

Clearly, the Hungarian School recognises the existence of an intense early bond between mother and child. In contrast to Freud and Klein, this bond is accorded interrelational and reciprocal qualities by the Balints' and Benedek. That is, both mother and child together are seen to contribute to its development by interacting with one another. This 'interrelational view' is further espoused by Fairbairn.

3.2.4. W.R.D. Fairbairn

In a vein similar to that of the Hungarian School, Fairbairn (1952) depicts the infant's psychological state in the earliest weeks and months of life as a perpetuation of that which exists prior to birth. That is, a state of primary identification, "of total merger with the mother, which precludes his entertaining any thought of differentiation from the maternal body which constitutes his whole environment and the whole world of his experience" (p 34).

The inclination to merge with the mother derives from the infant's total helplessness and dependency. His survival is contingent upon the mother's presence and care, and he experiences himself either at one with her, or striving to be at one with her. This implies that the infant is intensely involved with others from the earliest days of existence. The

crucial feature of these infantile relations with objects is the lack of differentiation from them. Ego structuralisation is gradually established during this early relationship with the mother and underlies all further emotional development.

Where the natural, maturational sequence of emotional development is disturbed, internal fragmentation may result and the child then has difficulty moving on to the 'transitional phase' (p 34) which entails a renunciation of compulsive attachments to objects in favour of differentiation. The achievement of a state of 'mature dependence', in which the self can be experienced as fully differentiated and separate from other, signifies (for Fairbairn) the core of healthy development and is based on the healthy resolution of the primary relationship.

3.2.5. John Bowlby

Bowlby's work (1940, 1958, 1969, 1973, 1988) is almost exclusively concerned with the behaviours and experiences constituting the child's attachment to the mother. Essentially, Bowlby's theory of primary attachment implies that the child's psychological attachment and detachment are to be regarded in their own right, apart altogether from the extent to which the child appears at any one moment to be dependent on the mother for meeting his physiological needs. The mother is ***emotionally*** important from the beginning. Environmental factors (including the mother's care) as well as hereditary/constitutional factors, ***together*** are seen to contribute to emotional development.

Attachment behaviour is seen to be comprised of instinctual responses (sucking, clinging, following, crying and smiling) which mature during the first few months of life. Together, they function to bind the child to the mother, and contribute to the reciprocal binding of the mother to the child. In the course of development, these responses become integrated and focused on a single mother figure, to form the basis of attachment behaviour maintaining the child in proximity to mother (Bowlby, 1958, 1969). Bowlby's

thesis of the child's early relationship to the mother is interactional as well as instinctual. That is, the ***reciprocal*** pattern which develops between mother and child can be understood as the result of the contributions of each: each influences the behaviour of the other.

Bowlby's theory of primary attachment suggests that the tendency to make intimate emotional bonds to particular individuals is a basic component of human nature, already present in germinal form in the neonate. Initially communication between infant and mother is through emotional expression. Although later supplemented by speech, emotionally-mediated communication remains a principal feature of intimate relationships throughout life. The capacity to make intimate emotional bonds, based on the infant's primary attachment to a mother-figure, is a principal feature of effective functioning and mental health.

Like Bowlby, Winnicott considers the primary mother-child relationship to be crucially important for emotional development.

3.2.6. D.W. Winnicott

Winnicott (1945 : 145 - 156) postulates an initial state of 'primary unintegration' in the infant: a psychic state which is normal at the stage of primitive emotional development of the early months. Several developmental processes need to be negotiated by the infant during the early months; negotiation is, according to Winnicott, facilitated by both the 'technique' of infant care by the mother, as well as instinctual experiences.

During the early weeks and months, the mother is helped to co-exist with the infant's state of 'primary unintegration', 'primitive ruthlessness' and total dependency on her by being in a state "primary maternal pre-occupation" (Winnicott, 1956 : 300 - 305). This 'condition' develops gradually throughout pregnancy, to a state of heightened sensitivity, especially towards the end of pregnancy, and lasts for a few weeks after the birth of the

child. Being sensitised in this way, the mother can feel herself into the infant's place, and so meet the infant's needs, and become an 'ordinary devoted mother' (Winnicott, 1949). Gradually, the ego-supportive environment (mother) is introjected, and built into the child's personality, and there comes about the 'capacity to be alone' (Winnicott, 1958).

Hence, in Winnicottian terms, the infant and maternal care ***together*** form an inseparable unit: at the earliest stages, infant and maternal care belong to each other, and cannot be disentangled. One half of Winnicott's theory of the parent-infant relationship concerns the infant : the theory of the infant's journey from absolute dependence, through relative dependence, to independence. The other half concerns maternal care: the qualities and changes in the mother, moving from primary maternal pre-occupation through to the ordinary devoted mother, who provides good-enough mothering: "*... **the inherited potential of the infant cannot become an infant unless linked to*** [satisfactory] ***maternal care***" (Winnicott, 1960 : 43; emphasis in the original).

Although couched in different terminology, the ideas of Mahler largely dovetail with those of Winnicott.

3.2.7. Margaret Mahler

The separation-individuation theory of development posited by Mahler (1974, 1975, 1976, 1979a and 1979b) details a complex, intra-psychic developmental sequence, beginning with physical birth and continuing towards psychological birth - an ongoing process. The sequence involves ***separation*** - the child's movement away from psychic fusion with the mother, and ***individuation*** - the steps that lead to the development of the child's personal and unique character.

According to Mahler (1976 : 7 ff) immediately following birth (0 - 2 months) the infant exists in a state of normal autism - "a twilight state ... of primitive, hallucinatory disorientation". It is an objectless period of absolute primary narcissism, marked by the

infant's unawareness of the mothering person and which is centred around attempts to achieve physical homeostasis. At about 3 – 4 weeks, through the mother's ministrations, the infant is gradually brought into sensory awareness and contact with the environment and then moves into a phase of symbiosis with the mother. During the symbiotic phase, infant and mother form a dual unity. Symbiosis is a state of "undifferentiated psychic fusion between mother and child" (ibid., 9) and is the basis from which all other relationships are formed. In this ***normal*** symbiotic phase, the infant believes and functions as though he and mother are one omnipotent system, a dual unity within one common boundary. The infant is absolutely dependent on the symbiotic partner (mother).

The separation–individuation process proper (which the infant enters at about 4 – 5 months, following the symbiotic phase) is divided into four subphases: differentiation, practising, rapprochement, and an open–ended subphase. In the course of negotiating these subphases, the child acquires the beginnings of the ability to retain an internal representation of significant persons and the beginning of a sense of self as separate from others. Favourable negotiation of the separation–individuation sequence leads to psychological birth. Space precludes further exposition of the separation–individuation process proper, and the reader is referred to Mahler's writings (1963, 1974, 1975, 1976, 1979a and 1979b), and Edward et al (1981), for a detailed elaboration and synthesis of this.

Mahler stresses throughout that both constitutional endowment and the intactness of the infant's innate ego apparatus are extremely influential in determining the developmental outcome of the sequence. In addition, she lays particular emphasis on the mother's reactions during all the separation–individuation phases, and her theory provides detailed insights into the primary mother–child relationship.

Mahler's views conclude the literature review on primary relationships. The ideas presented appear to provide substantial argument, based partly on observational and

clinical evidence, for the existence of a unique, intense and intimate emotional bond between mother and child during the first weeks and months of life. The writer is, however, aware that the theories presented are predominantly from a psychoanalytic and object-relations orientation, and can therefore by no means be considered exhaustive. For alternative expositions, the reader is referred to, inter alia: Ainsworth (1963, 1967, 1969); Anthony (1980a, 1980b); Burlingham and Freud (1942, 1944); Coleman et al (1953); Erikson (1950); Guntrip (1961); Hartman (1964); Kernberg (1976, 1980); Kohut (1971, 1977); Robertson (1965); Schaffer (1977); Spitz (1946, 1965 1970); Stern (1977, 1985); Sutherland (1980) and Wickes (1927).

Three further areas require introductory consideration: the nature of the child's tie to the father, to siblings and the family group.

3.3. The Nature of the Child's Tie to the Father

In the foregoing presentation of ideas on primary relationships, discussion centred on the bond between ***mother*** and child, with little mention of the existence of such a bond between ***father*** and child. The literature cited points to the possibility that it is the biological processes of pregnancy which create the specific ***mother***-child unity, in which the bodily substances of one flow into the other, whilst a simultaneous and similar process occurs on a psychological level. No comparable link seems to connect father and child: the importance of the father in his relationship to a child appears to be further removed from instinctual roots than those of the mother.

The writer holds the view that it is largely because no biological link connects father and child in utero, and in early infancy, that there is so little evidence to be found for a comparable psychological link. For further debate of this important consideration the reader is referred to Benedek in Anthony and Benedek (1970c, 1970d); Burlingham (1973); Carlson (1984); Jessner et al (1970); Kolansky and Moore (1966); Kris and Ritvo (1983); Neubauer (1985); Panel (1978) and Walt (1986).

A similar debate exists concerning the question of the nature of the child's tie to parent substitutes – for example adoptive and foster parents. This area is however, considered to be beyond the scope of this paper and will therefore not be addressed.

3.4. The Nature of the Child's Tie to Siblings

More recent clinical findings (cf Colonna and Newman 1983; Neubauer, 1983, 1985; Provence and Solnit, 1983) have pointed to the need to explore the nature of the child's tie to siblings. Neubauer (1985) questions the assumption that the child's synchronicity with the primary object (ie mother) alone leads to object–self differentiation as a linear consequence solely because of their mutual interaction. He argues (p 164) that the child's rivalry with his siblings for the mother's affection constitutes a pre–oedipal triangularity (as is the case of the oedipal triadic interaction of mother–father–child); that the sibling (as a new object) allows for new islands of identification and for significant new interactions that give these experiences a singular significance.

Neubauer suggests (p 168) that intense rivalry in the second year of life is already a reflection of the pre–oedipal triangularity between the child, his sibling and their relationship to their mother and/or father. He further asserts that the relationship to the sibling is more than a repetition of the primary relationship to the mother – that children also form their own different relationships to each other. Hence, Neubauer raises the question of ***multiple primary objects*** in early life (as opposed to acceptance of the mother as primary object) and suggests the need to consider the impact which ***multiple relationships*** may have on the child's development.

Neubauer's question of the impact of multiple relationships on the child's development raises, in turn, the need to consider the role of the family group in the child's development and treatment.

3.5. The Nature of the Child's tie to the Family

A striking feature which emerges from an examination of the psychoanalytic literature is that it seldom deals with the family as an actual environment for the developing child and makes little mention of any impact that daily living within a family might have on the course and process of a child's treatment (cf also Anthony, 1980a). The focus is predominantly on the relationship of the parent (in almost all cases the mother) to the child. While the parent-child relationship was gradually admitted into individual child treatment, the family was still regarded as being part of the 'environment' and was therefore generally ignored (cf chapter two of this paper).

Although there appears to be little doubt that the child's parents may either help or handicap treatment and there is much clinical evidence to suggest that maternal disturbance ***does*** create a problem in child treatment (cf also chapters four, five and six of this paper) the relationship between parent and child psychopatholgy is not a simple matter of 'contagion' or 'reaction'. Similarly it is evident that the impact of the environment and of the process of the child in assimilating aspects of a disturbing environment into the internal psyche are far from understood and require further enquiry (cf Anthony, 1980b; A. Freud, 1965 and Winnicott, 1964).

From within a psychoanalytic orientation, Anthony (1980a) posits that parts of the familial milieu are gradually internalised into the conflictual spheres of the psyche, while other portions gain varying degrees of object-representation. Further aspects of the family are incorporated into the unconscious life of the child as he gradually comes to understand the complex elements that hold it together as a group, and his own place within the system of relationships. Hence from within this perspective it may be assumed that the conscious and unconscious thoughts and phantasies of family members would continuously impinge on the treatment of the child. Anthony (1980a) therefore argues for consideration of treatment of the ***family*** as an intergral and crucial part of the child's treatment: "There is no mysterious leap from parent to family in child analysis: the family

simply represents the next horizon ... One has developed the habit of negotiating with the parents, but one could as well deal with the family and at least help to dissipate some of its paralysing secrets" (p 16).

The above considerations clearly point to the need to appreciate family dynamics as part of the treatment of the child and the writer highlights the area as an important one for further exploration. Although the major focus of this paper is specifically on mother-child interactions, the writer does not wish to impart the impression that the mother-child unit is an entity isolated from the actual environment, or that maternal pathology is a simple backdrop against which the child's pathology runs it course. It appears more accurate to posit that the child's pathology interacts constantly with the parental pathology to constitute a total family pathology.

The nature of the child's tie to the father, to siblings and to the family group are three important areas which have been granted only cursory attention here. However, the theoretical and clinical controversies implicated in these areas are considered by the writer to be beyond the boundaries of the present paper and therefore will not be further addressed in the course of the argument presented.

3.6. Conclusions

The psychoanalytic and object-relations perspectives presented in the foregoing discussion appeared to provide substantial argument for the existance of a unique emotional bond between mother and child during the first weeks and months of life. The writer now wishes to suggest that, in addition to the ***actual conscious*** interactions that take place between mother and child, there are in fact many ***unconscious*** processes operating within the primary relationship - that primitive unconscious interconnections between mother and child exist and may persist and impede the child's psychological development. These unconscious links appear to account for both the the 'normal' intense early mother-child bond, which (under favourable circumstances) wanes as the

child progresses through the separation–individuation process, as well as for pathological relationships between mother and child. Where unconscious interconnections of a primitive nature persist between mother and child, where the primary relationship is not satisfactorily negotiated, the potential for childhood disturbances is laid.

The writer contends that failure to take into account the complexities of the nature of the primary relationship and the extent to which it was negotiated by both mother ***and*** child, appear to provide possible explanations for the many difficulties experienced by early child psychoanalysts and therapists in their attempts to work with disturbed children, as well as to some extent account for the problems encountered in involving parents in child treatment (cf chapter two). It is for this reason that the writer asserts that an understanding of the formation, development and resolution of the primary relationship, including its conscious ***and*** unconscious nuances and vissicitudes, is of crucial importance in the assessment, diagnosis and treatment of disturbed children.

The nature of these unconscious processes, and the extent of the persistence of primitive unconscious interconnections between mother and child and how they may impede psychological development, form the focus of discussion in the following chapter.

CHAPTER FOUR : THE UNCONSCIOUS LINKS BETWEEN MOTHER AND CHILD AND THE 'SPACE BETWEEN': AN OBJECT RELATIONS PERSPECTIVE

4.1. Introduction

Psychoanalytic and object relations perspectives pertaining to the nature of the primary relationship between mother and child were explored in the previous chapter. A dual unity, or symbiotic interconnectedness was posited as being appropriate and necessary immediately following birth, and during the first few months of the infant's life. Thereafter, optimally, mother and infant gradually begin to separate out of this unity : the mother to regain her former separate identity, and the infant to begin to develop as an individual, physically and psychologically separate from the mother. It was intimated by the writer that, in addition to the ***actual conscious*** 'external relationship' which exists between mother and infant, there also exists an intra-psychic, unconscious relationship; that within the primary relationship, there is an interplay of unconscious processes operating between the mother and child, which requires consideration. The nature of these unconscious processes of both mother and infant, as well as their interrelationship, form the focus of discussion in this chapter.

It will be argued that it is important for clinicians to determine the degree of movement made by the child and his mother away from the initial undifferentiated state, in which mother and child are united by unconscious currents of communication by means of primitive mechanisms such as projection, introjection, and projective identification. It will be further argued that the persistence of unconscious interconnections of a primitive nature between mother and child may impede the psychological development of the child. In instances where mother and child remain joined by such archaic, pathological ties, the writer suggests that simultaneous treatment of mother and child may be considered as an appropriate and effective treatment approach.

4.2. The Influence of the Mother's Unconscious Processes on the Pychological Development of the Infant

The view that mothers are 'responsible' for the pathology of their children is a persistent, albeit unpopular one – an idea often regarded as a simplistic and unwarranted attribution of blame to the person who is usually initially responsible for the child's development. However, as was demonstrated in the preceding chapter, the biological reality is that mothers remain the child bearers, and at the infantile stages of development they remain the primary nurturing objects for their children. This appears to have remained despite the increased involvement of fathers in the early lives of their children.

The earliest moments of psychological development largely, if not wholly, involve being fed and nurtured and emotionally 'held' by the mother. However, this in itself does not explain the mother's apparently unique influence on the child's psychological development. It has been shown (cf Benedek in Anthony, 1970; Deutsch, 1944; Mahler, 1963 and Walt, 1986) that there is, for the mother, in addition to the physical reality of her baby, a ***phantasy*** aspect to 'baby' that she has borne since long before the baby's actual birth. Phantasies concerning the baby are an integral part of the mother's phatasy structure, and occupy a deeply embedded place in her psyche, infused with meaning associated with her own history (cf Fraiberg et al, 1975, 1980).

There seem to be certain associations to 'baby' which are commonly connected in the female unconscious (Walt, 1986 : 65 – 68). Until the moment of its physical birth, the baby resides inside the mother's psyche as both a part of herself, and as an object separate from her. The baby serves as a container for aspects of the mother's psyche that are felt to be dangerous and threatening to her sense of herself, as well as those aspects felt to be precious and in need of special attention. Hence, for some mothers babies come to represent ameliorative, restorative objects, while for others they serve to confirm primitive, anxious phantasies, and consequently come to represent hostile or

dangerous objects. These primitive phantasies appear to be 'transmitted' from the mother via unconscious processes such as projection and projective identification.

According to Ogden (1979 : 371) "Projection and projective identification are viewed as representing two poles of a continuum of types of fantasies of expulsion of aspects of the self with the former seen as predominantly a one-person phenomenon involving a shift in self-and-object-representations; in contrast, the latter requires that one's projective fantasies impinge upon real external objects in a sequence of externalisation and internalisation".

Projection and projective identification, postulated by Klein (1946) as normal developmental processes used by the infant and young child, appear to be mechanisms or ways of relating which persist, on a lesser level, into adulthood. The situation of mother and infant evokes, in the mother, unconscious memories of her own infantile situation. If this has been largely satisfying, a nurturant, positive experience, her relationship involves largely positive projections into her child. Conversely, if the mother's own infancy was experienced as largely distressing, she retains images or memories of unmet needs, of an absent mother, of feeling abandoned. These may be re-evoked in phantasy to her own baby, and later, in the actual relationship with her child. In such a situation, the mother is likely to project negative and distorted images into the infant. The more distressing her experiences, the stronger her projections. Because the young infant has no way of processing and disowning the mother's projections, he has no choice but to make them part of himself and to act accordingly (Joffe, 1989).

Hence, each individual child has a certain specific meaning for the mother, determined by the phantasies she has connected to her child. Whether these promote a healthy or pathological disturbed relationship appears to be determined by the 'emotional valence' (Walt, 1986 : 68) attached to her associations:-

> "...there is a special legacy that the mother bestows on her child, the legacy of her phantasy meanings which she assigns to her child ... the mother feeds her child not only her milk during infancy, but also her phantasy ... this early currency of phantasy is as formative of psychic development as breastmilk is of corporeal development..." (Walt, 1986 : 71).

The above discussion has encompassed the idea that the uterus and subsequently the growing foetus and the baby serve as a container for psychic elements for the mother: the mother unconsciously assigns to her baby both positive and negative aspects of herself. The process described thus far may seem to suggest that the baby is merely a passive receptacle for the mother's phantasies – a tabula rasa upon which the mother's psychological phantasy can be imprinted. In reality, the process is never uni-directional: the baby's own unique biology, its constitutionally-determined drives, and its own rudimentary stores of phantasy also play a part and are drawn into both the actual and unconscious dialogue with the mother and influence how she responds to the baby.

At this point, it is pertinent to draw to the reader's attention a tendency on the part of theorists to posit external, environmental factors and internal biological factors as if they were discrete, separable entities and to argue that ***either*** the environment ***or*** the internal intra-psychic processes are of primary significance in influencing psychological development. Walt (1986 : 73) terms this the "dualistic fallacy" of inner vs outer worlds. For example, the ego psychology point of view (epitomised by Anna Freud) essentially posits that the successful development of psychic structures depends largely on the adequacy and appropriateness of the ***environment***. That is, internal structure and fantasy are the outcome of environmental provision. This viewpoint leads away from the unconscious and from phantasy – away from the internal world, to focus on the external.

The Kleinian object-relations approach, on the other hand, focuses almost exclusively on psychological contents:- their origins in biology; their intra-psychic elaboration (by means of splitting, projection, introjection etc.) and their interpersonal transformation (by means of projection and projective identification). (Klein, 1946; 1948; 1957; Ogden,

1985a). Klein's theory suggests that unconscious phantasy is constitutionally given, exists at birth and is merely elaborated and made more complex through inter-actions with the environment.

Hence, while the 'ego-Freudian' proponents emphasize environmental influences as formative in the development of psychic life, the Kleinian view identifies unconscious phantasy as the primary determining factor in psychological development - the external environment appears as almost a blank screen upon which internal phantasy is projected. By locating the main developmental impetus ***either*** internally ***or*** externally, both approaches "fail to articulate a model in which the dialectical interrelationship between material reality and psychical reality is fully represented, and both consequently neglect the importance of one corresponding pole of a dialectic" (Walt, 1986 : 81).

Following on from the above, the writer holds the view that mother and infant (and their internal and external realities) need to be defined in complementary relation to each other and that in the primary relationship, there exists an inextricable ***interaction*** of the phantasies and unconscious processes which result from the intimate involvement between mother and child. These phantasies cannot be said to belong to ***either*** mother ***or*** child - they exist only in an overlapping area of inner and outer worlds, and in the unique unconscious dialogue between them.

> "It is by means of this reciprocal process, ... whereby mother and infant are mutually immersed in a fluctuating current of phantasy that cannot really be called either mother's or infant's, but is perpetually being redirected and transformed, ... that something new is created, that is, the child's own personality" (Walt, 1986 : 71 - 72).

An attempt will now be made to explore in greater depth the ***infant's*** contribution to the reciprocal process which facilitates its psychological development.

4.3. The Early Psychic Life of the Infant : Its Influence on the Primary Relationship

Beginning with the premise that in the beginning there is no infant as such, only a state of unity of the infant and his mother, it will be shown that the infant's attempts to separate, differentiate, individuate – to emerge as a psychologically separate entity, appear to some degree to depend upon the mother's ability to provide an environment or context in which the infant is allowed his first rudimentary experiences of participating in and responding to his environment.

In the beginning, the infant is faced with a complicated, confusing and frightening barrage of external stimuli and internal phantasy experiences, which he needs to organise. The writer will draw on the work of Melanie Klein (1946, 1955b) in elucidating some of the early psychic processes operative in the infant's life. According to Klein (1946 : 1) object relations exist from the beginning and are from the beginning moulded by an interaction between introjection and projection, between internal and external objects and situations. Splitting of objects, projection and introjection processes are characteristic of the first few months of life and participate in the building up of the ego and super-ego. From the outset, the infant experiences destructive impulses and phantasies, which are first expressed in phantasied oral-sadistic attacks on the mother's breast and then later develop into phantasied onslaughts on her body as a whole.

Because the infantile ego largely lacks cohesion, the tendency towards integration alternates with a tendency towards disintegration – fluctuations characteristic of the first few months of life. From the outset, the anxiety experienced by the infant is felt to be caused by objects. Even when they are felt to be external, they become, through introjection, internal persecutors, which reinforce the internal fear of destructive impulses. The infant's vital need to deal with this anxiety forces the early ego to develop the fundamental mechanisms and defences of splitting into part objects, projection, introjection, and projective identification.

The infant's phantasied onslaughts on the mother, consisting of both the taking in of good contents (introjection) and the expelling of dangerous substances out of the self into the mother (projection) are the primary unconscious processes operative in the infant during the first few months. Introjection and projection constantly interact and this interaction both builds up the infant's internal world, and shapes his picture of external reality. The infant's own inner world is the product of his own impulses, emotions and phantasies, which are, however, "profoundly influenced by his good and bad experiences from external sources [among them ... the mother's attitude is of vital importance and remains a major factor in the development of the child]. But at the same time the inner world influences his perception of the external world in a way that is no less decisive for his development" (Klein, 1955b : 141 –142).

The mother (first her breast) is primal for both the introjective and projective processes: love and hatred are (from the beginning) projected into her and concurrently she is internalised with both these contrasting primordial emotions, which underlie the infant's feeling that a good and bad mother (breast) exist. The more the mother and breast are cathected, the more securely will the introjected good breast (the prototype of good internal objects) be established in the infant's mind. This, in turn, influences both the strength and nature of projections: in particular, it determines whether feelings of love or destructive impulses predominate.

Klein (1955b : 142) later came to recognise the major importance for identification of certain ***projective*** mechanisms which are complementary to the introjective ones. For example 'projective identification' or 'identification by projection' (1955b : 143) implies a combination of splitting off of parts of the (infant's) self and projecting them into another person (mother) in an attempt to be rid of the bad parts (which threaten to destroy the infant from within) and to control and take possession of the object.

In addition to the importance of certain mechanisms for identification, Klein (1955b : 143) suggests that the process of ***internalisation*** is of great importance for projective processes. In particular, the good internalised breast acts as the focal point in the ego, from which good feelings can be projected onto external objects. It strengthens the ego, counteracts splitting and dispersal processes, and enhances the capacity for integration and synthesis. The good internalised object is therefore one of the preconditions for an internalised and stable ego and for good object relations. The tendency towards integration, which is concurrent with splitting, Klein assumes to be a dominant feature of mental life from earliest infancy.

Returning to the process of projective identification within the mother-infant relationship, the writer finds Ogden's (1979 : 357 -373) ideas particularly illuminating. He suggests that projective identification can be understood as a bridging formulation between the intra-psychic sphere, and external reality. He defines projective identification as "a group of fantasies and accompanying object - relations having to do with the ridding of the self of unwanted aspects of the self; the depositing of these unwanted 'parts' onto another person and finally, with the 'recovery' of a modified version of what was extruded" (p 357).

Hence, projective identification is a psychological process that is simultaneously a type of defence, a mode of communication, a primitive form of object-relationship, and a pathway of psychological change. Each of these functions evolves in the context of the infant's early attempts to perceive, organise, and manage his internal and external experiences, and to communicate with his environment. With the help of ***'good-enough mothering'*** (Winnicott, 1949) the infant can begin to organise the complicated, confusing and frightening barrage of stimuli which constitute early experience.

Projective identification is an adjunct to the infant's ***defensive efforts*** at keeping what is felt to be good at a safe distance from what is felt to be bad and dangerous. Aspects

of the infant can in fantasy be deposited in mother in such a way that the infant does not feel he has lost contact with either that part of himself or with mother. In terms of ***communication***, projective identification is a means by which the infant can feel that he is understood by making his mother feel what he is feeling: he cannot describe his feelings in words for the mother, therefore he induces these feelings in her.

In addition to serving as a ***mode of interpersonal communication***, projective identification constitutes a primitive transitional type of ***object relationship***, that lies between the stage of the subjective object and that of true object relatedness. Projective identification functions as a ***pathway for psychological change***: through the mother's (healthy) interactions with the infant, the processed projections (which involve the sense of the mother's mastery of her frustrated feelings and destructive, retaliatory wishes) are available to the infant for re-internalisation (Ogden, 1979 : 363 -364).

What becomes apparent from the above is that an essential part of normal development is the infant's (and later the child's) experience of his mother as an object which can safely and securely be relied upon to act as a container for his projective identifications. Further, it seems clear from the foregoing that the infant cannot be regarded as a passive receptacle for the mother's phantasies: the infant makes his own active contribution to the processes from the outset and via fundamental processes such as projection and introjection, the infant's external environment (largely mother) is woven inextricably into the fabric of phantasy. Importantly, the mother's function during this early stage in the infant's life is to provide an ***external context*** in which he is allowed his first primitive experiences of responding to and participating in his environment.

Ogden (1985a) draws attention to Winnicott's conception of the maternal context as the infant's 'psychological matrix'. "It seems to me that matrix [Latin for 'womb'] is a particularly apt word to describe the silently active containing space in which psychological and bodily experiences occur" (p 355 fn). The importance of this mother -

matrix is that it provides the infant an experience of being 'held': the infant's unintegrated state is gathered together and contained by the ego support lent by the mother. What makes the mother 'good enough' is the provision of this context, the provision of a 'space between' her and the infant in which the infant's developmental tendencies can unfold (Walt, 1986 : 89).

Such a mother is able to tolerate the uncertainty, the unpredictability involved in providing a situation in which what happens is not entirely in her control; she is able to leave 'room' in which the infant can respond to and act upon his environment. Under healthy conditions, the mother is able to preside over this space, modifying the distance (both physical and psychological) according to the changing needs of the growing infant. Holding 'spaciously', with optimal distance between mother and infant, enables the infant to develop beyond its reflexive, primitive state. Failure to provide and maintain a space, that is, impairments in the maternal environment, lead to a corresponding impairment or pathology in the child's development (cf also Giovacchini in Anthony and Benedek, 1970; Ogden, 1978).

4.4. Dissolution of the Mother-Infant Unit : The Process

Ogden's paper (1985b; 129 - 141) in which he illuminates several Winnicottian ideas concerning this early period of the infant's development, was found by the writer to provide useful insights in terms of the dissolution process. Ogden, in contrast to the many dichotomous, dualistic views of mother vs infant suggests that a ***dialectical process*** is centrally involved in the evolution of the infant from biological unity and psychic fusion with the mother, to a separate, functioning individual. That is, each creates, informs, perceives and negates the other; each stands in a dynamic (ever changing) relationship with the other.

In the very beginning, there is only the illusion that mother and infant are not separate. The mother exists only in the form of the invisible holding environment in which there is

a meeting of the infant's needs in a way that is so unobtrusive that the infant does not experience his needs as needs. As a result, there is not yet an infant. If there is a good-enough fit between mother and infant (maternal matrix) there exists for the infant-mother unit an undisturbed state of 'going-on-being'. However, this harmoniously functioning mother-infant unit is only short-lived, because of the inevitable imperfections of fit between the two. The 'well-dosed frustration' which is then experienced by the infant provides him with the first opportunity for awareness of separateness, and heralds the dissolution of the mother-infant unity. This period of the very earliest awareness of separateness begins at "about four to six to eight to twelve months" (Winnicott, 1951 : 5).

According to Winnicott (ibid) and Walt (1986) for the transition from mother-infant unity, to a state in which there is a mother-and-infant, to be non-pathogenic, there must be ***potential space*** between mother and infant. Potential space is "the hypothetical area that exists (but cannot exist) between the baby and the object (mother or part of mother) during the phase of the repudiation of the object as not-me, that is, at the end of being merged with the object" (Winnicott, 1971 : 126). Potential space is always potential - never actual - because it is filled in with a state of mind that embodies the paradox that is never challenged : the infant and mother are one, and the infant and mother are two. The movement from mother-infant unity (invisible environment mother) to mother and infant (mother as object) requires the establishment of oneness and of separateness in which each creates and informs the other (Ogden, 1985b : 132).

At first the 'two-ness' (that co-exists with 'oneness') cannot be distributed between the mother and the infant in a way that clearly demarcates the two as separate individuals. At this point, 'two-ness' is a quality of the mother-infant; it is the infant's development of the capacity to be alone in the presence of the mother. The transitional object is a symbol for this separateness in unity, unity in separateness : it is at the same time the infant and not the infant. Ogden (1985b) contends that the appearance of a relationship

with a transitional object is not simply a milestone in the process of separation–individuation – it is as significantly a reflection of the capacity to maintain a psychological dialectical process. Attainment of this capacity involves the transformation of the mother–child unity that did not require symbols into 'threeness', in which mother and infant are created as objects and the infant, in addition, as a subject. The infant then becomes the creator and interpreter of his symbols.

In summary: The study of the infant's psychological development is not simply the study of the growth of the infantile psyche from primitivity to maturity; it is also the study of the development of the mother–infant into a mother ***and*** infant. Since the mother–infant is a psychological entity contributed to by both, the unit for psychological development is always both a primitive psychological organisation and a relatively mature one. Walt (1986 : 87) characterises this early situation as comprising two bodies, two psyches, one mature, and one undeveloped, but operating as if it were a unit, enclosed within the same skin, existing in complementary relation to each other (cf also J. Klein, 1987 : 359 ff).

Given the considerations explored above, the writer subscribes to the idea that there is a ***potential*** individuality which the infant has at birth, development of which is facilitated by the mother. The task of the mother is largely not to interfere with the infant's spontaneous development and of timeously handing over caretaking to the infant himself. The infant's psychological contents can only be understood in relation to the psychological matrix within which these contents exist. Since the infant's own psychological matrix (his internal holding environment) takes time to develop, the infant's mental contents initially exist within the matrix of the maternal mental and physical activity. In the beginning, the environmental mother provides the mental space in which the infant begins to generate experiences: a new psychological entity is created by the mother and (what is becoming) the infant.

> "... the crucial ingredients in the "good enough" mother environment are the sufficiency of space provided by the mother to enclose but not to impinge upon the fragile and unintegrated experiences of infancy; within the sufficient space mother and infant maintain an optimal distance, so that need, anxiety, frustration and conflict can be both satisfied and experienced by the infant in tolerable amounts ... This optimal distance is modified over time, allowing a back and forth oscillation between closeness and distance while moving in the direction towards separation and differentiation. These are the environmental preconditions for the development of subjectivity, within which context the infant's psychological life will germinate ..." (Walt, 1986 : 95, emphasis in the original).

In the context of mutuality and in the security of a predictable environment, the infant begins to recognise and distinguish objects in his environment. This marks the beginning of movement towards separation, since to recognise implies an ability to distinguish 'me' from 'not me'. Memories of 'not-me' objects can be summoned to fill a space left by the absent object. In this way, an internal space evolves, an area in which elements from the external realm and the biological world can be mediated and brought under rudimentary (illusory) control. Within this internal space, events in the external world as well as internal events are reshaped and given a personal quality. This intermediate area, which creates a bridge between external and internal worlds, joining them while maintaining a separation between them, is what Winnicott (1971) has called 'potential space'. "Potential space is thus preceded by and is the internalised version of, a "maternal space" in which the infant was held physically and psychologically by the mother" (Walt, 1986 : 8).

Potential space is, in fact, the area in which ***all*** reality is experienced, because potential space is created out of the capacity to transform things in reality into mental representation, which can be perceived and registered. The infant has become a person, a human subject, capable of creating his own personal object world. No longer is there a mother-infant, but two people, each with their own separate sphere of psychological experience - related, but not intertwined (cf also Neubauer, 1985; Ogden, 1978; 1979; 1983; 1985a; 1985b; Smith-Behrends and Blau, 1985; Torras De Beá, 1989; Walt, 1986).

4.5. Concluding Summary and Clinical Implications

The foregoing presentation has addressed the nature of the primitive emotional or psychological bond which exists between mother and child, as well as the process of developmental transformation which this bond undergoes. Specifically, the focus of discussion has been on the nature of the mutual interplay of unconscious processes which operate between mother and infant. It was shown that there are, in the mother, unconscious phantasies in operation which she has borne even prior to the infant's actual birth, and which are infused with meaning associated with her own history. Unconscious memories of the mother's own infantile situation are evoked by, and infiltrate, her actual relationship with the infant. The mother unconsciously assigns to her baby both positive and negative aspects of herself. Whether these come to promote a healthy or pathological maternal context for the infant's development was shown to depend to some extent upon the emotional valence which is attached to the symbolic association she has to her infant.

The infant's optimal emotional development was shown to be inextricably dependent upon the mother's ability to provide a maternal context or maternal space within which the infant's experiences are 'held'. This, together with the infant's own active contributions, and introjective and projective identification processes, facilitates development of the infant as a separate psychological entity out of the initial primitive state of primary undifferentiation. It was shown that under healthy conditions, the mother modifies both the physical and psychological distance between her and the infant, according to the changing needs of the infant and to allow the development of potential space. It was argued that this maternal function bears directly on the infant's development: maternal environment impairments result in a corresponding pathology in the infant's development. Where unconscious interconnections of a primitive nature persist between mother and child beyond the point at which dissolution of the mother-infant dyad should occur, movement of the infant towards psychological separateness from the mother is impeded, and subsequent psychological development is impaired.

The above conclusions suggest several clinical implications. The material presented seems to further substantiate the claim made earlier in this paper that it is of clinical import for clinicians working with disturbed children to pay attention to the nuances of the mother-child relationship. It may now be asserted with even greater authority that a detailed understanding of the primary relationship, in which particular account has been taken of its ***unconscious*** nuances and vicissitudes, is of critical importance in the assessment, diagnosis and treatment of disturbed children. Clinicians must be able to establish the extent to which primitive unconscious interconnections have persisted and have impeded the child's separation-individuation.

The writer wishes to argue that where such primitive interconnections are still operative, the clinician is likely to encounter the clinical problem in child treatment which was addressed earlier in this paper, ie the intrusion of the mother - with whom the child remains pathologically over-involved - into the treatment process. Chapter two of this paper reviewed the various approaches which have been utilised in attempts to include parents in the treatment of their child. It was, however, concluded that despite these attempts, the presence and involvement of parents (and of the mother in particular) remained one of the most confounding factors in child treatment.

The writer now wishes to suggest a possible explanation for the continued existence of this confounding factor. It appears that because clinicians' thinking did not extend to taking into account the pathogenic intermingling of phantasy between mother and child, they therefore also failed to evaluate the persistence of unconscious interconnections of a primitive nature between mother and child. Furthermore, it would appear that clinicians attempted to locate the source of pathology in ***either*** the mother ***or*** the child, instead of within the mother-child ***relationship***, and in the primary mother-child ***interactions***. For this reason, clinicians failed to adequately define treatment boundaries, and often failed to include the mother.

As a possible solution to the problem, the writer advocates consideration of simultaneous treatment of mother and child as an alternative to the more 'traditional' approaches to the treatment of disturbed children (cf chapter two). The writer suggests that simultaneous mother-child treatment is an object relations approach which makes possible the understanding of the ***interplay*** between phenomena in an intra-psychic sphere and phenomena in the sphere of external reality and interpersonal relations. Such an approach is grounded in object relations theory - which asserts that unconscious internal object-relations are in dynamic interplay with interpersonal experiences.

On the basis of this, analysis of internal object relations therefore centres upon the exploration of the ***relationship*** between internal objects and the ways in which individuals go about altering these unconscious internal object relations in the face of current experience. In such an object relations treatment approach, the focus of treatment is on the unconscious meanings and associations held by the mother in connection with her child and the ways in which these unconscious expectations are fulfilled by the symptomatic child.

The following chapter therefore reviews the literature pertaining to simultaneous treatment. It is the writer's contention that the extent of its applicability, and the efficacy of this treatment approach has only recently been brought to light, following the emergence of neo-classical and neo-Kleinian psychoanalytic and object relations theoretical conceptualisations (cf Bion, 1975; Green, 1978; Ogden, 1985a and 1985b; Pontalis, 1977; and Winnicott, 1988).

CHAPTER FIVE : SIMULTANEOUS TREATMENT OF PARENT AND CHILD : AN OBJECT-RELATIONS APPROACH TO WORKING WITH DISTURBED CHILDREN

5.1. Introduction

> "It is possible for the unconscious life of one person to be so completely fed from the unconscious of another, that it is as though the soul of one so fed remained like an infant in the mother's womb, drawing sustenance through the psychic umbilical cord. If this is suddenly stopped, it is as disastrous to the newborn individuality as the premature severing of the physical cord" (Wickes, 1927 : 36).

In the preceding chapter, the unconscious aspects of mother-child relationships were explored. It was suggested that where mother and child are still inappropriately locked into primitive processes begun in infancy, the child's intra-psychic conflict cannot be resolved. It therefore becomes necessary to help the ***mother*** alter her projections onto the child: "It is only when [the mother's] inner world of objects begins to alter, that she will be able to let the child go, and to perceive him as he is ..." (Joffe, 1989 : 28). For this to be made possible, it appears to the writer that simultaneous treatment of the mother and child is usually necessary.

In this chapter the literature pertaining to simultaneous treatment of parent and child is reviewed. A number of different terms are encountered in the course of the review viz 'simultaneous'; 'concurrent'; 'collaborative' and 'contemporaneous' treatment. All are found to refer to the same treatment approach. The bulk of the literature reviewed also refers to simultaneous ***analysis*** - as opposed to simultaneous ***therapy***. For the purposes of this paper, the two are viewed as synonymous - provided the differences between analysis and therapy, which were outlined in chapter two, are borne in mind.

Essentially, simultaneous treatment aims to provide the chance of successful treatment for children whose progress in development and in treatment has been (or is being) interfered with by unconscious processes operating within the mother.

In the most traditional form of simultaneous treatment, mother and child are seen by different clinicians. These two clinicians do not communicate with one another, but report the content of their respective treatment sessions to a third supervising clinician or co-ordinator (cf Hellman in Glenn, 1978; Hellman, 1980). An alternative form of simultaneous treatment is that in which the two clinicians treating the mother and child discuss the therapeutic material with one another, instead of reporting it to a co-ordinator (cf Kolansky and Moore, 1966). A further variation involves the same clinician treating both mother and child, and the absence of a co-ordinator (cf Sperling, 1949d, 1950a, 1951, 1954a; and Kohn, 1976).

5.2. Simultaneous Treatment of Parent and Child : Literature Review

Studies of simultaneous treatment appear to have originated in two countries: in Britain (at the Hampstead Child Therapy Clinic, London) and in the United States. Pioneering figures include Dorothy Burlingham (London); and Szurek, Johnson et al, and Melitta Sperling (New York). Application of the method appears to have begun in the early 1940's. The literature review traces, chronologically, the development of the approach in the two countries, beginning with the British studies.

5.2.1. The Development of Simultaneous Treatment in Britain

As alluded to above, the evolution of simultaneous treatment in Britain is largely attributable to the initiative and work of Dorothy Burlingham (cf Bulletin of the Hampstead Clinic, 1980; Editorial, Psychoanalytic Study of the Child, 1980; Jackson, 1984). Burlingham devised a particular ***method*** of simultaneous analysis: for each mother-child couple, a team of three analysts is needed. One for the mother, one for the child, and a third who acts as 'co-ordinator'. The analysts of both mother and child report each analytic session to the co-ordinator and submit weekly reports. In this way, the material of both analyses can be brought together without influencing the work of the two analysts concerned. Possible contamination of the therapeutic material and the difficulties of a double transference are minimized (Hellman, 1980 : 83).

Preliminary ideas on simultaneous treatment were presented by Bennett and Hellman (1951) and Hellman (1954).The first published report of a simultaneous analysis conducted using Burlingham's method appeared in 1955 (Burlingham et al, 1955). Bobby, four years old, was referred for feeding difficulties; enuresis; encopresis; speech retardation and biting attacks on his mother, which alternated with clinging behaviour. The authors note:

> "The case is one ... [where] ... 'though there seems to exist in the child a good potentiality for improvement or even for complete recovery, another force appears to be at work which counteracts constantly the therapeutic efforts ... this force emanates from the mother ... It seems to us that nothing short of an analysis of the mother can reveal in detail which influences are at work and what the more intimate relations are between the mother's unconscious fantasies and attitudes and her child's disturbance" (p 165).

The authors suggest (p 168) that seen from the point of the child's analysis only, it would appear that through his behaviour, the child forced his mother to react towards him as she did. However, when taking into account material from the mother's analysis, it became apparent that the mother was ***herself*** under the domination of powerful unconscious fantasies which determined her attitude and behaviour towards her child. In this light, the child's behaviour is explicable as a ***reaction*** to the ***mother's*** provocation. The authors conclude that the mother's problems were much too deep-seated and severe to be accessible to advice and guidance, hence the need for analysis. In relation to the child's treatment, "so far as he was under the influence of [his mother's] fantasy life, analysis was able to set him free, by lifting his reactions to consciousness, and working through them. Although originating in the mother's unconscious, the fantasy content had become his own, could be treated as such, and analysis of it was followed by relief..." (p 186).

In a similar vein; Hellman et al (1960 : 359) assert:-

> "The persistence of an intimate bond between certain children and their mothers well beyond the usual intensity and age has arrested the attention of child analysts ... Problems concerning the nature of such an exceptional tie, its effect on the growing

> child, and the means of communication between mother and child have led to the wish to study mother-and-child couples by means of simultaneous analysis. This wish has grown from clinical experience with cases in which the mother's participation in the child's disturbance forms an obstacle to his recovery, and in which it is felt that lasting, favourable results can be achieved and maintained only if the existing conditions within the mother can be altered too".

In the case discussed by Hellman et al (1960), that of Eric, an 11 year old who presented with hypochondriacal symptoms, the ***simultaneous experiences*** of mother and son of anxiety about their health and bodily pains emerged, as well as the interplay of the unconscious meaning which feeding and eating had in their relationship. Both led to the child's inability to separate from his mother and ultimately to his refusal to attend school. Assessment revealed several areas in which the mother's own disturbance seemed to be deeply linked to the child's, and the authors detail their observations of the simultaneous processes related to these areas which emerged in the two therapies. It became apparent that the mother made her son an object of projection : she did not react to the child's needs and impulses on the basis of her perception of his (actual) internal situation, but in line with her projections.

The overt behaviour and changing needs of the child revived a succession of different infantile conflicts in her. As these became pre-conscious, they precipitated manifestations of her own early anxieties, fantasies and defences. The child stood successively for aspects of herself, and for the different objects of her past, in relation to which she had originally experienced these conflicts. In by-passing Eric's needs, she forced her own needs in their place. The ensuing inconsistency of her responses to him induced in him a constant need to anticipate her feelings and actions. The distortion of external reality to which she subjected him led to faulty reality testing in him; the omnipotent denial she used in order to avoid intolerable facets of external reality were integrated by Eric and used in his own defense system.

It would appear from this paper that such children – whose tie to their mother is characterised by anxiety and distrust, and whose psychical bond to her is abnormally prolonged – become alert to and remain observant of minute non–verbal clues given ***unconsciously*** by their mothers, resulting in a heightened awareness of external perceptions. Only a change within the mother can ultimately free the child from the abnormal bond and from the real need to protect himself from her.

Levy (1960) and Sprince (1962) deal with the analyses of a mother, and her adolescent daughter Debbie, respectively. Both papers demonstrate that although Debbie's mother ***consciously*** wished to loosen the tie by which her daughter was attached to her (and which had produced an incipient school phobia during the nursery school period and school refusal in adolescence) she had ***unconsciously*** prolonged her infantile attachment. It was found to be impossible to loosen or change this inappropriate relationship by treating Debbie alone; only once the mother too was in treatment did a noticeable improvement occur in Debbie, and she returned to school. Levy (1960 : 391) concludes: "A true understanding of the main difficulties could be reached only by co–ordinating the vicissitudes of the oedipal conflicts of both mother and child, and their effect on each other".

Hellman (in Glenn, 1978 : 492 – 3) refers to several more unpublished simultaneous studies undertaken at Hampstead viz Burlingham, Schnurmann and Lantos, 1958; Frankl, 1965; Hellman, de Monchaux and Lodowyk–Gyomroi, 1961; and Hellman, Schnurmann and Todes, 1970. The next published Hampstead study, by Levinson appeared in 1984.

Levinson describes the treatment of 13½ year old Emma, who presented with a long–standing difficulty in attending school and who felt 'bewitched' by her mother. The paper highlights Emma's identifications with her disturbed mother; their impact on and distortion of the normal process of identification, and the resultant effects on a variety of Emma's ego functions and mechanisms of adaption. Levinson (pp 388 – 392) points out that

Emma's case amply demonstrates the pathogenic role played by a disturbed mother in the formation and maintenance of her child's symptomatology.

Emma's symptoms, which were focused mainly around separation, are viewed as attempts to be close to a mother for whom the idea of separation was intolerable. Hence treatment, which was directed towards freeing Emma to enter the world, posed a formidable threat to the precarious balance established between mother and child. In this instance, the fact that Emma's mother refused any real treatment posed the insurmountable obstacle to her daughter's chances at freedom, and emotional health. Levinson (p 392) quotes Anna Freud (1968 : 121):-

> "We may well ask ourselves how separation and the establishment of a separate identity can be expected to take place in a child for whom merging is not only his, but the mother's admitted need...".

By implication, it appears to the writer that the chances of successful therapy are reduced most in instances where the pathogenic influences are embodied in the mother herself. Where the disturbed mother is unable to support developmental progress, the child's conflict is most easily 'resolved' through ***accommodation*** to her disturbed needs. If the mother refuses to enter simultaneous treatment, it seems that the child has little hope of extricating himself from the pathological relationship, and of differentiating.

In the most recent of the Hampstead studies, Yorke (1987, unpublished) describes the 'contemporaneous analysis' of an elective single mother and her three year old son, Tom, who presented with behaviourial disturbances and intense outbursts of anger towards adults, which alternated with overwhelming sadness. "Tom had been in treatment for about six months, and [his therapist] had continued to see the mother at regular intervals, when it became clear to the mother herself that she was unlikely to be able to cope with Tom more effectively, or to achieve a greater degree of personal happiness, unless she were to seek treatment in her own right" (p 12). As a result of contemporaneous/ simultaneous analysis, substantial improvements occurred in both mother and child.

On the basis of the literature reviewed thus far, simultaneous treatment appears to the writer to be the method of choice for those carefully selected cases of children whose forward moves on the developmental scale have been held back because of the unconscious interplay between the child and the more significant parent. Simultaneous treatment appears to provide the opportunity to see how phantasies in mother and child co-exist, overlap, and mutually influence each other. It provides the opportunity to see how the interaction between mother and child is reflected in the treatment of each, how common events are experienced differently (or similarly) and how the pathologies appear to interact and influence each other.

However, according to Sprince (1962 : 450) where very early ego disturbances may have led to permanent ego damage, the decision for simultaneous treatment may have to be undertaken with limited aims for the child. The treatment aim may be simply to strengthen the damaged ego to the limits of its capacity, thereby reducing the danger of psychotic illness in the child. If the need for infantile gratification is substantially reduced, and is replaced by new and more stable object relations, the child may be enabled to function with a greater degree of stability – even in instances where a final severing of the infantile object tie seems improbable. The aim of the mother's treatment remains the same: that of reducing her involvement in the child's pathology to the extent of minimizing the pull towards infantile gratifications.

This concludes the literature review of the British studies on simultaneous treatment, undertaken at the Hampstead Clinic, London. The following section reviews the development of the simultaneous treatment approach in the United States.

5.2.2. The Development of Simultaneous Treatment in the United States

As stated in the introduction to this chapter, simultaneous treatment of parent and child emerged in the United States during approximately the same time period as in Britain, that is, the early 1940's.

Pioneers in the use of simultaneous treatment in the United States were Johnson et al (1941) who used the approach in the treatment of school phobias, and Szurek et al (1942) who treated anti-social acting out behaviourial problems, and later, neurotic disturbances. This 'collaborative psychiatric therapy' approach is defined by the authors as "... a technique for psychiatric treatment and research in the behaviour problems and psycho-neurotic disorders of children, in which concomitant therapeutic efforts are made by two psychiatrists, one of whom deals with the significant parent, and the other directly with the child" (Szurek et al, 1942 : 162). The rationale for this approach developed out of an increasing awareness that the behaviour of a child is to be understood fundamentally only in the context of intrafamilial, interpersonal relationships; that pathological relationships between mother and father, and child, play a great role in maintaining distorted and unintegrated tendencies in the child.

The major difference between the British and American approaches observed by the writer is that of the omission, in the American approach, of a third supervising therapist, or co-ordinator. Instead, the two therapists collaborate with one another, by exchanging information. Szurek et al (1942 : 163) do, however, stress that: "Probably the most fundamental requirement of such [an approach] is that the competitiveness of the psychiatrists involved in the treatment be at a minimum". In the British (Hampstead) approach, on the other hand, it is considered crucial that the two analysts involved in the treatment do not exchange or discuss therapeutic material with one another, only with a supervising analyst, to prevent contamination of the analytic material (Hellman, 1978).

In their collaborative studies of neurotic and 'acting-out' anti-social children and their parents, Johnson et al (1941); Szurek et al (1942) and Johnson and Szurek (1952) observed clear indications that the unconscious gratification that parents derive from their unintegrated tendencies were a powerful stimulus in fostering certain behaviours in the child. They also observed that parental neurosis often provided the unconscious impetus for the child's neurosis. Regularly, the more significant parent - usually the mother

(although the authors found that the father was almost always also involved in some way) was seen to ***unconsciously*** encourage the anti-social or neurotic behaviour of the child. The needs of the parent are vicariously gratified by the child's behaviour.

On the basis of these studies, the authors concluded that a collaborative approach by two therapists is frequently necessary and more rapidly effective in the treatment of behaviour problems, and the more severe neuroses in children. In order to determine the genetics of symptom choice, or pathologic formation in children, the meanings of such manifestations to the parent must be known. The collaborative or simultaneous treatment approach appears to make it possible to observe something of the genesis of disturbances in children and the part parents play in this (cf also Johnson 1953; Johnson and Szurek, 1952, 1954; Szurek, 1950, 1952).

The work of Johnson, and Szurek, and their collaborators, briefly reviewed above, is predominantly concerned with collaborative treatment of cases of school phobia, anti-social behaviour and some neurotic disturbances. The work of Melitta Sperling (1946 - 1970) another strong advocate of simultaneous or collaborative treatment, reflects her primary interest in psychosomatic disorders in children and their relation to parental pathology. Sperling has, however, explored a wide range of childhood difficulties, and the reader is referred to the reference section of this paper, where a comprehensive listing of her publications is to be found. Only the literature most pertinent to the limited scope of this paper will be reviewed below.

Sperling's approach to treatment of childhood disturbances was via psychoanalysis of the mother and child, sometimes conducted simultaneously or successively by her, and at other times carried out collaboratively with another analyst. This approach proved useful in understanding the psychology and psychopathology of the mother-child relationship, and in revealing the symbiotic nature of the unconscious and non-verbal communication between mother and child (Sperling in Anthony and Benedek, 1970).

Sperling (ibid, 541 ff) in drawing together almost three decades of her work in treating childhood disturbances, observed that at certain phases during treatment, a seemingly inexplicable exacerbation of the child's condition took place, or treatment was suddenly terminated. These occurrences invariably turned out to be the result of unconscious resistances on the part of the ***mother*** to the treatment of her child, at the time when the child was attempting, with the help of treatment, to dissolve the symbiotic relationship. The mother – because of her own unconscious needs – was unable to accept this. Unless she could be helped, through analytic intervention, to understand and to overcome her resistance, she could not allow this basic change in the relationship to occur, and hence the child's treatment could not succeed.

Sperling (1950a, 1951, 1959) found the use of simultaneous analysis fruitful in the treatment of severely disturbed children, whose bizarre, explosive and unpredictable behaviour could not be fully understood or influenced by individual treatment alone. The child's behaviour was repeatedly shown to be a reaction to the mother's ***unconscious*** wishes, to her ***latent*** feelings and needs, which became apparent only in the course of her own analysis.

Sperling's observations seem to indicate that the severity of a child's reaction to parental neurosis, and the consequences for later development, appear to depend to a large measure upon the age at which this pathogenic interaction begins and upon the nature and severity of the parental neurosis. A maternal neurosis has the potential to affect every area of the child's development from birth onwards. The child may even have been 'assigned' – **prenatally** – a specific unconscious role by the mother. This role may be based on an early childhood identification of the mother, or on a rejected part of herself (Sperling, 1950a, 1951, 1954a, 1970; cf also Berger and Kennedy, 1975; Walt, 1986 and chapter four of this paper).

According to Sperling (1970) the earliest indication of a disturbed mother-child relationship usually manifests itself in disturbances of food intake, excretion or sleep. Severe disturbances of these functions sometimes appear (for which no apparent explanation, or remedy can be found) and which are of more serious significance than the mild and transitory disturbances encountered during the developmental phases. In such cases, Sperling claims, superficial reassurances or advice are ineffectual : only interpretations exposing the unconscious motivations and conflicts of the mother are effective.

In what Sperling (1970 : 548) describes as the "psychosomatic type" of mother-child relationship, the mother sets a premium on her child's illness and consequent dependence on her. The mother tries to maintain, in several disguised ways, the kind of control over her child which she had prenatally:-

> "I found a certain quality existing in the relationship between the mother and these children which ... served as a dynamic force precipitating as well as perpetuating the child's illness. The mother ... had an unconscious need to keep her child in a helpless and dependent state ... mother and child represented a psychologic unit in which the child reacted to the unconscious need of the mother with correspondingly unconscious obedience; it was as though the child was given a command to get sick, which meant, in reality, to stay dependent and helpless" (Sperling, 1949d : 377).

Sperling (ibid.) considers this specific relationship of mutual dependence and almost magical control existing between mother and child as an important predisposing factor in the development of psychosomatic disorders in a child : the mother's neurosis is decisive for the reactions of the child. However, because this specific relationship is usually limited to only one of the children in the family, the mother's behaviour may not initially appear particularly disturbed. Sperling (1949d : 384) suggests that it is only through the observations made in psychoanalytic treatment that the degree of the mother's disturbance and its effect on the child can be recognised and addressed.

In several other insightful papers, Sperling (1950a, 1951) explores children's interpretations and reactions to their mother's unconscious. Using material from simultaneous analyses, she again demonstrates convincingly that the children's behaviour represented their responses to their mother's unconscious wishes. Reactions and behaviour could be understood as an unconscious answer to an unconscious wish of the mother for the child to act in this particular way. Neither mother nor child was aware of the underlying unconscious motivations. Sperling (1950a : 40) asserts that "Treatment of the child alone ... does not reveal those forces to which the child is reacting, nor does it make growth possible unless the mother can give up her own infantile strivings which are reflected in the child's illness".

In summary, it appears to the writer that the central thesis of Sperling's work points to the necessity for consideration of simultaneous treatment of mother and child in certain instances. Where the mother, because of her own pathology, carries over to the child, by unconscious means such as projection and projective identification, her unresolved infantile conflicts and is unable to separate herself from the child, a continuation of the symbiotic relationship assumed to exist in infancy is perpetuated. The child remains extraordinarily sensitive to the mother's behaviour and a state of heightened emotional 'rapport' exists between them, which may interfere with the progression of the child's development.

> "We cannot hope, through any method of treatment, permanently to change the child's behaviour unless we can modify the unconscious of the mother" (Sperling, 1954a : 512).

The ideas presented above are those of the most prominent early figures in the field of simultaneous analysis in the United States, who pioneered, researched and experimented with the approach over several decades. A paper by Kolansky and Moore (1966) marks the point at which the British and American approaches to simultaneous treatment appear to dovetail. In drawing together all the major publications on simultaneous treatment in

the two countries up to that point, the authors are able to highlight the extent to which the findings of the different centres corroborate - despite various technical differences.

On the basis of these corroborative findings, as well as their ***own*** experiences in treating parent and child simultaneously, Kolansky and Moore (1966 : 266 - 267) conclude that simultaneous analyses:-

- bear out the claim that child analysis alone is inadequate when the unconscious forces in the parent work in the direction of enhancing the child's psychopathology;
- provide more definitive information about the foundations of personality and the roots of mental illness;
- demonstrate that the unconscious wishes of parent and child often coincide.

Kolansky and Moore (ibid : 242 - 265) discuss the case of a simultaneous analysis of a ***father***, and his 13 year old son Dick, referred for poor scholastic performance and lack of initiative and responsibility. The authors note that the case was an unusual one in that all other documented cases of simultaneous analysis involved ***mother*** and child, whereas in this instance the father was engaged in a long-standing pathological relationship with his son.

The case history and details of the treatment illustrate several advantages of the simultaneous approach : a clear picture of the child's developmental lines (his inhibitions, regressions and progressions) was obtained and the mutual psychopathology of neurotic interaction of father and son was illuminated. Once again, it was shown that it was only once the father's treatment became effective that the child was able to progress in his own analysis.

Following the publication of Kolansky and Moore's article in 1966, no further publications of simultaneous studies appeared in America until the 1970's. Kohn (1976 : 481 - 499) in a paper of a more technical nature, advocates simultaneous analysis of parent and child by the same analyst. Kohn found that seeing both the mother and child allowed him to observe the effects of the mother on her child, and of the child on the mother; to

be in the middle of the process of defense and character-formation in the child; and to observe how the child identified with the mother's attitude, and reacted defensively against her.

The successful concurrent treatment of a mother and her four year old daughter is described by Clemente et al (1986 : 140 - 150). The central problem emerged as that of arrested separation-individuation. The child's presenting symptoms of night terrors, a tendency to withdraw from the outside world, and her heightened sensitivity to and over-involvement with her mother, all pointed to a child at risk for the more symptomatic development of school refusal and more serious psychopathology. In the course of concurrent treatment, the symbiotic mutually anxious attachment between mother and child; the genesis of the child's avoidance in school participation; and a four-generation transmission of excessively demanding attachment between mother and child, all became apparent. The authors attribute the child's improvement to the treatment approach, which was seen to facilitate separation-individuation in the mother from her family of origin. This, in turn, enabled her to foster appropriate growth and development in her daughter, thereby helping her to separate and individuate.

In a paper on the involvement of mothers in the treatment of their electively mute children, Atoynatan (1986 : 15 - 27) suggests that the symptom of elective mutism is an expression of a pathological mother-child relationship. Through it, the child indirectly expresses the mother's hostility, and at the same time gains an exclusive relationship with her. The authors reviewed the various forms of therapy which had been used to treat electively mute children. On the basis of their own experiences with the use of concurrent treatment, they state:

> "It is our impression that the involvement of the mother in psychotherapy is the key to the solution of the problem ... The dependent relationship between mother and child cannot be resolved unless the mother can be helped through psychotherapeutic intervention to understand and overcome her resistance to basic change in the relationship. In spite of a conscious attitude on the part of the mother, treatment of the

> child alone will not succeed ... Our findings suggest the importance of focusing attention on parent-child relationships" Atoynatan (1986 : 25 - 26).

This concludes the literature review on the development of simultaneous treatment in the United States. Despite the technical differences in the British and American approaches, it is apparent that the aims of both are essentially the same, and that clinical work on both continents yielded corroborative findings.

References to simultaneous treatment of parent and child in other centres were not encountered in the course of the writer's literature search, and hence it appears that the British and American authors reviewed represent the main proponents of this approach. Of note however, is the work of Frances Wickes, a Jungian analyst practising in the 1920's. Wickes (1927) in her work with disturbed children also found that the process of therapy repeatedly led ***back*** from the problem of the child to the problem of the parent, and that analysis of the parent most closely connected with the child's emotional development was necessary. She provides (pp 61 - 77) several graphic illustrations of the power which the mother's projected images may have for her child and concludes: "It is a long journey from identification and projection to a clear and conscious relationship. Before this can be accomplished, the magnetic power of the projection must be broken by each of the persons involved through bringing the unconscious elements into the light of consciousness" (p 77).

> "... The things which have the most powerful effect upon children do not come from the conscious state of the parents, but from their ***unconscious*** background .... What usually has the strongest psychic effect on children is the life which parents have not lived ..." (Jung in Wickes, 1927; xvii - xxiii).

5.3. Conclusions

This chapter has provided a comprehensive overview of the available British and American literature pertaining to simultaneous treatment of parent and child. The literature review has revealed the range of presenting problems which may be treated via

this method; the different ages of the children which may be treated, including pre-latency, pre-adolescent and adolescents; as well as the range of parental pathology and how this impinges upon the child's functioning and the treatment endeavour.

The material reviewed appears to provide strong theoretical and clinical substantiation for the claim that analysis of the unique mother-child bond and its unconscious, mutually interrelated processes, is of crucial importance in the treatment of disturbed children encountered in clinical practice. The case excerpts presented in the course of the review are thought to be illustrative of the many developmental repercussions of failures of the earlier relationship with the mother, and demonstrate how vulnerable children are to wholesale incorporation of their mother's phantastical projections, complying with her phatasies in relation to them by processes of projective and introjective identification. For this reason, a central concern of the clinician should be to evaluate the persistence of unconscious interconnections of a primitive nature between mother and child that may be impeding the child's development.

Essentially, the case material presented points to the need for clinicians to re-examine the question of the role of the mother in the child's treatment. On the basis of the material presented in the paper thus far, the writer wishes to assert that it seems clear that the mother plays a crucial role in the child's development and, by implication, it therefore seems almost self evident that where optimal development has been disturbed by her, she must of necessity play a crucial role in the child's treatment. Greater therapeutic involvement on the part of the mother than has previously generally been the case is required. Whether the mother is seen by the child's therapist, by another clinician, more frequently or less frequently, is perhaps not the issue. What is of importance is that the mother be addressed in a particular way: contact with her should focus on involvement with her child, with attention to the unconscious meaning and associations held by her in connection with her child, as well as ways in which the child fulfils her unconscious expectations in the form of his symptomatology.

CHAPTER SIX : SIMULTANEOUS TREATMENT OF MOTHER AND CHILD : A CLINICAL ILLUSTRATION

6.1. Introduction

The preceding chapter comprised a literature review on simultaneous treatment of parent and child. The literature provided a convincing argument, backed by clinical examples, that in certain instances treatment of the child does not proceed satisfactorily without simultaneous treatment of the more significant parent – who is usually the mother. Simultaneous treatment was shown to be invaluable in highlighting the points of interaction between the disturbances of mother and child. Where the neurotic symptom, the conflict, or regression of a child is anchored not only in the child's own personality, but is also held in place by the powerful emotional forces in the parent to whom the child is tied, the therapeutic action of treatment may be slowed and in extreme cases, made impossible. The case material presented demonstrated instances in which the child's symptoms were given up in direct relation to the mother's relinquishing of either a fixed pathological position of her own, or in relinquishing her pathological hold on the child.

This chapter provides a clinical illustration[1] of simultaneous treatment of mother and child, undertaken by two clinicians at a Child Psychiatry Unit from March 1988 to March 1990. The case was chosen as it is thought, by the writer, to be illustrative of the possible developmental repercussions of failures in the early mother–child relationship. The case history and course of treatment vividly demonstrate disturbances in the mother–child relationship and the pathogenic effects of persistent unconscious ties between mother and child. The writer hopes, in presenting this case illustration, to provide clinical substantiation for the theoretical arguments developed in the preceding chapters of this paper, as well as to demonstrate the efficacy of the simultaneous treatment approach. The writer wishes to stress that the purpose of the case presentation is illustrative : the

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[1]Identifying details have been altered, to preserve the patients' anonymity.

emphasis is on the ***qualitative*** aspects of the case material and conclusions drawn are not necessarily generalisable to other cases.

6.2. ANN AND IAN : AN OLD, ARCHAIC WAR IN THE HERE-AND-NOW

6.2.1. Description of the Index Patient:

Ian was referred for treatment in March 1988, aged ten years. Ian had been in treatment at the Unit twice previously: in 1981, aged 3 years, he presented as hyperactive, aggressive and sleepless. The parents entered marital therapy and mother was seen for several individual therapy sessions. In 1985, when Ian was seven years, he presented with a major depression. However, mother discontinued his treatment after a few sessions and there were no further contacts until he presented for the third time in 1988. He is the only child of now divorced, lower-middle-class parents, and lives with his mother Ann, and her boyfriend of six years, Kenny. Presenting problems (as described by his mother) included several recent instances of stealing, mainly from his mother; behaviour problems at the school after-care centre; decreased concentration at school, and deterioration in his scholastic performance. In addition, his mother had noted that he had seemed 'down' and 'not himself' for about three months prior to the referral; he was not listening to her, and she felt that she 'could not get through to him'.

6.2.2. Highlights of the Family History:

Mother: Ann, 30 years, a secretary, is the eldest of three children. Her parents divorced when she was 13 years and she subsequently had little contact with her father, who abused alcohol and was frequently violent towards her. Ann felt that he used to understand her completely' but had 'changed completely' after the divorce. She feels that Martin, Ian's father, is like ***her*** father. Although she initially reported that she and her mother were close, it later emerged that her mother was not at all emotionally available to her as a child. Ann suffers from a debilitating skin disease, of unknown aetiology, which is apparently stress-related and incurable.

The writer now wishes to illustrate, in chapter six, by means of a case from clinical practice, her view that failures in the mother-infant relationship lead to psychopathological elements in the child. These are then perpetuated by the mother, who participates in the psychopathology and remains invested in its continuation. The writer hopes that the clinical material presented will demonstrate to the reader how the simultaneous treatment approach facilitated the recovery of the child.

Father: Martin, 31 years, is the second of four siblings. His parents divorced when he was eight years; violence was a feature within the family. His relationship with his parents was extremely negative. He was described by Ann as immature, unstable, unpredictable, and softhearted (words she often used later to describe her father). Martin takes no responsibility for Ian, is selfish, and she feels she 'can't get through to him'.

Marital Relationship: The parents married in 1978, separated in 1983, and were divorced in 1984. Ann felt that she could not communicate with Martin; that he was always out drinking and never there for her, when she needed him. Since the divorce, Ann has lived with Kenny, 28 years – a very quiet, reserved person, who comes from a large, affectionate family. Martin married again in 1986; his wife has a son Ian's age. The marriage is fraught with conflict and violence.

6.2.3. Highlights of the Index Patient's Developmental History

The Primary Relationship

The mother–child relationship was problematic from the outset. Mother reported that Ian was a difficult, aggressive baby, who screamed continuously, ate poorly, had colic, hardly slept and Ann "couldn't stand it". At two years he developed viral meningitis and was hospitalised for a week; mother was asked not to visit him. Ann subsequently returned to work and Ian started créche. He started school aged six–and–a–half years and coped reasonably well.

Functioning at the Time of Referral

Prior to his referral in 1988, Ian was generally a happy, enthusiastic and energetic child, but then became lethargic, lost interest in all his usual activities, complained of boredom, was unable to concentrate at school and seemed exhausted. He began to tell lies, started stealing, sulked if asked to do anything, was selfish and just wanted to play. He had begun to wake up at night, and then was unable to fall asleep again; he sometimes sleep–walked and screamed in his sleep.

6.2.4. Highlights of the Psychiatric Assessment

Mother: Ann presented with a coping facade and was extremely adept at hiding her serious depression and very poor self-esteem. She was deeply fearful of entering intimate relationships, lest she be let down. The assessment revealed that Ann used projection as her major defence and that she had in fact projected most of her problematic images and feelings out of herself and into Ian, so that he was carrying all her problems. He had become the 'container' for her projections and she consequently perceived ***him*** as having the problems and herself as problem-free. He became, from early on, the container for her primitive, unconscious phantasies and therefore came to represent the hostile, dangerous object.

Ann related to Ian primarily through projective identification, perceiving in him all her own feelings of badness and inadequacy, as well as her feelings of abandonment and depression. Ian also stood for her image of others (especially of her father and ex-husband) whom she perceived as having ill-treated her and having let her down, and she consequently felt ill-treated and let down by her child. Ann attacked Ian continually for all her hurts and distress. Her major expressed feeling was anger, with very little expression of affection. Initially however, she was unwilling to acknowledge that she herself had any difficulties and was unable to address these for some time.

Child: On assessment, it was established that Ian was seriously depressed. He felt himself to be all bad and the cause of the emotional problems of the family. He felt abandoned by both his parents and was afraid of being further abandoned by his mother. To prevent catastrophe, he had developed obsessive compulsive rituals; he seemed unable to think about anything other than ghosts and could not allow himself to relax and sleep for fear that the ghosts could cause bad things to happen at night. He was concerned about his mother's mental state and feared that he was responsible for it.

6.3. Treatment

6.3.1. Initial Phase : Joint treatment of mother and child, by one therapist

Because Ann initially did not experience herself as having any difficulties, did not at first see the need for any treatment for herself and would not accept treatment without Ian, she and Ian were seen together for joint sessions every alternate week and Ann was seen alone every other alternate week. In the course of these sessions, which continued for a ten-month period (from March 1988 to December 1988) the nature and strength of Ann's projections onto Ian became very clear to the therapist. Ian's stealing stopped as soon as it was interpreted to him that he felt that he was like a very bad robber, and his mother began to understand that his behaviour was in response to her interactions with him. His depression lifted on a course of anti-depressants but he became depressed again towards the end of this first year in treatment (1988) ***as there had been no fundamental change in terms of his having to receive and live Ann's projections.*** At the end of that year it was agreed that he should repeat standard two (as it seemed unlikely that he would cope in standard three); the following year he began to do well at school with remedial help.

It was only after ten months of joint treatment that the therapist felt Ann was ready to engage in her own therapy and that Ian would benefit from having his own therapy. Although Ann's projections were not altered in the course of the joint-sessions, she did begin to focus more on her own issues and with this she became more and more overtly depressed. At this time, Ian drew a picture of her **(FIGURE 1, p71)** saying: "All her problems are coming out". Ann's essential conflicts were centred around relationship difficulties, her "people problem" as she called it. She maintained that she did not need people and would rather be alone. Yet, she was intensely affected by what she felt people did to her - that they exploited her and attempted to get things from her, or envied her and tried to take away what she had. As a result of her emotional deprivation in childhood, and the loss of her father's understanding, she continuously ***expected*** to be deprived of what she had and her horror of Ian's stealing derived from this.

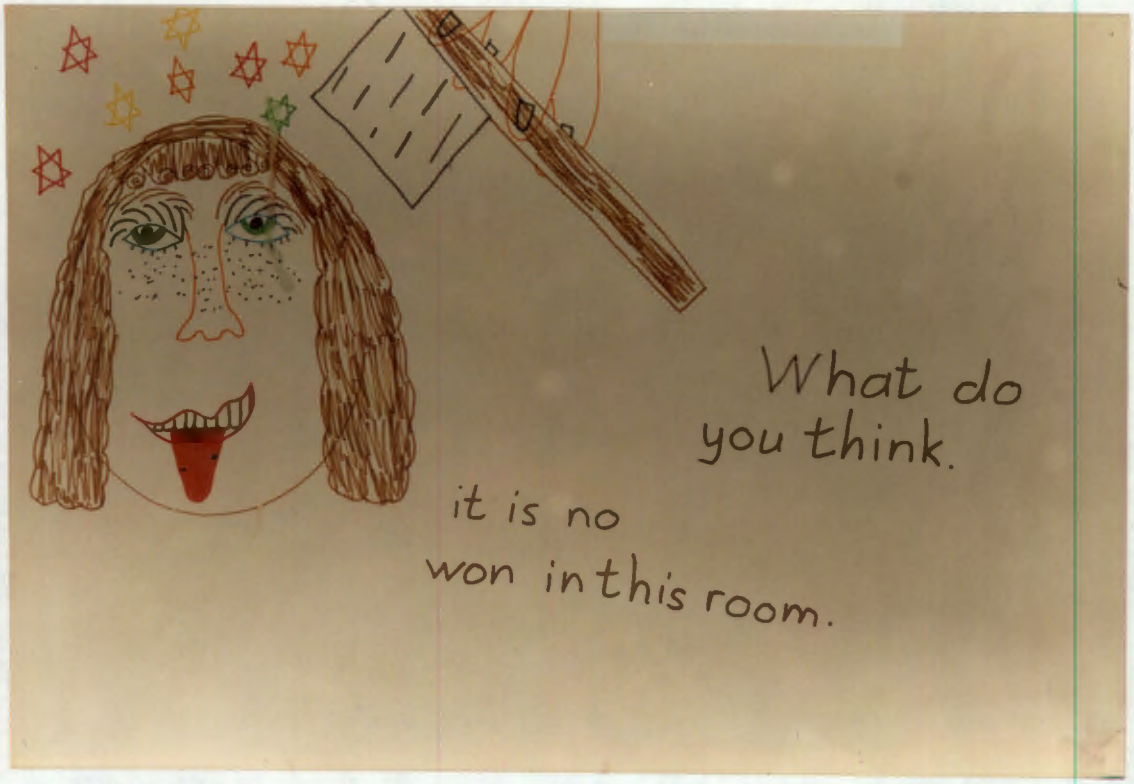

FIGURE 1 : ALONE AND DESPERATE

Ann's convincing coping facade was developed in order to get rid of vulnerabilities and needs, so that she could not be hurt again. The skin illness which she suffers from is the only way in which she is able to acknowledge vulnerability and it was perceived by her therapist as serving as a symbolic representation of her emotional illness. Her true self-image was made up of qualities such as no-good, all wrong, stupid, silly, bad, inadequate. These images she projected into Ian completely, so that there were none of them left in her ***conscious*** self-image or in the way she came across. Together with projections onto Ian of her object images (that is, stealing, unreliable, unco-operative, selfish etc.) these projections onto him were the cause of his depression. His ***unconscious*** perception of his entanglement with his mother is illustrated in **FIGURE 2 (p73)** the picture he drew immediately before beginning his own individual therapy.

6.3.2. Treatment Proper : Simultaneous Treatment of Mother and Child, by Two Different Therapists, in Collaboration with One Another

The initial ten-month phase of the treatment, in which mother and child were seen jointly every alternate week and mother was seen alone every other alternate week by the same therapist for 'counselling' sessions, focused almost entirely on Ann's problems in managing Ian. Gradually, as she became more conscious of her own difficulties, the focus began to shift towards her own internal conflicts and with this Ann became more overtly depressed. Finally, she was able to acknowledge her own difficulties and was ready to enter individual therapy with the therapist who had undertaken the earlier joint sessions.

Ian at this point (February 1989) entered individual therapy with another therapist. The two therapists concerned met regularly with one another, to exchange therapeutic material and to discuss the mental state of both mother and child. Both clinicians also met separately with their respective supervisors for further analysis of the case material which emerged in the two therapies. After 15 months of therapy Ian's functioning had improved to such an extent that his therapy was terminated (April 1990). His functioning

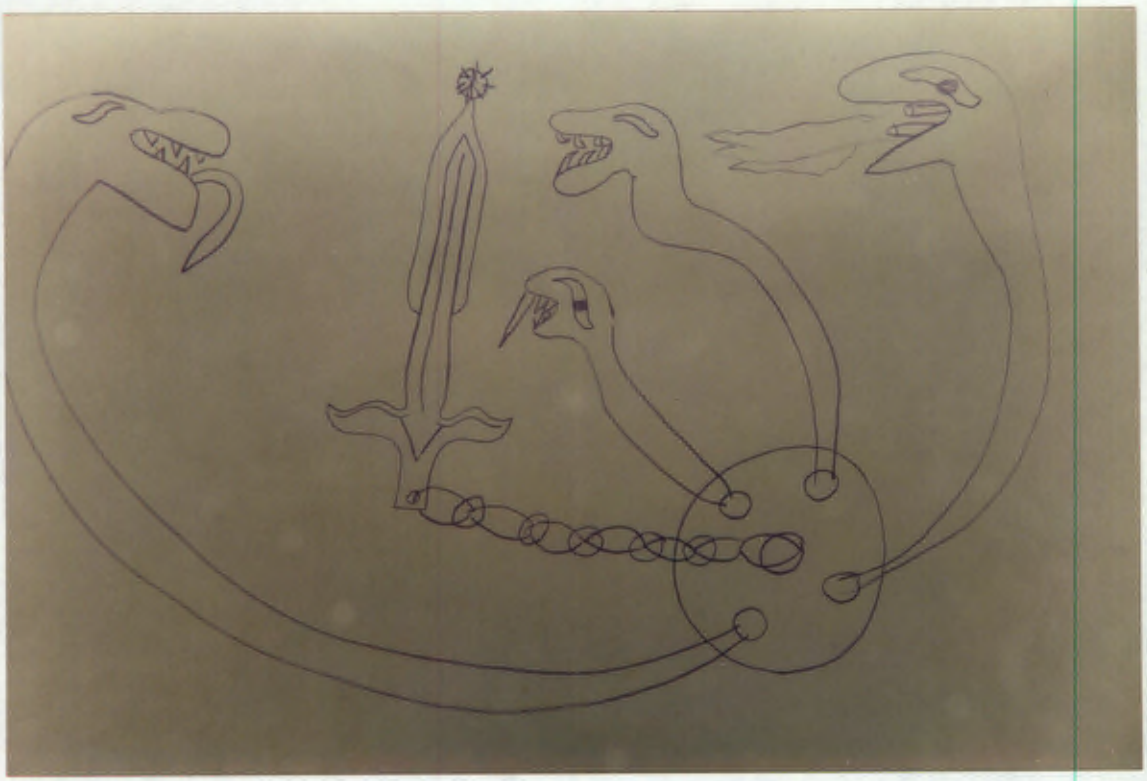

FIGURE 2 : ARCHAIC ENGULFMENT

has remained stable, to date. His mother has continued in individual therapy.

The two therapies are presented simultaneously, showing the interrelationship and overlapping of psychic material between mother and child which emerged at various intervals in treatment. The divisions in the clinical material presented occur at the points in the two therapies when the interlocking processes between mother and child emerged most clearly.

IAN

Ian presented for therapy as an attractive, very well mannered nine year old who was, interestingly, usually dressed in play clothes which often matched his mother's outfit. He was anxious to please and extremely sensitive to underlying meanings. In the 15 months he was in therapy there was seldom direct communication between him and the therapist: in most sessions he drew pictures which started out as a simple scene and which would then progress to a more complex theme. Occasionally he would model plasticine. When he talked his apparently every-day themes were taut with underlying meaning and there were frequently two conversations in progress: an apparently superficial one about, for example, fishing or skateboarding, which usually disguised a serious deeper communication about his fears and wishes. The therapist therefore had to reply in a similar manner, that is, on the superficial level, but in a way which nevertheless conveyed an understanding of the disguised deeper communication. Any attempts to address an issue directly resulted in withdrawal into himself and termination of the conversation, or destruction of the drawing.

In the first session, Ian drew a fish enclosed inside jaws with sharp pointed teeth. **(FIGURE 3, p75).** He said this was a baby killer whale [himself][1] about to be eaten by

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[1]The writer's interpretive comments clarifying aspects of the clinical material are placed within square brackets.

FIGURE 3 : DANGEROUS MATERNAL ENGULFMENT

a shark [mother]. It was a tough little whale which tried to defend itself but was not strong enough to escape from the danger. A diver [therapist] came to see if he could help the whale and shot some arrows at the shark. But the water was murky because of the struggle and he couldn't see to aim so hurt the whale. Eventually, the diver decided that drastic methods were required and used dynamite to blow up the shark. This led to the death of the baby whale – who didn't deserve to live anyway, because he was so bad. The diver would then shrug his shoulders and leave – he'd done his best and it didn't work – it couldn't be helped [Ian was questioning whether the therapist could in fact 'rescue' him from the engulfment he experienced as a result of his mother's unconscious projections, or whether the therapist would fail and he would 'go under', further lose his sense of self and become more bad – just as his mother made him feel and expected him to be]. This drawing took the whole session. Ian was distressed, pale and kept asking to lie down as he was tired out and needed to sleep. By the end of the session he had decided that the diver would return to see if he could rescue the whale after all.

In the second session, he drew a man struggling to keep the balance between two unequal weights and in the third session he drew **FIGURE 4 (p77)** which exhausted him, and which he refused to discuss. [An unconscious communication conveying both his anger and his woundedness]. After this session, he began visiting his father regularly (which he had not previously done) though expressing very ambivalent feelings about him. He started to become more relaxed and in the fifth session modelled a bird pecking its way out of an egg on which he scratched the words : 'It is a bird' and 'it is hatching'. [This seemed to indicate that Ian was feeling less engulfed by his mother and was making his first attempts at emerging from the symbiotic relationship with her, to begin his own journey of separation, differentiation and individuation]. He then modelled a basket with the lid open, full of buried treasure and asked the therapist to keep it [thereby indicating that there was a great deal that was still 'buried', unconscious, which still had to be searched for – but that the way was open and he had entrusted, symbolically, all

FIGURE 4 : WOUNDED AND ANGRY

this precious material to the therapist, indicating that he thought she would keep it safe, contain it and would be there with him as he uncovered it].

However, after this session he became very reluctant to do anything in therapy; he refused to touch any materials or to talk and actually kept falling asleep. The therapist's impression was that separation issues might be arising ie that 'hatching' was a scary business and Ian was therefore afraid to use material that might betray his innermost feelings. At this time, Ann's therapist reported from mother's material that at home Ian had been distant and uncommunicative; he was also manifesting separation anxiety symptoms, objecting and clinging to his mother whenever she wanted to go out. Ann's mental state was giving cause for concern as she was becoming more and more depressed as she engaged in therapy. Ian's lethargy and sleepiness in the therapy sessions seemed to be a powerful reflection of his unconscious identification with his mother's psychic state, a mirror-reflection of her depression.

Over the ensuing few weeks Ian spoke about streams and oceans and of all the things he had found in them - some of them very precious treasures and also dark and dangerous things. His discoveries varied from week to week and seemed to reflect what was happening in his unconscious. Water, as the symbol of the unconscious, held the treasured aspects of his 'self' which had previously not been able to emerge due to his mother's powerful negative unconscious processes operating, impinging upon and delaying the emergence of his 'subjectivity' (cf Walt, 1986). Also becoming conscious were his ambivalent and angry feelings towards his mother - the 'dark and dangerous things'.

Ian then began to appear depressed and brought an aura of loneliness into the room with him. His mental state again paralleled that of his mother's at the time; he seemed 'infected' by her state, became increasingly lethargic and unable to function. At about this time, his mother reported to her therapist that Ian was getting to be "the little man"-

very independent and choosing to visit his father rather than go out with her. Ann appeared to be having difficulty coming to terms with Ian's increasing separation from her, her depression deepened and her therapist was concerned about a suicide risk.

In the next session, Ian drew an Alien **(FIGURE 5, p80)** – a scorned, unloveable and stupid creature, who had found an arrow, thrown it to see what would happen and had only succeeded in hurting himself. He deserved no sympathy. Ian's therapist's impression was that Ian had been experimenting with his own aggression – 'the dark and dangerous things' – and had hurt himself. She also felt that something inside was starting to come alive. Collaborating with Ann's therapist, Ian's therapist established that Ann was giving Ian a very hard time [hence his Alien feelings] but he was standing up to her and holding his own...

In his next session Ian drew what he described as "a baby picture", which he would never do at school **(FIGURE 6, p80)**. The duck [mother] laid an egg [her 'unhatched' psyche] in the ocean, but she would have to be pushed down onto the bottom to make her sit on it and she would have to be held there [by her therapist] as she wouldn't do it herself. When asked if the duck would survive this, Ian measured the depth of the ocean and then the duck's neck and said she wouldn't drown. The egg would hatch out a creature half duck and half fish, which was doomed, because the duck part [conscious ego] would have to leave the water to breath, but the fish part [unconscious id] would then die and drag it back under the water [the internal struggle would be too great]. The duck would then eat the dead fish [mother would swallow ie. repress the unconscious conflicts]. Ian's therapist noted that there was no tension during this session; the material which had emerged did not appear to be his own. (When producing material that was clearly his own, he would be distressed and exhausted). On comparing the material which mother and child had produced in their respective sessions on this day, the symbolic material presented in Ian's drawing very clearly 'belonged' to his mother.

FIGURE 5 : THE ALIEN

FIGURE 6 : THE DUCK PICTURE

ANN

In the simultaneous session in which Ian drew his duck picture **(FIGURE 6, p80)**. Ann spoke in **her** therapy session of feeling 'slowed down, extremely tired and unable to function; she felt her fingers wouldn't work properly'. Retrospective reflection on the part of the two therapists illuminated the symbolism of Ian's duck picture. That is, that Ann was not feeling able or prepared to work on her issues (contained in the egg); she would need holding down ie support from her therapist; with help she would survive this difficult time, though she would initially not succeed with unconscious issues.

Ann said she had had her thyroid tested and was disappointed that this was normal – she'd hoped this was the 'cause' of her tiredness. The doctor had said she was depressed ... she maintained she wasn't feeling ***depressed***, she was feeling ***ill***. Ann's therapist said that this feeling reminded her of Ann's previous fear of slowing down and stopping completely, if she let go and stopped trying to cope. Her fear was interpreted as one of being dependant and of having no one to take care of her.

Ann's feeling continued in the next few sessions. She became concerned that her therapist would become bored with her repetitiveness, that work colleagues would ask her to leave if she tried to make them understand and that even the doctors would say they couldn't deal with it, if she tried to make them see how really bad she felt. She then told the therapist that she'd felt terrible the day before, at work. Her therapist commented (inaccurately) on how often Ann told her about how bad she'd felt another day, but when she came to therapy she was feeling better or didn't say how bad she felt. Ann didn't agree.

The following week, Ann telephoned to say she would not be able to come to her session as she was going into hospital. When the therapist saw her for her session in hospital, Ann said that after the last session she just wanted to go away from everybody, not even see her therapist. She'd wondered: "What must I do to get her to believe me?" – she'd

thought that the therapist's comment had meant that she ***too***, like all other people didn't believe how badly she felt and didn't understand her. Ann spoke of her anxiety that the doctors would say she's not ill, that there is nothing wrong with her. Even though she was still so tired, they kept saying it was depression.

Ann said that it was exactly as she'd always feared – it felt like she would never get up again. She feared having to depend on people – they wouldn't be reliable. She then told her therapist how important her therapy days had become for her and how close to the therapist she felt; her therapist talked again of how terrible it must have felt for Ann when she didn't understand her the previous time. Ann cried and spoke of how nervous she is of people – she feels she can't talk properly, her face is all skew – she feels all wrong, like a helpless child, who needs to be looked after. She related her 'all wrong' feelings to Ian, who also feels like this and said: "I've done this to him ... we're both dying inside". [Ian's 'scorned, unloveable and stupid Alien' picture, drawn a few weeks prior to Ann's admission, seemed on reflection, to symbolise both his own, and his mother's feelings].

When the therapist saw Ann in hospital the following week, she had been told that there was nothing medically wrong with her; she felt angry that they didn't believe her. She said the doctors used to be kind and caring, but now they weren't. She had felt cared for – like a child in hospital; she felt so small and the doctor seemed so huge.

IAN

A week after Ian had drawn his "duck picture" **FIGURE 6 (p80)** he drew **FIGURE 7 (p83)**. The skateboard rider [himself] had taken a risk, got scared and jumped off at the last minute. As a punishment for this, a saw had been erected which could destoy his skateboard. However, this rider would return with a new skateboard and try again [he has courage and ego strengths].

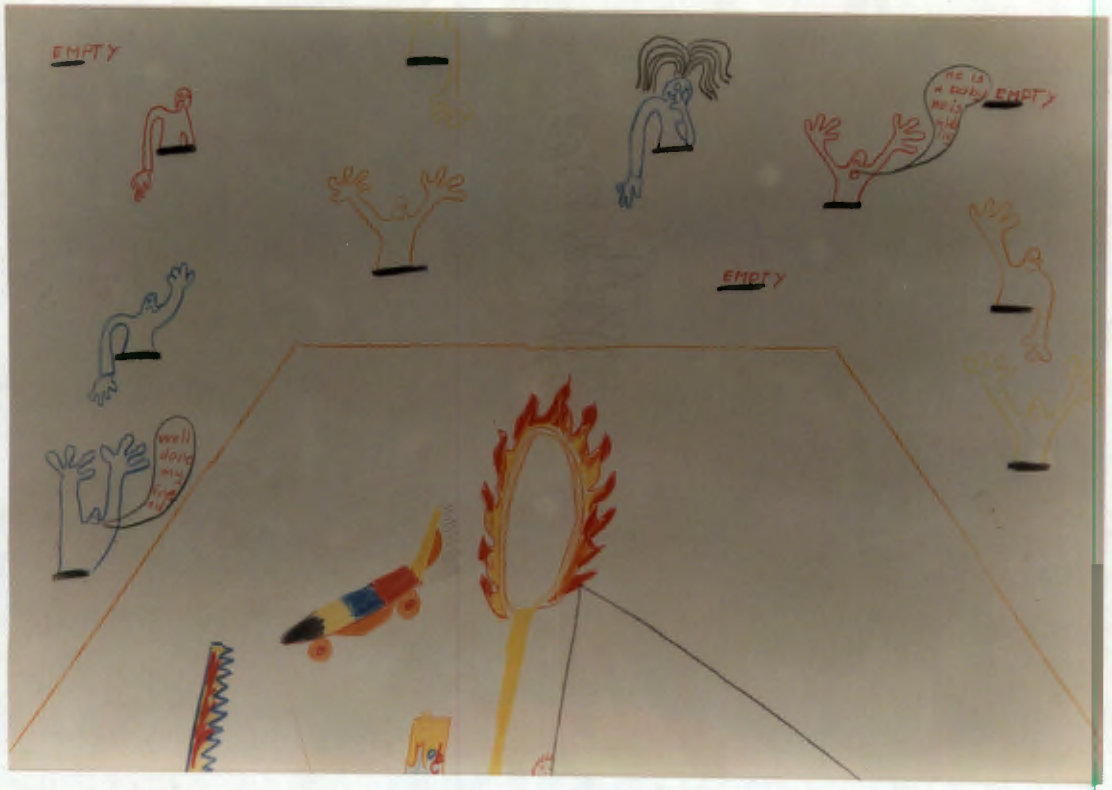

FIGURE 7 : THE SKATEBOARD RIDER

His therapist noted that throughout the therapy had been running the theme of Ian's badness, his sense of shame and his feeling that he could not relax and be himself. When his mother was admitted to hospital, Ian's anxiety levels increased and his poor self-esteem became increasingly apparent, together with his expectations that people would see only the bad side of him. He made a letter for his mother, telling her that he loved her, but would not give it to her in case she didn't want it.

Ian's mid-year school report was very good, but after the holiday his first session was tense. He blurted out that his father was going to live in Durban and he admitted to feeling empty and aching. He then cut off and drew **FIGURE 8 (p85)**. He said the therapist must find where the treasure was buried - she had one chance only. [The treasure was at the X under the '***no entry***' sign]. He elaborated on the drawing: The man [Ian] had come to the picnic ground and gone across the stream to the other side. It had started raining over the picnic area [he was feeling weepy and let down]. He had come to where two streams [representing his unconscious relationship with his father] went under ground and there was a 'no entry' notice. The forbidden area contained graves [containing the angry and painful feelings which had to be buried] - he quickly corrected himself and said it was snakes and dangerous. [His entanglement with his mother].

Ian became impatient with the therapist's questions and ordered her to find the treasure - which she did - buried under the 'no entry' notice. He then drew a bridge over the stream and said the man could now get back to his picnic [Ian had 'by-passed' the feelings because they were too painful to confront]. The therapist observed that there had been a great deal of tension during the session and she viewed this picture as being of key importance in the therapy. Ian's 'communication' was respected and no further attempts were made by her to explore his sense of loss.

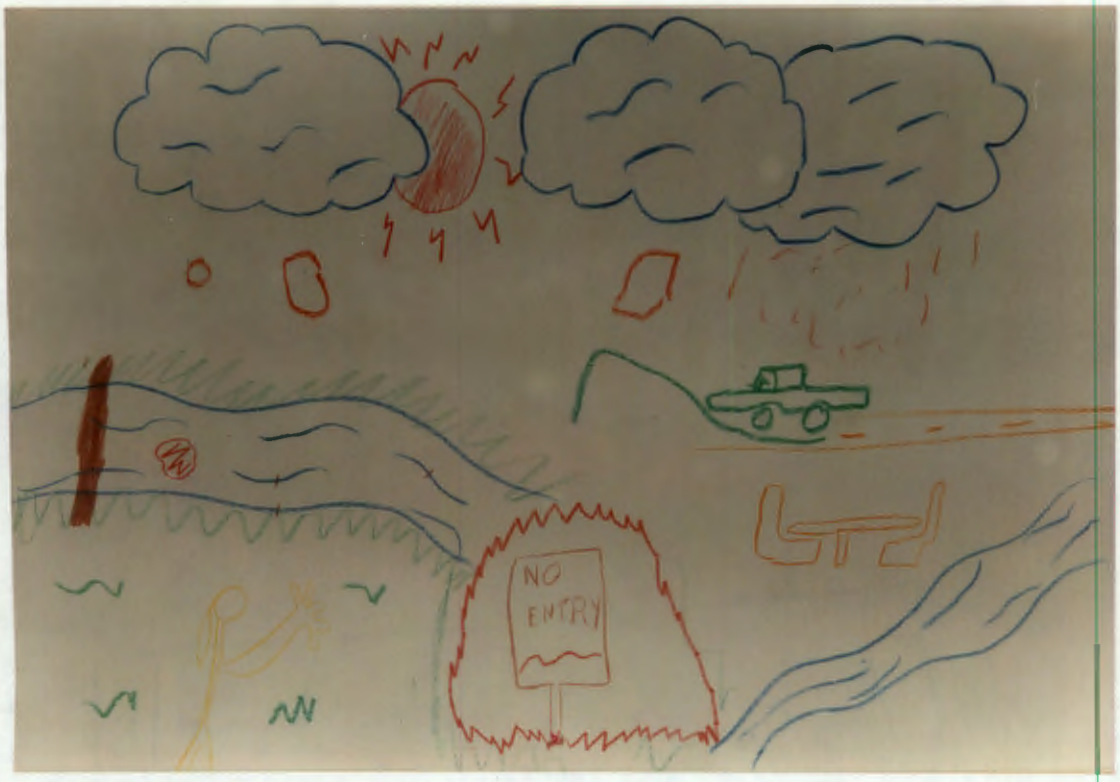

FIGURE 8 : BURIED TREASURE AT THE PICNIC

For the next few weeks Ian's defences were high: sessions were spent talking about aeroplanes – he seemed to be trying to come to terms with his father's possible move by concentrating on practical matters. However, his misery surfaced painfully in the next drawing he did **(FIGURE 9, p87)** which he described as "an ugly, wicked skolly dog" [himself] thrown away at birth and living in a dustbin, drinking from a leaky glass. He was surrounded by fire to keep him away from nice people and someone had pierced his heart with an arrow. No one would be moved to rescue this dog. There was no hope for him [he was conveying his own sense of abandonment and rejection].

Ian's depressed mood continued for about a month, after which he again seemed more cheerful and drew a picture of a war – a very old war in which destruction and confusion reigned **(FIGURE 10, p87)**. It was about possession of a rich and fertile land. Once again, during this session, his therapist was struck by the seeming incongruency of mood – the war of destruction, yet Ian's mood was light and the material appeared not to be his own.

ANN

For a while after her hospital experience, Ann was devastated, feeling that the understanding father (represented by the doctors and hospital staff) had again let her down. She was extremely upset and after reliving painful childhood memories then tried to get rid of all her feelings in an attempt to retrieve her 'coping facade'. She read books on macrobiotics and tried to cure herself of her illness, so that she would not need the doctors. During this time she began to complain again of Ian's behaviour – his uncooperativeness, his irresponsible and selfish attitude and spoke of his similarity to his no-good father. [It was at this time that Ian drew his "skolly dog" picture **(FIGURE 9, p87)**]. Ann's projections into him of all her bad feelings, together with her unconscious phantasies of him having 'inherited ' or taken on all his father's "badness", coloured her

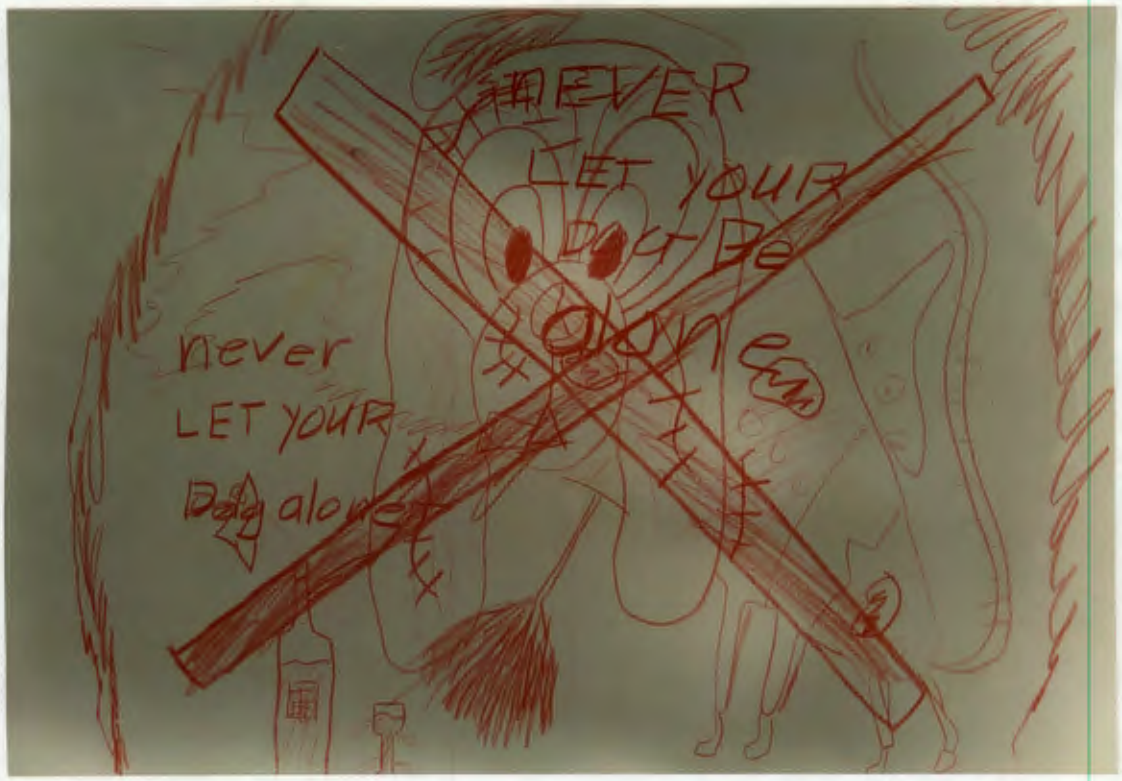

FIGURE 9 : SKOLLY DOG

FIGURE 10 : AN OLD, ARCHAIC WAR

perceptions of him and his actual behaviour to such an extent that Ian actually experienced himself as ugly, wicked, no-good – in fact, that he had to be kept away from all nice people, condemned to a life of badness, without hope.

After a period in which Ann maintained her defensive stance, external changes began to occur and gradually she allowed more feelings to emerge. She began to assert herself at work and with other people and began to get in touch with the aggressive, assertive side of herself, which felt entitled to have what she wanted. She herself ***felt*** aggressive and nasty; her therapist experienced her as having mellowed, having become more vulnerable – very different from the raging person she had been the previous year.

In one session, she told her therapist all her fantasies of revenge on the people who had hurt, betrayed and abandoned her. She felt anxious about her murderous wishes, as if she was sitting on a time bomb. The therapist felt that Ann's explosive internal situation was superbly expressed (***unconsciously***) in Ian's picture of the 'old war' **(FIGURE 10, p87)**. Her war was indeed an old war, even though the explosive feelings were then being currently experienced. A great deal of work had to be done with her feelings and she was able to relate them more and more to original childhood feelings of being let down by her father and of feeling that he was stolen away from her. She also addressed feelings about her mother, who had ridiculed her feelings and opinions and made her feel that they were not allowed. She observed: "I'm not allowed to exist".

IAN

After the session in which he drew the "old war" **(FIGURE 10, p87)** Ian went into a prolonged period devoted to the subject of skateboards. He talked about them, drew them, described tricks, even brought his own to show his therapist. They seemed to have an importance which consumed him and to have deep inner significance. It became evident that his developing male identity was bound up with his capacity to perform on a skateboard and he was concerned that what his mother, father and Kenny

were prepared to give him was insufficient for his needs. His sense of deprivation came through very strongly.

He started to act out at home and began confronting his father for making promises and then letting him down. He discovered that his father could accept his anger and nothing terrible happened and he started to show some self-confidence. For the first time in nine months of therapy, he spent an entire session angrily criticising his parents; he felt they both lied to him, talked to suit themselves and treated him like an idiot. He admitted that at times he could not stand his mother and he wanted to tell her so but reckoned that she would not be able to take it, as his father had. He also indicated that if he wasn't doing so well it was because he wasn't getting any help, rather than because there was something wrong with him [ie. If he had a better skateboard, he would be doing first class...].

After this outburst, he was noticeably more cheerful and confident. He drew a picture of a hand **(FIGURE 11, p90)**. He admitted that in this picture, everything was alive except for a small part that was rather dead-looking (as opposed to earlier pictures where only a small part would be colourful and alive) and that that was the way things were now [ie he was no longer feeling depressed]. He reckoned that the central part could perhaps be coloured in very faintly too, because it ***was*** alive. He started colouring the diamonds, and said that they weren't perfect but it wasn't important, it wasn't necessary to do everything perfectly [indicating an integration of both good and bad aspects of himself]. He continued with this latter thought for a few weeks, repeating it often in relation to what he was doing. He seemed delighted by this new discovery and became visibly more confident and relaxed.

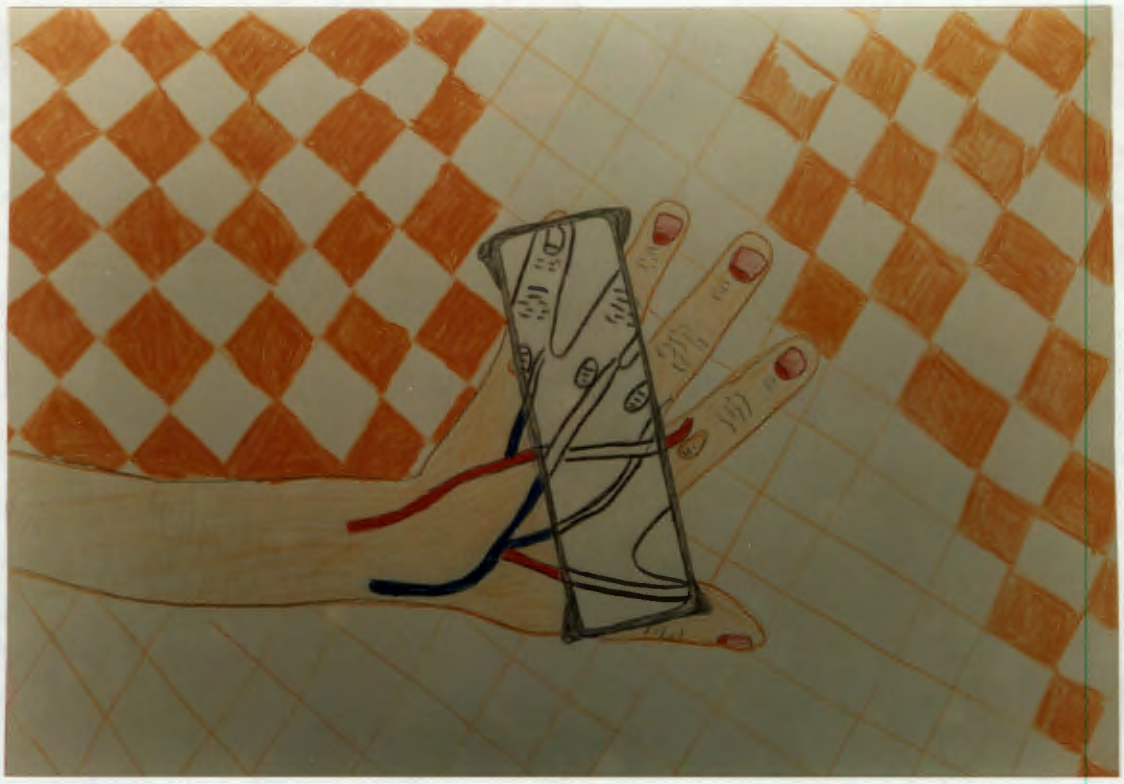

FIGURE 11 : COMING ALIVE

In November 1989, after ten months of simultaneous therapy, Ann's therapist was away; Ian was brought by his mother to see his therapist. He seemed tense and unwilling, and eventually expressed his anger at having to attend therapy, when his mother did not, because ***he now believed that it was his mother who had problems rather than himself***, but that everyone, as usual, was blaming him and making him pay. This issue was explored over two sessions, as well as his feeling that his mother considered him stupid and bad, and that Kenny never really considered what he had to say. He expressed unhappiness, considerable anger, and a desire to hurt the adults in his life, as they hurt him. However, he terminated his sessions by modifying his opinions, mentioning redeeming features and by saying that things were going to be better – his row was over now ...

From then on he was a different child. He had an excellent end of year report and won a prize. For a while, it looked as though he was overconfident and accepting no responsibility for any interpersonal conflicts that arose. Gradually this seemed to settle. He persisted with the theme of skateboards and issues of growing up and needing male company and examples were explored. He decided that Kenny was not helping and that while his father's contribution was not the very best, it would do – it was enough. He said he felt his father was doing a better job with him than his mother, but confided that he was not angry or disappointed, because he now realised she was doing the best she could. However, he did wish that things could be better and commented that his mother was unable to give things, or to enjoy what she had. He was happy to do without therapy for the entire Christmas holidays.

In the New Year, Ian did not want to come to therapy, was initially somewhat subdued and again preoccupied with skateboards. However, in the fourth session after the holidays, he produced the drawing of a ship[himself]; strong, forging ahead in stormy seas with a strong wind blowing **(FIGURE 12, p92)**. The ship was travelling at speed,

FIGURE 12 : FORGING STRONGLY AHEAD IN STORMY SEAS

with cannon firing, to tell everyone on shore it had weathered the storm and was coming in safely ...

After this, Ian started playing games of 'Baddies and Goodies' in which tame animals and Goodies won. The therapy sessions were relaxed and comfortable and he and his therapist played games. His difficulty in stating his own views and preferences was discussed, as well as his tendency to try and gauge other people's needs and wishes rather than just getting on with his life. The subject of termination was broached and he eventually, with help, made his decision to terminate (March 1990). He appeared sad, with a sense of loss and in the last session asked what would happen if he should want to come back to his therapist again; he accepted the therapist's telephone number.

ANN

As therapy progressed Ann began to realise more and more how she prevented people from getting close to her because of her "protections" as she put it. That is, her need to prevent herself from getting hurt again. Her feeling of being used by people remained very strong and was repeatedly projected during this period onto Ian who, she said, completely disregarded her feelings. (Ian was at this time ruthlessly demanding skateboards from her and was reportedly extremely difficult to manage).

Prior to this, her therapist had not interpreted her projections, as she felt Ann needed them and would experience interpretation as an attack. At this point, her therapist felt she was ready and interpreted that she thought that when Ann felt hurt by people, she saw Ian as if ***he*** was all the people who had hurt her and then she acted towards him as if he ***was*** these people. Ann accepted this and said that Ian doesn't only remind her of ***his*** father, but also of ***her*** father. She said she didn't want to harm him by doing this to him.

In the next session she again reported that Ian was difficult – he was not what she had expected from her child. Again, the therapist interpreted it as her perception of him. Ann then told her therapist she had been having anxiety attacks – she felt that there was about to be a disaster all the time. She imagined something happening to Ian and so begged him not to go in the road on his skateboard. She was having to clean the house all the time, otherwise she felt guilty.

In a later session, Ann said that her anxiety had decreased, but that she was still cleaning all the time. She referred to what the therapist had said about how she perceives others in Ian and said: "I don't want to be the cause of all his problems". Although the therapist could have reassured her at this point, she felt it was necessary for Ann to face her part in her child's problems, so she just reflected her pain. Ann then spoke of conscious wishes she'd had to hurt Ian and about which she felt terrible. (Her anxiety about Ian being harmed then became clear). The therapist was then also able to tell her that Ian's stealing symbolised ***her*** (Ann's) feelings of people taking from her and Ann was able to accept this. Gradually too, she began to realise how her own feelings of inadequacy made her suspicious of other people's motives towards her.

Ann became more and more in touch with her own feelings of inadequacy and her neediness. She spoke of her altered perceptions of the world: she felt disillusioned – everyone was just ordinary, not good or bad, just ordinary. She had thought her father and her uncle and her brother and his wife were so perfect – they were never really like that, just ordinary. Ian is not perfect, or all bad , just normal. Thus, from perceiving people as being either perfect or all bad, she began to be able to see them as normal and ordinary and then also began to feel more acceptance within herself.

Ann is still in therapy and she still has a long journey ahead of her before she will be able to establish the world as a truly good place, in which she can allow herself to be needy within it. With respect to Ian however, her perceptions of him have altered

radically in accordance with her altered internal objects. This altered perception of him has enabled her to relate to him in an appropriate way, rather than in accordance with her phantasised, distorted perceptions of him. By owning her projections, Ann has freed her child, enabling him to continue along his path of differentiation and individuation, largely unhampered by the burdensome, inherited legacy which she so unconsciously bestowed upon him from very early on.

6.4. Discussion and Concluding Comments

The clinical material presented above highlights significant aspects of 15 months of simultaneous treatment of a mother and her child. Representative vignettes were related from the two respective therapies in order to bring to life the theoretical claims made in the preceding chapters of this paper. In concluding the presentation, the writer will attempt to discuss the ways in which the case illustrates the pathogenic effect which the mother's unconscious legacy bestowed upon Ian and the subsequent impairments in Ian's functioning which resulted from these maternal impingements. Essentially, the case material presented demonstrates how Ian's symptoms were given up in direct relation to his mother relinquishing a pathological position of her own and in this way contributed to his recovery.

6.4.1. Clinical Observations and Implications

The background data to the case suggests that there may have been early indicators – which pointed to the early mother-child relationship impairment – when Ian presented for treatment for the first time in 1981, aged three years. At that time, mother reported that their relationship had been an extremely difficult one from the outset. The writer proposes that had the more subtle nuances of this relationship been explored more deeply at the time and, more specifically, had the presence of persistent unconscious interconnections of a primitive nature between mother and child been evaluated, the ***extent*** of the difficulties on the mother-child locus is likely to have been more apparent. Detailed exploration of the ***mother's*** childhood experiences would have provided the

clinician with the key to some of the unconscious meanings and expectations which Ann held in relation to her child, and which were being fulfilled by Ian, even at that early stage, in the form of his symptomatology. Essentially, the case highlights the need for a form of assessment and treatment in which the unconscious interdependence between mother and child is brought to light and addressed. The simultaneous treatment approach, which was subsequently used in this instance, appears to have done precisely this.

By the time Ian presented for therapy for the third time in 1988, he had been the object of, and receptacle for, his mother's projections for a ten year period, during which time his ability to function in interpersonal, scholastic and emotional spheres had been increasingly impaired. This observation appears to substantiate the conclusion drawn in the preceding chapter that maternal impingements result in subsequent impediments in the child's psychological development. On assessment in 1988, the clinician concerned, informed by an object relations orientation, was immediately able to diagnose the locus of the problem as being that of the mother, locked into a pathological relationship with her child, in which her interactions were dictated by distorted, unconscious, archaic object images. On the basis of this understanding, she initially defined the treatment boundary as that of the mother-child unit and offered joint treatment, respecting that the mother was not able to acknowledge her own difficulties at that time and that she needed to engage Ann via treatment of the mother-child relationship – if Ann was to be engaged in treatment at all.

The clinical material clearly shows, however, that Ian was unable to begin his recovery until Ann had undergone fundamental change in terms of her internal object and self images, following which he no longer had to receive and live her projections. This clinical observation appears to support the writer's earlier contention that where the ***mother's*** pathology is not addressed, where treatment remains at a superficial conscious or pre-conscious level, without unconscious material being addressed, treatment of the child

alone is largely ineffectual (cf chapter five). In addition, this observation supports the writer's plea for greater utilisation of an object relations approach, in which the relationship between real, external people and internal images and residues of relations with them and the significance of these residues for psychic functioning, are taken into account.

Ian's drawings repeatedly demonstrated the extent to which he was attuned to his mother's emotional state, as well as his unconscious understanding of their disturbed relationship. **FIGURE 1 (p71)** portrays his understanding of his mother's sense of aloneness and desperation. **FIGURE 2 (p73)** strikingly conveys his unconscious perception of his entanglement with his mother, that is, a relationship in which he is completely engulfed by an environment comprised of persecutory and dangerous objects which have the ability to injure him. This unconscious theme is repeated in **FIGURE 3 (p75)** in which Ian, symbolised by the baby killer whale, is completely enclosed within the (maternal) shark jaws and is about to be eaten.

The writer suggests that these two drawings encapsulate, symbolically, the essence of Ian's relationship with his mother ***from early infancy onwards*** and that the basis of this pathological relationship was in fact laid prior to Ian's birth during Ann's pregnancy, or even earlier. It seems likely that the phantasies which Ann had concerning her baby were already deeply embedded in her psyche, ***infused with meanings associated with her own history*** (cf chapter four). Ann's 'phantasy baby' served as a container for the largely negative aspects of all ***her*** early object-relationships. Once born, baby Ian, with his early difficulties, served only to confirm these primitive, anxious phantasies and came to represent a hostile, dangerous object rather than an ameliorative, restorative object for her. Through the early largely negative 'currency' of phantasy which Ann 'fed' Ian, she unconsciously assigned to him many dangerous, unwanted aspects of herself; her provision of a largely hostile, uncontaining maternal matrix precluded Ian's optimal psychological development.

The 'normal' destructive impulses and phantasies postulated by Melanie Klein (1946, 1955b) and characteristic of early infancy seem, in Ian's experience, to have been ***compounded*** by the destructive impulses and phantasies which his mother projected onto him from very early on, which did not subside in infancy and which engulfed him even at the start of therapy. Therefore, even though he was a 'tough little whale' **(FIGURE 3, p75)** and tried to defend himself, he was aware that he was not strong enough to escape from the danger of the powerful hold which his mother's unconscious projections had over him and that he needed the diver-therapist's help to rescue him. Hence, it was only within the containing safety of a supportive, nurturing and 'holding' therapeutic environment that Ian began to feel able to attempt to start 'hatching' and to resume the developmental tasks which had been forestalled by maternal impingements.

Not unpredictably (cf chapter five, p58) there occurred at this point in Ian's therapy an impasse: unconsciously, he responded to his mother's anxiety surrounding his separation from her. The impasse was the result of Ann's ***unconscious*** resistance, at the time when Ian was attempting with the help of treatment, to dissolve the disturbed relationship with her. Ann seemed to sense that she was loosing her 'projection container', which in effect meant that she would be forced into confronting her projections, which she could no longer displace and disown, as Ian was no longer accepting them. Ian however, was able to withstand her attempts to maintain her pathological hold over him; as he continued on a phase of psychological growth, Ann grew more and more depressed. Ian was able to take risks and made attempts to integrate the positive and negative aspects of himself - the 'very precious treasures' ie. the fragile, vulnerable and good parts which had to be protected from his mother, as well as the 'dark and dangerous things' - his feelings of anger, aggression, hostility and hatred which he was experiencing towards her.

Symptoms of depression were manifested ***simultaneously*** in the therapies of both mother and child, providing further clinical substantiation for the existence of an

unconscious interrelationship between the processes of mother and child. Ian became depressed, both as an unconscious response reflecting his mother's mental state, as well as in response to his fear of abandonment by her, as she became emotionally unavailable and increasingly hostile towards him, making him feel unloveable and unwanted, and projecting her own feelings of being 'all wrong' and out of place into him – so that he ***felt*** like an Alien **(FIGURE 5, p80)**.

The "duck picture" **(FIGURE 6, p80)** provided a clear indication that he perceived, at an unconscious level, his mother's psychic predicament and struggle and her need for help with this. ***Simultaneously***, in her concurrent session, Ann spoke about feeling unable to function and shortly thereafter, went into hospital in a desperate attempt to avoid confronting her emotional state and to find instead a physiological "cause" for her depression. Finally, after being faced with irrefutable medical evidence that there was nothing medically wrong with her, and in her state of vulnerability, she was able to acknowledge her own distress, to perceive Ian's pain and to acknowledge her part in Ian's difficulties.

In contrast to his mother's debilitating psychic immobilisation, Ian the skateboarder took great risks and would return – even in the face of great danger – to try again **(FIGURE 7, p83)**. Despite greater psychic integration however, the possibility of being abandoned by his father (if he went to live elsewhere) could not be tolerated by Ian's still fragile self-structure and hence he needed to re-erect his defence system, to protect his vulnerable self, shutting out even his therapist **(FIGURE 8, p85)** . "Skolly dog" **(FIGURE 9, p87)** symbolised his feelings of abandonment, rejection, helplessness and aloneness, with no one to depend on or to help him out of his misery.

Another striking example of Ian's unconscious knowledge of his mother's mental state appeared in his picture of the "old war" **(FIGURE 10, p87)**. The writer views this symbolic depiction as a crucial example in view of the simultaneous treatment approach

advocated in this paper. In essence: The simultaneous approach appears to have facilitated the confrontation, playing out and resolution of Ann's psychic war (with her internal object images) which had become a mother-child war, played out in the here-and-now. Ann's archaic phantasies, which were an accumulation of her childhood experiences, formed the legacy which she transferred onto Ian. Her unconscious projections resulted in the destruction and confusion which constituted Ian's external world and which were internalised by him. Gradually, within the safety of her therapy, she was able to confront her ***actual*** war, ie the war within herself, which was about the struggle against ***her*** own legacy, inherited in the course of development and which she needed to overcome, in order to experience the riches of psychological integrity and wholeness.

As Ann began to be in touch with her negative, angry feelings and to relate them to her childhood experiences, it was no longer necessary for Ian to carry the projections for her and this freed him to embark upon essential developmental tasks. In the course of this process, he faced the inadequacies of all the important adults in his life – mother, father and Kenny and was able to express anger at them, perceiving their part in his difficulties. Despite the limitations of his legacy he had managed and had come to realise that although not perfect, he was in fact, very much alive **(FIGURE 11, p90)**. As captain of his ship, he had weathered the storm and had come in safely. **(FIGURE 12, p93)**.

6.4.2. Conclusion

It is the writer's opinion that, albeit several years belatedly, the simultaneous therapeutic endeavour provided the context from within which both mother and child could move towards recovery. Ian, within the holding, containing (maternal) therapeutic matrix, was provided the opportunity to recoup his former developmental interruptions and was able to experience the 'good enough' maternal environment with a 'sufficiency of space', which enclosed but did not impinge and within which there was sufficient space to maintain an 'optimal distance', modified over time, allowing oscillation between closeness and

distance, while moving towards separation and individuation (Walt, 1986). The therapeutic environment provided the context from within which Ian's psychological life was able to germinate.

Simultaneously with Ian's psychic process went that of his mother. Because Ann's archaic legacy is of far longer standing than Ian's, it will take longer to resolve. However: "... one constructive reason that we can have for going back into the past [is] to discover the places where we first went astray, and the influences which were at work then... [so] that we may gain understanding, which will enable us to separate ourselves from these influences where they are still in operation, and that we may look squarely at what in ourselves is handicapping us... the primitive and childlike forces, of which we prefer to remain unconscious, must be met and acknowledged, before we can grow up ..." (Wickes, 1927 : 117 – 118).

Ann has already met and acknowledged some of these primitive forces; many more remain to be confronted.

CHAPTER SEVEN : CONCLUDING SUMMARY AND CLINICAL IMPLICATIONS

It has been the writer's aim to elucidate an object relations approach to therapeutic work with children. The study was approached by means of a critical theoretical evaluation of psychoanalytic and object relations conceptualisations of the primary biological mother-child relationship and of the mother's involvement in and contribution to both optimal and pathological development in the child. This theoretical exposition was supplemented by the presentation and examination of clinical material derived from a mother-child treatment case in clinical practice.

The writer hopes to have shed light on the issues of the primary relationship , and the role of the mother in the treatment process, by situating them within an object relations framework. This framework is informed by theoretical tenets which are concerned with the dynamic ***interplay*** of unconscious internal object relations and current interpersonal experience. The writer also hopes to have provided clinicians with some guidelines on how to locate the locus of pathology as well as how to define treatment boundaries.

At the outset of this paper it was stated that although it has been acknowledged that there is often more than one participant in the disturbance with which a child presents for treatment, and that psychogenetic origins of the disturbance may not reside within the child himself, the question of how to take this into account in the therapeutic endeavour has not always been addressed by clinicians. The present paper has been an attempt to address this issue, together with that of the role of the parents (in particular the mother) in child treatment.

In the course of the overview of the development of child treatment, the need to examine the development of various treatment approaches in which the inclusion of and role of the parents in the child's treatment were addressed, emerged. It was concluded that parent-therapist contact of a superficial nature often proved to be inadequate; one or both parents needed to be directly involved in the treatment process. In most instances, the ***mother's*** involvement (more so than the father's) appeared to be crucial.

Critical exploration of various psychoanalytic and object relations conceptualisations of the primary relationship indicated that this relationship is of special importance and crucial to the emotional development of the child. Failure to take into account the complexities of the nature of the primary relationship and the extent to which it is negotiated by both mother and child may hamper clinicians in their attempts to successfully treat children. It was concluded that an in-depth assessment focusing specifically on the interrelationship between the index child and the mother is required.

Exploration of the unconscious aspects of the mother-child relationship showed that under optimal conditions, the mother is able to modify both the physical and psychological distance between her and the infant, according to the changing needs of the infant. In instances where this does not take place, the child's psychological development may be impaired. It was therefore concluded that the nature of unconscious processes should be accorded careful consideration in the course of the assessment, diagnosis and treatment procedures.

Specifically, it was argued that clinicians must be able to establish the extent to which primitive, unconscious interconnections have persisted and have impeded the child's psychological development. In instances where such primitive interconnections are still operative, the clinician is likely to encounter the problem of the mother's intrusion (consciously or unconsciously) into the treatment process. It was concluded that when clinicians fail to take into account the intermingling of phantasy between mother and child, they also fail to evaluate the persistence of primitive unconscious interconnections. Where clinicians attempt to locate the source of pathology in ***either*** the mother ***or*** the child, instead of within the mother-child ***relationship*** and in the primary mother-child ***interactions***, they fail to adequately define treatment boundaries and in so doing often omit to include the mother.

As an alternative to this dualistic approach, the writer advocated consideration of simultaneous treatment of mother and child. It was suggested as an object relations approach which makes possible the understanding of the ***interplay*** between phenomena in the intrapsychic sphere and

phenomena in the sphere of external reality and interpersonal relations. The focus of treatment is therefore on the unconscious meanings and associations held by the mother in relation to her child and the ways in which these unconscious expectations are fulfilled by the symptomatic child.

Simultaneous treatment was shown to be invaluable in highlighting the points of interaction between the disturbances of mother and child by providing access to the unconscious meaning and motivation of mother-child interactions. The approach was also found to assist the clinician in tracing the pathways of unconscious communication through which aspects of the mother's disturbance reach and affect the child. Simultaneous treatment case material clearly demonstrated instances in which the child's symptoms were given up in direct relation to the mother relinquishing either a fixed pathological position of her own, or relinquishing her pathological hold on the child. These observations provided substantiation for the writer's claim that treatment of the child alone is inadequate when unconscious forces in the mother work in the direction of enhancing the child's pathology.

Although the views of this paper were illustrated by just one clinical example, and the conclusions drawn therefore cannot be considered generalisable, the simultaneous treatment undertaken did appear to provide the context from within which both mother and child could begin to move towards recovery, and hence provided substantiation for the theoretical argument which was presented by the writer.

Both the theoretical argument developed and the clinical material presented within this paper suggest the need for clinicians to pay increased attention to parts of the personality that have their roots in the earliest undifferentiated moments of life (i.e. within the period of the child's undifferentiated involvement with the mother) and to the subtleties of the unconscious legacy which the mother bestows upon the child.

The writer hopes to have demonstrated that an object relations perspective in conjunction with a simultaneous treatment approach can be a valuable adjunct in assessing psychological

functioning in the child patient, and a most useful guideline in establishing the parameters and perimeters of child treatment.

In concluding, the writer echoes Grotstein's sentiments:-

> "It has become my belief that the psychopathology of all disorders can be looked at from the vantage point of the success or failure to achieve bonding or attachment between the infant and the mother, and that a more convenient paradigm for gauging normalcy and psychopathology is the nature of the interrelationship with the other rather than of the individual self".
>
> (Grotstein, 1983 :572).

REFERENCES

Ackerman, N. (1958) The Psychodynamics of Family Life. New York : Basic Book.

Adams, P.L. (1974) A Primer of Child Psychotherapy. Boston : Little Brown.

Ainsworth, M. (1963) The Development of Infant-Mother Interaction among the Ganda. In B.M. Foss (Ed). Determinants of Infant Behaviour II. London : Metheuen.

_____ (1967) Infancy in Uganda : Infant Care in the Growth of Attachment. Baltimore : John Hopkins Press.

_____ (1969) Object-Relations, Dependency and Attachment : A Theoretical Review of the Infant-Mother Relationship. Child Development, 40 : 969-1027.

Alpert, A. (1967) Pre-Nursery Project : Indications and Contra-indications for Therapeutic Intervention in the Pre-Nursery via the Mother. The Psycho-Analytic Study of the Child, 22 : 139-155.

Allen, F. (1942) Psychotherapy with Children. New York : W.W. Norter and Co. Inc.

Anthony, E.J. (1970) Parenthood : Its Psychology and Psychopathology. Boston : Little Brown.

_____ (1980a) The Family and Psychoanalytic Process in Children. The Psychoanalytic Study of the Child, 35 : 3-34.

_____ (1980b) Psychoanalysis and Environment. In G.H. Pollack and S.I. Greenspan (Eds.). Psychoanalytic Contributions toward Personality Development. Washington : National Institute of Mental Health.

Atoynatan, T. (1986) Elective Mutism : Involvement of the Mother in the Treatment of the Child. Child Psychiatry and Human Development, 17(1) : 15-27.

Axline, V. (1947) Play Therapy. New York : Balantine Books, 1969.

Balint, A. (1939) Love for the Mother and Mother Love. In M. Balint (Ed.) Love and Psychoanalytic Technique (pp 91-108). London : Tavistock Publications. 1965.

Balint, M. (1937) Early Developmental States of the Ego. Primary Object Love. In Primary Love and Psychoanalytic Technique. (pp 74-90). London : Tavistock Publications, 1965.

_____ (1961) Contribution to the Symposium on the Theory of the Parent-Infant relationship. In Primary Love and Psychoanalytic Technique. (pp 145-147). London : Tavistock Publications, 1965.

_____ (1968) Primary Love. In The Basic Fault : Therapeutic Aspects of Regression. (pp 64-72). London : Tavistock Publications, 1984.

Barker, P. (1981) Basic Family Therapy. London : Granada, 1983.

Benedek, T. (1938) Adaption to Reality in Early Infancy. Psychoanalytic Quarterly, 7 : 200-215.

_____ (1949) The Psycho-Somatic Implications of the Primary Unit : Mother-Child. American Journal of Orthopsychiatry, 19 : 642-654.

_____ (1956) Towards the Biology of the Depressive Position. Journal of the American Psychoanalytic Association, 4 389-427.

_____ (1959) Parenthood as a Developmental Phase. Journal of the American Psychoanalytic Association, 7 : 389-417.

_____ (1960) The Organisation of the Reproductive Drive. International Journal of Psychoanalysis, 41 : 1-15.

_____ (1970a) The Psychobiology of Pregnancy. In E.J.A. Anthony and T. Benedek (Eds.). Parenthood (pp 137-151). Boston : Little Brown and Co, 1970.

_____ (1970b) Motherhood and Nurturing. In E.J.A. Anthony and T. Benedek (Eds.). Parenthood. (pp 153-165). Boston : Little Brown and Co, 1970.

_____ (1970c) Fatherhood and Providing. In E.J.A, Anthony and T. Benedek (Eds.). Parenthood. (pp 167-183). Boston : Little Brown and Co, 1970.

_____ (1970d) Parenthood During the Lifecycle. In E.J.A. Anthony and T. Benedek (Eds.). Parenthood. (pp 185-206). Boston : Little Brown and Co, 1970.

Bennett, J. & Hellman, I. (1951) Psychoanalytic Material Related to Observations in Early Development. The Psychoanalytic Study of the Child, 6.

Bentovim, A. (1979) Family Therapy when the Child is the Referred Patient. In S. Bloch (Ed.). An Introduction to the Psychotherapies. (pp 172-195). Oxford : Oxford University Press.

Berger, M. & Kennedy, H. (1975) Pseudobackwardness in Children : Maternal Attitudes as an Etiological Factor. The Psychoanalytical Study of the Child, 30 : 279-306.

Bick, E. (1962) Child Analysis Today. In E. Bott Spillus (Ed.). Melanie Klein Today. Developments in Theory and Practice. Volume 2 : Mainly Practice. (pp 168-176). London : Tavistock, 1988.

Bion, W.R. (1957) Differentiation of the Psychotic from the Non-Psychotic Personalities. International Journal of Psychoanalysis, 38 : 226 -275.

Bloch, S. (1978) Introduction to the Psychotherapies. Oxford : Oxford University Press.

Bonnard, A (1950) The Mother as Therapist in a case of Obsessional Neurosis. The Psychoanalytic Study of the Child, 5 : 391-408.

Bornstein, B. (1935) Phobia in a two-and-a-half year old child. The Psychoanalytic Quarterly, 4 : 93-119.

_____ (1945) Clinical Notes on Child Analysis. The Psychoanalytic Study of the Child, 1 : 151-166.

_____ (1948) Emotional Barriers in the Understanding and Treatment of Young Children. American Journal of Ortho-psychiatry, 18 : 691-697.

Bornstein, S. (1935) A Child Analysis. Psychoanalytic Quarterly, 4 : 190-225.

Boscolo, L., Ceccin, G., Hoffman, L. & Penn, P. (1987) From Psychoanalysis to Systems. In Milan Systemic Family Therapy : Conversations in Therapy and Practice. (pp 3-28) New York : Basic Books.

Bowlby, J. (1940) The Influence of Early Environment in the Development of Neurosis and Neurotic Character. International Journal of Psychoanalysis, 21 : 154 -178.

_____ (1956 - 1958) Psychoanalysis and Child Care. In The Making and Breaking of Affectional Bonds. (pp 1-24). London : Tavistock Publications, 1979.

_____ (1958) The Nature of the Child"s Tie to his Mother. International Journal of Psychoanalysis, 39 : 350-373.

_____ (1969) Attachment and Loss. Vol. I : Attachment. Harmondsworth, Penguin : 1978.

_____ (1973) Attachment and Loss. Vol. II : Separation : Anxiety and Anger. Harmondsworth : Penguin, 1978.

_____ (1988) The Role of Attachment in Personality Development. In A Secure Base : Clinical Applications of Attachment Theory. (pp 119-136). London : Routledge.

Brinich, P.M. (1984) Aggression in Early Childhood : Joint Treatment of Children and Parents. The Psychoanalytic Study of the Child, 39 : 493-508.

(1980) Bulletin Hampstead Child Therapy Clinic, 3 : 75-84.

Burch, B. (1988) Melanie Klein's Work : An Adaption in Practice. Clinical Social Work, 16(2) : 125-142.

Burlingham, D. (1932) Child Analysis and the Mother. The Psychoanalytic Quarterly, 1935, 4 : 64-92.

_____ (1935) Empathy between Infant and Mother. Journal of the American Psychoanalytic Association, 1967, 15 : 764-780.

Burlingham, D. (1951) Present Trends in Handling the Mother-Child relationship during the Therapeutic Process. The Psychoanalytic Study of the Child, 6 : 31-37.

_____ (1973) The Pre-oedipal Infant-Father Relationship. The Psychoanalytic Study of the Child, 28 : 23-47.

Burlingham, D. & Freud, A. (1942) Young Children in War-Time. London : Allen and Unwin.

_____ (1944) Infants without Families. London : Allen and Unwin.

Burlingham, D. Goldberger, A. & Lussier, A. (1955) Simultaneous Analysis of Mother and Child. The Psychoanalytic Study of the Child. 10 : 165-186.

Burlingham, D. Schnurman, A. & Lantos, B. (1958) David and his Mother. Unpublished paper. Simultaneous Research Project. Hampstead Child Therapy Clinic, London. Quoted by I. Hellman in J. Glenn (Ed.). Child Analysis and Therapy. (p. 492). New York : Jason Aronson, 1978.

Byng-Hall, J. (1973) Family Myths used as a defence in Conjoint Family Therapy. British Journal of Medical Psychology, 46 239-250.

Carlson, B.E. (1984) The Father's Contribution to Child Care. American Journal of Orthopsychiatry, 54 : 123-136.

Chethik, M. (1976) Work with Parents : Treatment of the Parent-Child Relationship. American Academy of Child Psychiatry, 15 : 453-463.

Clemente, J., Brafmann, M. & Cohen, C. (1986) Concurrent Treatment of Mother and Child in Resolutoin of Multigenerational Separation and Individuation Difficulties. Journal of Contemporary Psychotherapy, 16(2) : 140-150.

Coleman, R., Kris, E. & Provence, M.D. (1953) The Study of Variations of Early Parental Attitudes. A Preliminary Report. The Psychoanalytic Study of the Child, 8 : 20-47.

Colonna, A.B. & Newman, L.M. (1983) The Psychoanalytic Literature on Siblings. The Psychoanalytic Study of the Child, 38 : 285-310.

Crowther, C. (1988) A Psychoanalytic Perspective on Family Therapy. In G. Pearson, J. Treseder, M. Yelloly (Eds.). Social Work and the Legacy of Freud : Psychoanalysis and its Uses. (pp. 129-145). London : McMillan Education.

Dare, C. (1986) Psychoanalytic Marital Therapy. In N. Jacobson and A. Gurman (Eds.). Clinical Textbook of Marital Therapy. (pp 13-20). New York : Guilford.

Deutsch, H. (1938) Folie a deux. Psychoanalytic Quarterly, 7 : 307-318.

_____ (1944) Psychology of Women. New York : Grune and Statton.

Editorial. (1980) In Memoriam : Dorothy Burlingham, 1891 - 1979. The Psychoanalytic Study of the Child, 35 : ix-xxii.

Edward, J., Ruskin, N. & Turrini, P (1981) Separation-Individuation : Theory and Application. New York : Gardner Press Inc.

Erikson, E. (1950) Childhood and Society. Harmondsworth : Penguin, 1965.

Fairbairn, W. (1952) An Object-Relations Theory of the Personality. New York : Basic Books, 1952.

Foss, B.M. (1965) Determinants of Infant Behaviour. London : Methuen.

Fouché, G.W. (1985) Child Psychotherapy and Family Therapy - a Comparative Perspective. Psychotherapeia and Psychiatry in Practice, 39 : 34-38.

Frankl, L. (1965) George and his Father. Unpublished paper : Simultaneous Analysis Research Project, Hampstead Child Therapy Clinic, London. Quoted by I. Hellman in J. Glenn (Ed.). Child Analysis and Therapy. (p 492). New York : Jason Aronson, 1978.

Fraiberg, S., Adelsohn, S. & Shapiro. V. (1978) Ghosts in the Nursery : A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships. Journal of the American Academy of Child Psychiatry, 14 : 387-421.

Fraiberg, S., Shapiro, V. & Spitz-Cherniss, D. (1980) Treatment Modalities. In S. Fraiberg (Ed.). Clinical Studies In Infant Mental Health : The First Year of Life. London : Tavistock, 1980.

Freud, A. (1922-1935) Introduction to Psychoanalysis. The Writings of Anna Freud, Vol. VI. New York : International Universities Press.

_____ (1926-1928) The Psychoanalysis of Children. London : Imago Publishing Co. Ltd., 1946.

Freud, A. (1929) On the Theory of the Analysis of Children. The International Journal of Psychoanalysis, 10 : 29-38.

_____ (1945) Indications for Child Analysis. The Psychoanalytic Study of the Child, 1 : 127-149.

_____ (1965) Normalcy and Pathology in Childhood : Assessments of Development. The Writings of Anna Freud VI. New York : International Universities Press.

_____ (1966) A Short History of Child Analysis. In Problems of Psychoanalytic Training, Diagnosis and Technique of Therapy. The Writings of Anna Freud Vol III. 1965-1970 (pp 48-58). New York : International Universities Press.

_____ (1968) Indications and Contra-Indications for Child Analysis. The Psychoanalytic Study of the Child, 23 : 37-46; also in Writings, VII. (pp 110-123)

Freud, A. (1971) The Infantile Neurosis: Genetic and Dynamic Considerations. The Psychoanalytic Study of the Child. 26 : 74–90.

_____ (1979) The Role of Transference in Children. In C. Schaefer (Ed.). The Therapeutic Use of Child's Play (pp 141–149). London : Jason Aronson.

_____ (1980) Modifications of Technique. In J. Sandler, H. Kennedy and R. Tyson (Eds.). The Technique of Child Analysis : Discussions with Anna Freud (pp 199–208) London : Hogarth Press and Institute of Psychoanalysis.

_____ (1981) The Concept of Developmental Lines : Their Diagnostic Significance. The Psychoanalytic Study of the Child, 36 : 129–136.

_____ (1983) Problems of Pathogenesis : Introduction to the Discussion. The Psychoanalytic Study of the Child, 38 : 383–388.

Freud, S. (1893) Studies on Hysteria. (In Conjunction with J. Breuer). Pelican Freud Library Volume 3. Harmondsworth : Penguin, 1980.

_____ (1895) On Psychopathology. Pelican Freud Library Volume 10. Harmondsworth : Penguin, 1983.

_____ (1900) The Interpretation of Dreams. Pelican Freud Library Volume 4. Harmondsworth : Penguin, 1983.

_____ (1901) The Psychopathology of Everyday Life. Pelican Freud Library Volume 5. Harmondsworth : Penguin, 1982.

_____ (1905) On Sexuality. Pelican Freud Library Volume 7. Harmondsworth : Penguin, 1984.

_____ (1908) Case Histories I : 'Dora' and 'Little Hans'. The Pelican Freud Library. Volume 8. Harmondsworth : Penguin, 1977.

_____ (1916–1917) Introductory Lectures on Psychoanalysis. Pelican Freud Library Volume 1. Harmondsworth : Penguin, 1982.

_____ (1920) Beyond the Pleasure Principle. In On Metapsychology : The Theory of Psychoanalysis. Pelican Freud Library Volume 11. Harmondsworth : Penguin, 1985.

_____ (1926) Inhibitions, Symptoms and Anxiety. In On Psychopathology (p 229 ff). Pelican Freud Library, Volume 10. Harmondsworth : Penguin, 1983.

_____ (1931) Female Sexuality. In On Sexuality. Pelican Freud Library Volume 5. Harmondsworth : Penguin, 1982.

_____ (1933) New Introductory Lectures on Psychoanalysis. Pelican Freud Library Volume 2. Harmondsworth : Penguin, 1981.

_____ (1938) An Outline of Psychoanalysis. In Historical and Expository Works on Psychoanalysis. (pp 375–378) Pelican Freud Library Volume 15. Harmondsworth : Penguin, 1986.

Freud, S. & Breuer, J. (1893–1895) Studies on Hysteria. Pelican Freud Library Volume 3. Harmondsworth : Penguin Books, 1980.

Furman, E. (1957) Treatment of under-fives by way of their Parents. The Psychoanalytic Study of the Child, 12, 250–262.

_____ (1966) Treatment of the under-five by means of his Mother : Assessment of Mother. Paper presented at the meeting of the American Association of Psychoanalysis, Topeko, Kansas.

_____ (1969) Treatment via the Mother. In E. Furman and A. Katan (Eds.). The Therapeutic Nursery. (pp 64–329) New York : International Universities Press.

Furman, E. & Katan, A. (1969) The Therapeutic Nursery. E. Furman and A. Katan (Eds.). New York : International Universities Press.

Giovacchini, P. (1970) Effects of Adaptive and Disruptive Aspects of Early Object Relationships upon later Parental Functioning. In E.J.A, Anthony and T. Benedek (Eds.) Parenthood. (pp 525–537) Boston : Little Brown and Co., 1970.

Glenn, J. (1978) Controversy regarding the Analyst–Parent Relationship. In J. Glenn (Ed.) Child Analysis and Therapy. (pp 406–409) New York : Jason Aronson.

Green, A. (1978) Potential Space in Psychoanalysis : the Object in the Setting. In S.A. Grolnick and L. Barkin (Eds.) Between Reality and Fantasy. New York : Jason Aronson.

Greenberg, J. & Mitchell, S.A. (1983) Object–Relations in Psychoanalytic Theory. London : Harvard University Press.

Grotstein, J.S. (1983) Proposed Revision of the Psychoanalytic Concept of Primitive Mental States, Part II. Contemporary Psychoanalysis, 19 : 570–604.

Guntrip, H. (1961) Personality Structure and Human Interaction : The Developing Synthesis of Psychodynamic Theory. New York : International Universities Press.

Haley, J. (1971) Changing Families : A Family Therapy Reader. New York : Grune and Stratton.

Hartman, H. (1964) Essays on Ego Psychology. New York : International Universities Press.

Hayworth, M. (1964) Child Psychotherapy. New York : Basic Books.

Hellman, I. (1954) Some Observations of Mothers of Children with Intellectual Inhibitions. The Psychoanalytic Study of the Child, 9 : 259–273.

_____ (1978) Simultaneous Analysis of Parent and Child. In J. Glenn (Ed.) Child Analysis and Therapy. (pp 473–493) New York : Jason Aronson.

Hellman, I. (1980) Contributions Read During the Memorial Meeting at the Hampstead Clinic. Bulletin of the Hampstead Clinic, 3 : 83–84.

Hellman, I., de Monchaux, C. & Ludouwyk–Gyomroi, E. (1961) Simultaneous Analysis of a mother and her eleven–year daughter. Unpublished paper : Simultaneous Analysis Research Project, Hampstead Child Therapy Clinic. London. Quoted in J. Glenn (Ed.). Child Analysis and Therapy. (p 492) New York : Jason Aronson, 1978.

Hellman, I. Friedman, O. & Shepheard, E. (1960) Simultaneous Analysis of Mother and Child. The Psycho–analytic Study of the Child, 15 : 359–377.

Hellman, I., Schnurman, A. & Todes, C. (1970) Simultaneous Analysis of a Mother and her four year old Daughter. Unpublished paper : Simultaneous Analysis Research Project, Hampstead Child Therapy Clinic, London. Quoted in J. Glenn (Ed). Child Analysis and Therapy. (p 492) New York : Jason Aronson, 1978.

Hug–Hellmuth, H (1921) On the Technique of Child–Analysis. In International Journal of Child Analysis, 2 : 287–305.

Jackson, D.J. (1984) Contributions to the History of Psychology : XXXV. Dorothy Burlingham. Psychological Reports, 54 : 855–863.

Jacobs, L. (1949) Methods used in the Education of Mothers. The Psychoanalytic Study of the Child, 3–4 : 409–422.

Jessner, L., Weigert, E. & Foy, J. (1970) The Development of Parental Attitudes During Pregnancy. In E.J.A. Anthony and T. Benedek (Eds.). Parenthood. (pp 209 –244) Boston : Little Brown and Co.

Joffe, A. (1989) The Contribution of the Mother to the Illness and Recovery of her Child. Paper presented to the Congress of the Association for Child and Adolescent Psychiatry, Cape Town.

Johnson, A. (1953) Factors in the Etiology of Fixations and Symptom Choice. Psychoanalytic Quarterly, 22 : 475–496.

Johnson, A. & Szurek, S.A. (1952) The Genesis of Anti–Social Acting Out in Children and Adults. Psychoanalytic Quarterly. 21 : 323–343.

——— (1954) Etiology of Anti–Social Behaviour in Delinquents and Psychopaths. Journal of the American Medical Association, 154 : 814–817. Reprinted in S.A. Szurek (Ed.) Training in Therapeutic Work with Children. (pp 182–191) New York : Science and Behaviour Books Inc., 1967.

Johnson, A. Falstein, E.I., Szurek, S.A. & Svenson, M. (1941) School Phobia. American Journal of Orthopsychiatry, 11 : 4ff.

Jones, E. (1953–1957) The Life and Work of Sigmund Freud. Harmondsworth : Penguin Books, 1984.

Kernberg, O. (1976) Object Relations Theory and Clinical Psychoanalysis. New York : Jason Aronson.

_____ (1980) Internal World and External Reality. New York : Jason Aronson.

Klein, J. (1987) Our Need for others and its Roots in Infancy. London : Tavistock Publications.

Klein, M. (1919) The Development of a Child. International Journal of Psychoanalysis, 1923, 4.

_____ (1921–1945) Love, Guilt and Reparation and Other Works. The Writings of Melanie Klein. Volume I. London : The Hogarth Press, 1985.

_____ (1927) Symposium on Child Analysis. International Journal of Psychoanalysis, 8.

_____ (1930) The Importance of Symbol – Formation in the Development of the Ego. In Love, Guilt and Reparation and Other Works 1921–1945. The Writings of Melanie Klein. Volume I (pp 219–232) London : The Hogarth Press, 1985.

_____ (1932) Early Anxiety States and their Effect on the Development of the Child. In The Psychoanalysis of Children. The Writings of Melanie Klein. Volume II (pp 123–278). London : The Hogarth Press, 1986.

_____ (1946) Notes on some Schizoid Mechanisms. In Envy and Gratitude and Other Works. 1946–1963. The Writings of Melanie Klein Volume III. (pp 1–24). London : The Hogarth Press, 1987.

_____ (1946–1963) Envy and Gratitude and Other Works 1946–1963. The Writings of Melanie Klein Volume III. London : The Hogarth Press, 1987.

_____ (1948) On the Theory of Anxiety and Guilt. In Envy and Gratitude and Other Works 1946–1963. The Writings of Melanie Klein Volume III (pp 25–42). London : The Hogarth Press, 1987.

_____ (1952a) Some Theoretical Conclusions Regarding the Emotional Life of the Infant. In Envy and Gratitude and Other Works 1946–1963. The Writings of Melanie Klein. Volume III (pp 61–93). London : The Hogarth Press, 1987.

_____ (1952b) On Observing the Behaviour of Young Infants. In Envy and Gratitude and Other Works 1946–1963. The Writings of Melanie Klein. Volume III (pp 94–121). London : The Hogarth Press, 1987,

_____ (1952c) The Origins of Transference. In Envy and Gratitude and Other Works 1946–1963. The Writings of Melanie Klein Volume III (pp 48–56). London : The Hogarth Press, 1987.

Klein, M. (1955a) The Psychoanalytic Play Technique : Its History and Significance. In Envy and Gratitude and Other Works 1946-1963. The Writings of Melanie Klein Volume III (pp 122-140). London : The Hogarth Press, 1987.

_____ (1955b) On Identification. In Envy and Gratitude and Other Works 1946 -1963. The Writings of Melanie Klein Volume III (pp 141-175). London : The Hogarth Press, 1987.

_____ (1957) Envy and Gratitude. In Envy and Gratitude and Other Works 1946 - 1963. The Writings of Melanie Klein Volume III (pp 176-235). London : The Hogarth Press, 1987.

_____ (1959) Our Adult World and its Roots in Infancy. In Envy and Gratitude and Other Works 1946-1963. The Writings of Melanie Klein Volume III (pp 247-264). London : The Hogarth Press, 1987.

_____ (1961) Narrative of a Child Analysis. The Writings of Melanie Klein Volume IV. London : The Hogarth Press, 1984.

_____ (1979) The Psychoanalyitic Play Technique. In C. Schaefer (Ed.). The Therapeutic Use of Child's Play. (pp 125-140). London: Jason Aronson.

Kohn, B. (1976) Simultaneous Analysis of Child and Parent by the Same Analyst. Journal of the American Academy of Psychoanalysis, 4(4) : 481-499.

Kohut, H. (1971) The Analysis of the Self. New York : International Universities Press.

_____ (1977) The Restoration of the Self. New York : International Universities Press.

Kolansky, H. (1960) Treatment of a three year old girl's severe Infantile Neurosis; Stammering and Insect Phobia. The Psychoanalytic Study of the Child, 15 : 261-285.

Kolansky, H. & Moore, W. (1966) Some Comments on the Simultaneous Analysis of a Father and his Adolescent Son. The Psychoanalytic Study of the Child, 21 : 237-268.

Kramer, C.H. (1968) The Relationship between Child and Family Pathology. Chicago : Kramer Foundation.

Kris, M. & Ritvo, S. (1983) Parents and Siblings. The Psychoanalytic Study of the Child, 38 : 311-324.

Levinson, L. (1984) Witches - Bad and Good. Maternal Psychopathology as a Developmental Interference. The Psychoanalytic Study of the Child, 39 : 371-392.

Levy, K. (1960) Simultaneous Analysis of a Mother and her Adolescent Daughter. The Mother's Contribution to the Loosening of the Infantile Tie. The Psychanalytic Study of the Child, 15 : 378-391.

Mahler, M. (1963) Thoughts about Development and Individuation. In Infantile Psychoses and Early Contributions. The Selected Papers of Margaret Mahler Volume I (pp 3–19). London : Jason Aronson, 1979.

_____ (1974) Symbiosis and Individuation. The Psychological Birth of the Human Infant. The Psychoanalytic Study of the Child, 29 89–100.

_____ (1976) On the concepts of Symbiosis and Separation–Individuation. In Separation–Individuation : In Selected Papers of Margaret Mahler Volume II (pp 7 ff). London : Jason Aronson, 1979.

_____ (1979a) The Selected Papers of Margaret S. Mahler Volume 1 : Infantile Psychoses and Early Contributions. New York : Jason Aronson.

_____ (1979b) The Selected Papers of Margaret S. Mahler Volume 2 : Separation–Individuation. New York : Jason Aronson.

Mahler, M., Bergman, A. & Pine, F. (1975) The Psychological Birth of the Human Infant. New York : Basic Books,

Malone, C. (1974) Observations on the Role of Family Therapy in Child Psychiatry Training. Journal of the American Academy of Child Psychiatry, 13(3) : 437–458.

_____ (1979) Child Psychiatry and Family Therapy : An Overview. Journal of the American Academy of Child Psychiatry, 18 : 4–21.

Marks–Mishne, J. (1983) Clinical Work with Children. New York : The Free Press.

Martin, F. (1977) Some Implications of the Theory and Practice of Family Therapy for Individual Therapy (and vice versa). British Journal of Medical Psychology, 50 : 53–64.

McDermott, J. (1979) Family Therapy in Child Psychiatry. Journal of the American Academy of Child Psychiatry, 18 : 1–3.

McDermott, J. & Char, W. (1974) The Undeclared War between Child and Family Therapy. The Journal of the American Academy of Child Psychiatry, 13(3) : 422–435.

Minuchin, S. (1974) Families and Family Therapy. London : Tavistock.

Mody, Z.R. & Buchholz, S. (1988) Education of a Mother–Child Relationship. Journal of Child Psychotherapy,14 : 81–97.

Moustakis, C. (1959) Psychotherapy with Children : The Living Relationship. New York : Harper and Row, 1975.

Nadelson, C.C. (1978) Marital Therapy from a Psychoanalytic Perspective. In T.J. Paolino and B.S. McGrady (Eds.). Marriage and Marital Therapy : Psychoanalytic, Behavioral and Systems Theory Perspectives. (pp 89-164). New York : Brunner-Mazel.

Neubauer, P. (1983) The Importance of the Sibling Experience. The Psychoanalytic Study of the Child, 38 : 325-336.

_____ (1985) Pre-oedipal Objects and Object Primacy. The Psychoanalytic Study of the Child, 40 : 163-183.

Ogden, T. (1978) A Developmental View of Identification Resulting from Maternal Impingements. International Journal of Psychoanalytic Psychotherapy, 7 : 486-507.

_____ (1979) On Projective Identification. International Journal of Psychoanalysis, 60 : 357-373.

_____ (1983) The Concept of Internal Object Relations. International Journal of Psychoanalysis, 64 : 227-241.

_____ (1985a) The Mother, the Infant and the Matrix. Contemporary Psychoanalysis, 21(3) : 346-371.

_____ (1985b) On Potential Space. International Journal of Psychoanalysis, 66 : 129-141.

Panel, N. (1978) The Role of the Father in the Pre-oedipal Years. Journal of the American Psychoanalytic Association, 26 : 143-162.

Pick, I. & Segal, H. (1978) Melanie Klein's Contribution to Child Analysis : Theory and Technique. In J. Glenn (Ed.). Child Analysis and Therapy (pp 427-449). New York : Jason Aronson.

Pontalis, J.B. (1977) Frontiers in Psychoanalysis : Between the Dream and Psychic Pain. New York : International Universities Press, 1981.

Province, S. & Solnit, A.J. (1983) Development-promoting aspects of the Sibling Experience. The Psychoanalytic Study of the Child, 38 : 337-351.

Rangell, L. (1984) The Anna Freud Experience. The Psychoanalytic Study of the Child, 39 : 29-43.

Robertson, J. (1965) Mother-Infant Interaction from birth to twelve months. In B.M. Foss (Ed.). Determinants of Infant Behaviour. (pp 111-127). London : Methuen.

Sandler, J. (1987) Projection, Identification and Projective Identification. Madison : International Universities Press.

Schaefer, C. (1979) The Therapeutic Use of Child's Play. London : Jason Aronson.

Schaffer, R. (1977) Mothering. Glasgow : Fontana/Open Books.

Schwartz, H. (1950) The Mother in the Consulting Room. The Psychoanalytic Study of the Child, 5 : 343–357.

Segraves, G.T. (1982) Psychoanalytic Theory and Marriage. In G.T. Segraves. Marital Therapy : A Combined Psychodynamic – Behavioural Approach. (pp 58–75) New York : Plenum Press.

Slipp, S. (1984) Object-Relations : A Dynamic Bridge between Individual and Family Treatment. New York : Jason Aronson.

Smith-Behrends, R. & Blau, S. (1985) Internationalisation and Psychological Development throughout Life-cycle. The Psychoanalytic Study of the Child, 40 : 11–39.

Sours, J.A. (1978) The Application of Child Analytic Principles to forms of Child Psychotherapy. In J. Glenn (Ed.). Child Analysis and Therapy (pp 615–646) London : Jason Aronson.

Sperling M. (1946) The Psychoanalytic Study of Ulcerative Colitis in Children. Psychoanalytic Quarterly, 15 : 302–329.

_____ (1949a) Analysis of a case of Recurrent Ulcer of the Leg. The Psychoanalytic Study of the Child, 3–4 : 391–408.

_____ (1949b) Neurotic sleep disturbances in Children. Nervous Child, 8 : 28–46.

_____ (1949c) Problems in Analysis of Children with Psychosomatic Disorders. Quarterly Journal of Child Behaviour, 1 : 12–17.

_____ (1949d) The Role of the Mother in Psychosomatic Disorders in Children. Psychosomatic Medicine, 11 : 377 ff.

_____ (1950a) Children's Interpretation and Reaction to the Unconscious of their Mothers. International Journal of Psychoanalysis, 31 : 1–6.

_____ (1950b) Indirect Treatment of Psychoneurotic and Psychosomatic Disorders in Children. Quarterly Journal of Child Behaviour, 2 : 250–266.

_____ (1950c) Mucous colitis associated with Phobias. Psychoanalytic Quarterly, 19 : 318–326.

_____ (1951) The Neurotic Child and his Mother. American Journal of Orthopsychiatry, 21 : 351–364.

_____ (1952a) The Psychoanalytic Study of Migraine and Psychogenetic Headache. Psychoanalytic Revue, 39 : 152–163.

_____ (1952b) Psychotherapeutic Techniques in Psychosomatic Medicine. In G. Bychowski and T. Despert (Eds.) Specialised Techniques in Psychotherapy. New York : Basic Books.

_____ (1954a) Reactive Schizophrenia in Children. The American Journal in Orthopsychiatry, 24 : 506–512.

Sperling, M. (1959) A Study of Deviate Sexual Behaviour in Children by the Method of Simultaneous Analysis of Mother and Child. In L. Jessner and E. Pavenstedt. (Eds.) Dynamic Psychopathology in Childhood. New York : Grune and Stratton.

_____ (1964a) The Analysis of a boy with Transvestite Tendencies. The Psychoanalytic Study of the Child, 19 : 470–493.

_____ (1964b) Dynamic Considerations and Treatment of Enuresis. Journal of the American Academy of the Child Psychiatry, 4 : 19–31.

_____ (1967) School Phobias : Classification and Treatment. The Psychoanalytic Study of the Child, 22 : 375–401.

_____ (1969) Ulcerative Colitis in Children : Current Views and Therapies. Journal of the American Academy of Child Psychiatry, 8 : 336–352.

_____ (1970) The Clinical Effects of Parental Neurosis on the Child. In E.J.A. Anthony and T. Benedek (Eds). Parenthood (pp 539–569). Boston : Little Brown and Co.

Spitz, R. (1946) Anaclitic Depression : An enquiry into the Genesis of Psychiatric Disorders in Early Childhood II. The Psychoanalytic Study of the Child, 2 : 313–342.

_____ (1965) The First Year of Life. New York : International Universities Press.

_____ (1970) The Effects of Personality Disturbances in the Mother on the Well-being of her Infant. In E.J.A. Anthony and T. Benedek (Eds.). Parenthood (pp 501–524) Boston : Little Brown and Co.

Sprince, J. (1962) The Development of a Pre-oedipal Partnership between a Adolescent Girl and her Mother. The Psychoanalytic Study of the Child, 17 : 418–450.

Sterba, E. (1949) Analysis of Psychogenic Constipation in a two year old. The Psychoanalytic Study of the Child, 3–4 : 227–252.

Stern, D. (1977) The First Relationship : Infant and Mother. London : Fontana/Open Books.

_____ (1985) The Interpersonal World of the Infant : A View from Psychoanalysis and Developmental Psychology. New York : Basic Books.

Strean, H. (1967) A Family Therapist Looks at 'Little Hans'. Family Process, 6(2) : 227–234.

Sutherland, J. (1980) The British Object Relations Theorists : Balint, Winnicott, Fairbairn, Guntrip. Journal of the American Psychoanalytic Association, 28(4) : 829–860.

Szurek, S.A. (1944) Child Therapy Procedures. Psychiatry, 7 : 9–14. Reprinted in S.A. Szurek and I Berlin (Eds.) Training and Therapeutic Work with Children (pp 119–129). New York : Science and Behaviour Books Incorporated.

_____ (1950) Problems around Psychotherapy with Children. Journal of Paediatrics, 37 : 671–678. Reprinted in S.A. Szurek and I. Berlin (Eds.). Training in Therapeutic Work with Children (pp 128–138). New York : Science and Behaviour Books.

_____ (1952) Some Lessons from Efforts at Psychotherapy with Parents. American Journal of Orthopsychiatry, 109 : 296–310.

Szurek, S.A., Johnson, A. & Falstein, E. (1942) Collaborative Psychiatric Therapy of Parent–Child Problems. American Journal of Orthopsychiatry, 12 : 511–516. Reprinted in S.A. Szurek and I Berlin (Eds.) Training and Therapeutic Work with Children. (pp 162–169). New York : Science and Behaviour Books.

Taft, J. (1933) The Dynamics of Therapy. New York : McMillin.

Torras de Béa, E. (1989) Projective Identification and Differentiation. International Journal of Psychoanalysis, 70 : 265–274.

Walt, A. (1986) The Child, the Mother and the Space Between : The Role of the Mother in the Psychoanalytic Treatment of Children. Unpublished doctoral dissertation. The Wright Institute, Berkeley, California.

Wickes, F. (1927) The Inner World of Childhood : A Study in Analytical Psychology. Boston : Sigo Press, 1988.

Will, D. & Wrate, R.M. (1985) Integrated Family Therapy : A Problem – Centred Psycho–Dynamic Approach. London : Tavistock.

Winnicott, D., (1945) Primitive Emotional Development. In Through Paediatrics to Psychoanalysis (pp 145–156). London : Hogarth Press.

_____ (1949) The Ordinary Devoted Mother. In The Child and the Family. London : Tavistock Publications.

_____ (1951) Transitional Objects and Transitional Phenomena. In Playing and Reality (pp 1–25). New York : Basic Books, 1971.

_____ (1954) Metapsychological and Clinical Aspects of Regression within the Psychoanalytical Set–up. In Through Paediatrics to Psychoanalysis (pp 278–294). London : Hogarth Press, 1987.

_____ (1956) Primary Maternal Pre–occupation. In Through Paediatrics to Psychoanalysis (pp 300–305). London : Hogarth Press, 1987.

_____ (1958) The Capacity to be Alone. In The Maturational Processes and the Facilitating Environment : Studies in the Theory of Emotional Development (pp 29–35). London : Hogarth Press, 1972.

Winnicott, D., (1960) The Theory of the Parent-Infant Relationship. In The Maturational Processes and the Facilitating Environment : Studies in the Theory of Emotional Development (pp 37-55). London : Hogarth Press, 1972.

_____ (1962) Ego Integration in Child Development. In The Maturational Processes and the Facilitating Environment : Studies in the Theory of Emotional Development (pp 56-63). London : Hogarth, 1972.

_____ (1964) The Child, the Family and the Outside World. Harmondsworth : Penguin.

_____ (1971) Playing and Reality. Harmondsworth : Penguin.

_____ (1988) Human Nature. London : Free Association Books.

Yorke, C. (1987) The Contemporaneous Analysis of a Mother and her Child. Unpublished Paper : Simultaneous Research Project, Hampstead Child Therapy Clinic, London.

Zinner, J. & Shapiro, R. (1974) The Family Group as a Single Psychic Entity : Implications for acting Out in Adolescence. International Revue of Psychoanalysis, 1 : 179-186.