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**My mom is not interested:  
A case study of a daughter and her intellectually disabled mother**

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for the award of the degree of Master of Arts in Clinical Psychology**

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**COMPULSORY DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Abstract**

“Intimate attachments to other human beings are the hub around which a person’s life revolves, not only when (she) is an infant or a toddler or a schoolchild but throughout (her) adolescence and (her) years of maturity as well, and into old age” (Bowlby 1980, p. 422).

The attachment literature is a growing area of interest, with renewed focus pioneered by Bowlby. In the South African context attachments to primary caregivers have been under siege of the apartheid group areas act, migrant labour, endemic poverty, widespread HIV/Aids and ongoing political uncertainty.

As disorganised attachments in early life result in complex relational disturbance, this research paper commences with a detailed review of the literature on disorganised attachment. It describes the intergenerational transmission of disorganised attachment in one particular case. The research concludes with a reflection on the challenges of interventions in cases of this kind, where resources are limited and work is complex and intransigent.

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## CHAPTER ONE

### INTRODUCTION

This research paper uses a single case study approach to illustrate a therapeutic process in a family with intergenerational attachment difficulties. It focuses on a dysfunctional attachment system which spans three generations. The study uses the history, symptoms and my experience of the family during the therapeutic process to describe the attachment system in order to understand patterns of behaviour as they unfold, and to suggest ways in which this might inform the intervention with this family.

The family presented in this study is representative of many families in South Africa. The family's attachment patterns formed in the context of their lived experience of poverty, unemployment, substance abuse, overcrowded living conditions, domestic violence and low levels of social support. Their attachments are further complicated by the intellectual disability of a family member, which necessitates cognisance of the influence of intellectual disability on the roles of daughter, mother and grandmother. In this family the daughter is reaching adulthood and is in the process of detaching from her parents who have neglected her by never fulfilling a parenting role. Her mother is intellectually disabled and her father was mostly absent from her life and disruptive when present. Living without her parents' consistent, calming and soothing efforts in early childhood, she was unable to articulate or even know her deeper narcissistic needs for a mirroring and idealizing figure.

The research paper is underpinned by the Freudian notion (1920) "that those who do not remember and come to terms with the past are destined (are more likely) to repeat it, at least with their children" (Fonagy, 2001, p. 27). The implication is that without intervention, mothers mother as they have been mothered. The mother-infant attachment has been described as the prototype of all later relationships, although Fonagy (2001) describes the early mother-child relationship as "crucial not because it shapes the quality of subsequent relationships ..., but because it serves to equip the individual with a mental processing system that will subsequently generate mental representations, including relationship representations" (Fonagy, 2001, p. 31). Sensitive responsive parenting during infancy may be assumed to generate a working model of relationships in which positive expectations regarding intimacy and care from others are indelibly encoded and this cognitive affective structure goes on to selectively affect perception, cognition and motivation (Bretherton & Mulholland, 1999).

Mothers' ability to think about the infant in terms of thoughts, feelings and desires in the infant's mind and in their own mind in relation to the infant and her/his mental state is the key mediator of the transmission of attachment. Even highly stressed mothers who are faced with single parenting, parental criminality, unemployment, overcrowding and psychiatric illness, were found to be more likely to have securely attached infants if their reflective function was high (Fonagy, Steele, Steele, Higgitt & Target, 1994).

Bowlby (1944) sees the disruption of the early mother-child relationship as a key precursor of mental disorder. He focused unwaveringly on the infant's need for an unbroken (secure) early attachment to the mother. There is general agreement that attachment security can protect against psychopathology and is associated with healthier personality variables such as lower anxiety (Collins & Read, 1990), less hostility, greater ego resilience (Kobak & Sceery, 1988) and greater ability to regulate affect through interpersonal relatedness (Simpson, Rholes & Nelligan, 1992; Vaillant, 1992). Conversely insecure attachment is viewed as a risk factor for psychopathology and is associated with more depression (Armsden & Greenberg, 1987), anxiety, hostility, psychosomatic illness (Hazan & Shaver, 1990) and lower ego resilience (Kobak & Sceery, 1988).

In this study self psychology was used as the theoretical basis together with selected concepts from attachment theory and motivational systems theory for understanding the attachment systems in this family. Infant research within the general framework of psychoanalytic theory has confirmed Kohut's insistence on the relational aspect of self-development. Attachment theory provided a framework for examining and understanding the behavioural, emotional, cognitive and relational impairments of children who have suffered neglect, abuse and abandonment in their early years. Viewing attachment disorganisation in an intergenerational context provides valuable information regarding the aetiology, developmental course and outcomes of mother-infant relationships. Attachment theory is further used to underscore the intergenerational transmission of attachment classification and the effect of the mother's intellectual disability on her own attachment classification and that of her daughter.

Motivational systems theory provided a basis to use sustained empathic inquiry to understand which goal-directed motivation was dominant within a mutually designed context. Brownlow (2001) describes how congruence between affect and cognition will facilitate comfort and security in attachment relationships and shift the dominance from attachment and physiological regulation to the exploratory-assertive motive. Self-righting occurs with the reorganisation of motivational systems, which in turn triggers a growth process that leads to change.

It is hoped that this study will contribute to the literature on the application of infant research findings to the clinical context and particularly to therapeutic interventions aimed at the interruption of the intergenerational transmission of disorganised attachment. Furthermore it aims to contribute to the limited literature on issues of intellectual disability in South Africa (Adnams, 2009), the children of parents with intellectual disabilities (Perkins, Holburn, Deaux, Flory & Vietze, 2002) and inform treatment interventions with such children and parents.

## **CHAPTER TWO**

### **THEORETICAL CONTEXT AND REVIEW OF THE LITERATURE**

The literature review commences with a discussion of attachment theory focusing on the findings most relevant to this case study, followed by an overview of the development of disorganised attachment and the link between insecure attachment and psychopathology. Thereafter the implications of research findings for the therapeutic relationship are considered. The first section is concluded with an integration of the two domains of knowledge of infant research and self psychology.

The second section includes a discussion of the recent findings on the intergenerational transmission of attachment and mechanisms attempting to bridge the transmission gap. Thereafter follows a consideration of the implications of the intergenerational transmission of attachment organisation for intersubjectivity and the influence of contemporary grandmother-mother relationships.

The final section considers the effect of the mother's intellectual disability in the context of the challenges posed by motherhood. In this study, due to the father's unwillingness to participate, the focus falls on motherhood. However, it is acknowledged that both mothers and fathers face similar difficulties.

#### **ATTACHMENT THEORY**

This section focuses on what is viewed as attachment and the findings of attachment theory pertinent to this study. The influence of the severing of attachments, family circumstances and trauma on attachment classification is examined, followed by a consideration of the link between attachment classification and psychopathology. On the basis of recent findings in attachment theory, emphasis is placed on the interface between attachment and intersubjectivity together with the implications of recent findings for the therapeutic relationship. The section concludes with a discussion of the application of findings from infant research to psychoanalytic treatment.

#### **What is attachment?**

Fonagy (2001) states that to understand attachment theory as a developmental theory, it is necessary to distinguish between what attachment is and what it is not. According to Ainsworth (1989) affectional bonds differ from relationships in three ways. Firstly, affectional bonds are relatively long lasting, while relationships may or may not last; secondly, relationships are dyadic, while affectional bonds are characteristic of the individual, not the dyad, and entail representation in the internal organisation of the individual person; and lastly, the total history of the interaction between two individuals determines the nature of their relationship. This interaction usually involves a number of categories of content, some of which may be irrelevant to what is required for an attachment or any kind of affectional bond.

Ainsworth (1989, p. 711) defines an affectional bond "as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other". She emphasises that it entails a desire to maintain closeness to the partner. Older children and adults are able to maintain the closeness during absences and over time and distance, but experience at least an intermittent desire to re-establish closeness and interaction which leads to pleasure - often joy - on reunion. Distress is caused by inexplicable separation, while grief follows permanent loss.

Ainsworth (1989) describes an attachment as an affectional bond, but highlights one criterion of attachment that is not necessarily present in other affectional bonds. "This is the experience of security and comfort obtained from the relationship with the partner, and yet the ability to move off from the secure base provided by the partner, with confidence to engage in other activities. Because not all attachments are secure, this criterion should be modified to imply a seeking of the closeness that, if found, would result in feeling secure and comfortable in relation to the partner" (p. 711).

Ainsworth (1989) found that potential attachment figures such as older siblings, a grandparent, an understanding teacher or a parent of a friend, also deserve research attention. She states that children may become attached to parent surrogates who may play an important role in their lives. They may find the security they could not attain with their own parents in these relationships.

### **Findings of Attachment Theory**

According to Bowlby (1969, 1973, 1980) the universal human need to form close affectional bonds, forms the basis of attachment theory. The attachment behaviours of infants (sucking, clinging, following, crying, vocalising and smiling) aimed at maintaining proximity, are reciprocated by adult attachment behaviour (touching, holding, soothing) which reinforces the attachment behaviour of the infant toward that adult (Fonagy, 1999). Attachment behaviours are seen as part of a behavioural system, which exists to ensure a stable internal organisation. The attachment system functions as a regulator of emotional experience by which the infant learns that the caregiver will be there to re-establish equilibrium by understanding and responding to the infant's signals when aroused. The experience of security is the goal of the attachment system (Sroufe, 1996). Sroufe and Waters (1977) extended the applicability of the concept of attachment from early childhood to older children and even adults (Cicchetti, Cummings, Greenberg & Marvin, 1990) by stating that the set goal of the attachment system was "felt security" rather than physical distance regulation.

Past experiences with the caregiver over a significant time period are combined into representational systems (Bowlby, 1973) referred to as "internal working models" (Craik, 1943). Representational systems where the caregiver is seen as accessible and responsive when needed are present in secure attachments. All later relationships are influenced by these internal working models of the self and others (Fonagy, 1999).

Attachments happen at all ages, although the first attachment is likely to be with the mother. Bowlby (1951) emphasises the infant's need for an unbroken and secure early attachment to the mother. Ainsworth (1969) found that once formed, an attachment tends to endure even under adverse conditions. Bowlby (1988) concurs that once the attachment bonds are stabilised during infancy and early childhood, they tend to persist thereafter especially in stable child-rearing environments, although they may undergo later changes and re-integrations. The affectional bonds of attachment relevant for the motivational system are strengthened during the life span, including the attachments of children to their parents, the attachments of parents to their children, attachments to other kin, sexual partners, and the bonds between friends (Sameroff, 1983; Maslin-Cole & Spieker, 1990; Ammaniti, van Ijzendoorn, Speranza & Tambelli, 2000). Ainsworth (1991) describes how these classes of relationships may play a different role in the attachment system and especially in regulating felt security, considering also their interplay with other behavioural systems.

Attachment behaviour is determined by the strategies children use to regulate their affect. As affect regulation is acquired with the help of the child's primary caregiver, these strategies will reflect the caregiver's behaviour towards the child (Fonagy, 1996). Gergely and Watson (1996) found that superior affect regulation stems from the caregiver's accurate reading of the child's mental state, moderated by indications that the caregiver has coped with the child's distress. Thus affect regulation is determined by an understanding of internal experience, which is most likely to arise in the context of an early caregiving relationship. Sroufe (1996) reconceptualises attachment theory in terms of affect regulation. He contrasts securely attached individuals who have internalised the capacities for self-regulation with avoidant individuals who down-regulate affect and those who are resistant and up-regulate affect. Avoidant infants learn to defend against intimacy and develop relationship strategies that make them less vulnerable, like seeking closeness when they are not distressed (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1973; Main & Weston, 1982) whereas resistant infants remain hyperactivated, possibly to ensure more consistent availability from unpredictable caregivers (Bowlby, 1973; Cassidy & Berlin, 1994).

In accordance with the ideas from attachment theory, Winnicott (1962) recognises the importance of the caregiver's psychological understanding of the infant in the emergence of the true self, and the dialectical aspect of this relationship. Fonagy (2001) states that "parents who cannot reflect with understanding on their child's inner experience and respond accordingly deprive the child of a core psychological structure that he or she needs to build a viable sense of self" (p. 169). Furthermore he found that the lack of "good enough" mothering (Winnicott, 1960) causes distortions or changes in mental functioning which prevents the establishment of an internal environment that could become the essence of the self.

Fonagy (2001) describes mentalization as a specific symbolic function central to attachment and psychoanalytic theory. Reflective function enables children to make meaning of others' beliefs, feelings, attitudes, desires, hopes, knowledge, pretence and plans. Secure parent-infant attachments ensure that the infant develops an autonomous

sense of self allowing her to move toward understanding self and others as intentional beings whose behaviour is organised by mental states, thoughts, feelings, beliefs and desires, while severe deprivation undermines the acquisition of mentalization (Fonagy 1996, 2001; Sroufe, 1996). Fonagy and Target (1997) found that reflective function may make a critical contribution to affect regulation, impulse control, self-monitoring and the experience of self-agency.

Ainsworth (1969) describes sensitive mothers as having to see things from the child's point of view. Even if the mother is aware of and understands the baby's behaviour and the circumstances causing the baby's distress or demands, she may tease her back in good humour, laugh at her or just ignore her if she is unable to empathise with her baby (Meins, 1999). Bernier and Dozier (2003) suggest that mind-mindedness is a prerequisite for sensitivity and is expected to predict attachment security. Fonagy (1999) states that sensitive caregiving, which implies the parent's capacity to observe the moment to moment changes in the child's mental state, is viewed by attachment theorists as the cornerstone of secure attachment.

In summary, Bowlby (1969, 1973, 1980) asserts that infants are biologically predisposed to become attached to their caregivers and that early disturbances in primary attachment relationships could lead to emotional insecurity and to later disturbances in the development of meaningful relationships.

Recent findings in attachment research emphasise the role of attachment in social engagement. Hofer's (1995) reformulation of attachment in terms of regulation processes led to attachment being conceptualised "as a process that brings into being complex mental life from a multi-faceted and adaptable behavioural system" (Fonagy, 2001, p. 17). Fonagy and Target (2005) argue that the attachment relationships of infancy are a major organiser of brain development, which equips the individual for future relationships with other people. "The attachment relationships of infancy fulfil an evolutionary role in ensuring that the brain structures that come to subserve social cognition are appropriately organised and prepared to equip the individual for the collaborative existence with other people for which his or her brain was designed" (p. 333). They contend that this broader conception of attachment as an organiser of physiological and brain regulation (Sroufe, 1996; Hofer, 2004) makes it even more crucial to understand the processes that support the intergenerational transmission of attachment patterns.

Similarly Lyons-Ruth (2006) reframes attachment strategies as "strategies of human sharing around the need for security" (p. 603), while Fonagy, Target, Gergely and Jurist (2002) view "attachment as the mechanism that perhaps evolution 'co-opted' to enable the human infant to work within a social system" (Target, 2006, p. 618). Hobson (2002) states that the need for social engagement with each other has unequalled power in its formative potential and "propelled us into language" and that "the links that can join one person's mind with the mind of someone else – especially, to begin with, emotional links – are the very links that draw us into thought" (p. 2). Csibra and Gergely (2006) suggest that social cognition has the effect of turning the infant to the trusted other, to learn

everything about the world through that other. They emphasise the infant's readiness to be taught and the caregiver's inclination to teach. This sharing of knowledge is facilitated by three conditions namely eye contact, contingent responsiveness and talking to the infant.

## **DISORGANISED ATTACHMENT**

After reviewing the development of attachment theory relevant to this case study, factors that contribute to disorganised attachments, namely the severing of attachments, family circumstances and trauma are considered.

### **The severing of attachments**

The exploratory behavioural system is delicately interlinked with attachment, with exploration made possible by the secure base provided by the attachment figure (Ainsworth, 1963). The child's exploratory behaviour is consequently halted by the temporary absence of the caregiver (Rajecki, Lamb & Obmascher, 1978). In the absence of the attachment figure the fear system is aroused which leads to anxiety (Bowlby, 1973). Separation involves two stressors, namely unprotected exposure and the sense of losing the source of protection. The three behavioural systems of attachment, exploration and fear regulate the child's developmental adaptation. When the fear system is not aroused, the sociable or affectional behavioural system is activated which is seen in the child seeking companionship. "The child seeks a playmate when he is in good spirits and confident of the whereabouts of his attachment figure" (Bowlby 1969, p. 307). The caregiving system, consisting of parental behaviour aimed at ensuring proximity and comfort when the child is threatened (Cassidy, 1999), acts reciprocally to the child's attachment system. Bowlby (1969, 1973) describes the stages of protest, despair and detachment when an infant's early attachment to the mother is broken. In the final phase of detachment the child no longer spurns attempts by other adults to offer care.

Gunnar and Donazella (2002) found that the absence of an available and sensitive caregiver leads to significant elevations in cortisol levels due to stressors in infancy, which is larger than those observed in older children and adults. Experimental studies by Coplan et al. (1996); Francis, Diorio, Liu and Meaney (1999); Liu et al. (1997); Weaver and Meaney (2000) "underscore the importance of early nurturance by the caregiver for regulating the expression of a large array of genes involved in neurotransmitter and glucocorticoid function and for setting up enduring features of the stress response system that persist into adult life and are passed on to succeeding generations" (Lyons-Ruth, 2006, p. 599). Although a sensitive and responsive caregiver can provide a buffer for stress responses in the infant and toddler, insecurely attached and disorganised infants experience increased physiological responses to stress and they have inadequate behavioural strategies for achieving soothing in relation to the caregiver. This implies that the regulation of fearful arousal in the infant necessitates ongoing second-to-second intersubjective communications between caregiver and infant from

birth instead of only intermittent activations of the more visible attachment behaviours (Spangler & Grossman, 1993).

Similarly Van der Kolk and van der Hart (1989) found that childhood neglect and abuse may cause a long-term vulnerability to be hyperaroused which manifests as a decreased ability to modulate strong affect states. The absence of a familiar attachment figure, who modulates physiologic arousal by providing a balance between soothing and stimulation, can lead to the infant experiencing psychological disorganising extremes of under and overarousal.

### **The influence of family circumstances**

Fonagy (2001) points out the link between disorganised attachment and family risk factors such as maltreatment, major depressive or bipolar disorder and alcohol or substance abuse. Lyons-Ruth (2008) found that difficult family environments often involve exposure to trauma and abuse which can lead to borderline, antisocial and dissociative symptoms in late adolescence.

Crandell, Fitzgerald and Whipple (1997) found that the presence of the father in the mother's life, may divert the mother's attention from the needs of the infant to the needs of her partner. This could result in the mother being less sensitive to her infant in an effort to retain the father's affection or material help. Conversely, Egeland, Jacobvitz and Sroufe (1988) identify a supportive relationship with a partner as one of the factors that helps mothers break dysfunctional cycles, while Teti, Sakin, Kucera, Corns and Das Eiden (1996) point out the positive influence of marital harmony on mother-infant attachment security.

Amato, Loomis and Booth (1995) found that children from high-conflict homes often lack social skills such as compromise and negotiation, which are essential in functional relationships in childhood and adulthood. Jekielek (1998) and Kelly (1998) state that parental conflict may provide a social model of aggression with the result that children learn to use the same strategies. Furthermore, they found that when parents are preoccupied with their own problems, they tend to be less sensitive and warm toward their children. Kelly (1998) found that continuous and intense marital discord undermines the quality of parenting and diminishes parental capacity. Davies and Cummings (1998) describe domestic violence as a particularly powerful source of developmental problems as the fear of harm to the parent leads to anticipation of unavailability, which is confirmed by the inaccessibility of the mother at moments of heightened marital conflict.

## **The influence of trauma**

Herman (2001) contends that repeated trauma in adult life erodes the structure of the already formed personality, while repeated trauma in childhood forms and deforms the personality. "The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable and power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defences" (p. 96).

Herman (2001) describes the formidable developmental task facing the child in an environment of neglect. This includes finding a way to form primary attachments to caretakers who are dangerous, or from her perspective, negligent; to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe; to develop a sense of self in relation to others who are helpless, uncaring or cruel; and to develop a capacity for self-soothing in a disconsolate environment. Herman (2001) describes the abused child's existential task as equally formidable in that she must find a way to preserve hope and meaning as the alternative is utter despair, which no child can bear. To preserve her faith in her parents, she must reject the obvious conclusion that something is terribly wrong with them. All of the abused child's psychological adaptations are aimed at preserving her primary attachment to her parents in spite of their ongoing cruelty, helplessness or indifference. She does this by resorting to a range of psychological defences enabling her to wall off her reality from conscious awareness and memory so that it did not really happen or to minimise, rationalise and excuse it.

Herman (2001) describes the abused child's difficulties in modulating anger as further strengthening her conviction of inner badness. This sense of inner badness is often camouflaged by the abused child's ongoing attempts to be good. In her efforts she tries to do everything which is required of her and may become an empathic caretaker for her parents and an efficient housekeeper. She brings to this task perfectionist zeal, driven by the desperate need to find favour in her parents' eyes.

Herman (2001) describes the abused child as having contradictory identities, a debased and an exalted self, which cannot integrate. The abused child cannot develop a cohesive self-image with moderate virtues and tolerable faults because in the abusive environment moderation and tolerance are unknown. Thus the victim's self-representations remain rigid, exaggerated and split. Similar failures of integration are noticeable in the child's inner representations of others. In her desperate attempts to save her faith in her parents, she often idealises at least one parent, usually the abusive parent. Although she sometimes tries to preserve a bond with the non-offending parent, she often displaces all her rage onto the non-offending parent. Such glorified images of the parents cannot be reliably sustained as "the real experience of abusive or neglectful parents cannot be integrated with these idealised fragments" (Herman, 2001, p. 106). The child's inner representations of her primary caretakers, like her images of herself, remain contradictory and split. The abused child is unable to form inner representations

of a safe, consistent caretaker, which prevents the development of normal capacities for emotional self-regulation. “The fragmentary, idealised images that the child is able to form, cannot be evoked to fulfil the task of emotional soothing” (Herman, 2001, p. 107).

When a child achieves a secure sense of autonomy by forming inner representations of trustworthy and dependable caretakers, these representations can be evoked mentally when the child is distressed. However, the abused child is unable to develop a secure sense of independence and continues to seek desperately and indiscriminately for someone to depend on. Herman (2001) describes the survivors’ (of childhood abuse) relationships as driven by the hunger for protection and care and haunted by the fear of abandonment or exploitation.

Fragmentation becomes the central principle of personality organisation in chronic childhood abuse. Fragmentation in consciousness precludes the usual integration of knowledge, memory, emotional states and bodily experience. Fragmentation in the inner representations of the self precludes the integration of identity, while fragmentation in the inner representations of others precludes the development of a reliable sense of independence from attachment figures (Herman, 2001).

Van der Kolk and van der Hart (1989) found that many traumatised people expose themselves seemingly compulsively to situations reminiscent of the original trauma. These behavioural re-enactments are often not consciously understood to be related to earlier life experiences. They found that compulsive repetition of the trauma ultimately leads to chronic feelings of helplessness and a subjective sense of being bad and out of control, although it may provide a temporary sense of mastery or even pleasure.

## **ATTACHMENT AND PSYCHOPATHOLOGY**

Bowlby (1969, 1973, 1980) asserts that infants are biologically predisposed to become attached to their caregivers and links early disturbances in primary attachment relationships to emotional insecurity and to later disturbances in the development of meaningful relationships. Bowlby (1979) found that “those who suffer from psychiatric disturbances, whether psychoneurotic, sociopathic, or psychotic, always show impairment of the capacity for affectional bonding, an impairment that is often both severe and long lasting. Although in some cases this impairment is clearly secondary to other changes, in many it is probably primary and derives from faulty development having occurred during a childhood spent in an atypical family environment” (p. 71).

Both Bowlby (1979) and Ainsworth (1963) concur that a lack of opportunity to make affectional bonds or long and repeated disruptions of established bonds are significantly associated with psychiatric disturbance in childhood. Bowlby (1973) contends that differences in the security of infant-mother attachments would have long-term implications for later intimate relationships, self-understanding and psychological disturbance.

Studies that attempted to identify associations between attachment history and representational capacities concerning self, other and self-other relationships have indicated that while the residue of early attachment might not be apparent in overt functioning, it may have discernable effects on the mental processes that underpin personality and psychopathology (Cassidy, 1988; Belsky, Campbell, Cohn & Moore, 1996; Fonagy & Target, 1997). Main (1995) points out that insecure attachment may play a causal role in later maladaptation through the influence of working models, characterised by mistrust, anger, anxiety and fear, on parent-child interactions. Fonagy (2001) argues that the early relationship environment is crucial because it equips the individual with a mental processing system that will subsequently generate mental representations which include relationship representations. However, he found that evidence is lacking for the contention that the early relationship environment shapes the quality of subsequent relationships. Fonagy (2001) concludes that disorganised attachments in early life result in complex relational disturbance which can manifest in unpredictable and unwarranted aggression, but is perhaps better described as “a general sense of interpersonal incompetence” experienced by the child (p. 40).

Target (2006) argues that the withdrawal of the caregiver which leads to the absence of the essential source of information both about the self (through contingent mirroring) and about loved others and the rest of the world, is highly predictive of conduct and borderline problems. Similarly Lyons-Ruth (2006) found a strong relation between maternal withdrawal in infancy and borderline symptoms in late adolescence. In contrast to Bowlby’s predictions, Carlson (1998), Lyons-Ruth (1996), Lyons-Ruth, Alpern and Repacholi (1993) and Ogawa, Sroufe, Weinfield, Carlson and Egeland (1997) found that the secure, avoidant and resistant classifications of attachment tend not to be strongly associated with later measures of maladaptation. They point to the disorganised/disoriented category as having the strongest predictive significance for later psychological disturbance. This fourth category of infant responses to separation and reunion was identified by Main and Hesse (1990). The caregiver is both a source of comfort and a source of alarm for disorganised/disoriented infants. Lyons-Ruth, Bronfman and Parsons (1999) found that the lack of effective caregiver regulation of fearful arousal rather than explicit fear of the caregiver herself might be more generally related to disorganisation. Carlsson, Cicchetti, Barnett and Braunwald (1989) found that 83% of abused or neglected infants display disorganised attachment behaviours toward the parent.

Lyons-Ruth (2008) found that difficult family environments are associated with exposure to trauma and abuse, which precipitate defensive mental processes, such as borderline, antisocial and dissociative symptoms, designed to prevent us from constantly re-experiencing these traumatic events. The findings from the Harvard Family Pathways Study, a longitudinal study exploring the contributions of caregiving, trauma and genetic factors to overall adaptation and psychopathology in early adulthood, underscore the long-term importance of early disruptions in affective communication between parent and infant. Infants who were referred for early clinical home-visiting services because of concerns about the quality of care, were found more likely to display borderline or conduct disorder traits in young adulthood. Furthermore, maternal withdrawal in infancy

was particularly strongly related to borderline symptoms in late adolescence. The features of borderline and antisocial behaviour that were most frequently observed, were impulsive self-damaging behaviour, unstable relationships, illegal acts and aggressiveness (Lyons-Ruth, 2008).

When focusing on the type of maternal disrupted communications associated with later borderline or conduct symptoms, it was found that maternal withdrawal to the baby's attachment cues had the greatest impact by far. Results further revealed that children, who experienced lack of early maternal involvement in infancy, exhibited internalising symptoms of sadness, anxiety and withdrawal by Grade 2, which were notable to teachers. Based on results of the study thus far, Lyons-Ruth (2008) predicts the possibility that the quality of parent-child and parent-adolescent interaction will be involved in accounting for or "carrying forward" the prediction over time from the quality of early care to adolescent borderline and dissociative symptoms.

Consistent with the findings of Lyons-Ruth (2006) and Target (2006) linking maternal withdrawal and later borderline personality disorder symptoms, Gunderson (1984) describes the primary defect in borderline personality disorder as a failure to form reliable and well-integrated inner representations of trusted people. Furthermore, Adler (1985) found that people with borderline personality disorder are unable to calm or comfort themselves by calling up a mental image of a secure relationship with a caregiver. Kernberg (1967) found that patients with borderline personality disorder have inner images of the self and others that are split into extremes of good and bad. One of the major diagnostic criteria for borderline personality disorder is an unstable sense of self. Herman, Perry and van der Kolk (1989) found an inverse relationship between the age of onset of abuse and the likelihood of the survivor developing symptoms of borderline personality disorder.

## **IMPLICATIONS OF ATTACHMENT RESEARCH FOR THE THERAPEUTIC RELATIONSHIP**

### **The interface between attachment and intersubjectivity**

Lyons-Ruth (2006) considers the interface between the concepts of attachment and intersubjectivity in the light of infant research. While Tomasello (1999) and Hobson (2002) emphasise the *discontinuity* from primate to human evolution based on the flexible human capability for sharing mental states with others, attachment theorists stress the *continuities* between human attachment and attachment in other primates. Lyons-Ruth argues that due to the unique capacities of the human infant for intersubjective exchange, the organisation of human attachment is radically different from the organisation of attachment in all other species.

Lyons-Ruth (2006) contends that attachment research can contribute to understanding the development of joint attention and the sharing of mental states under conditions of increased emotional arousal. According to her the clinical implication is that fostering

more collaborative forms of communication may underpin evolutionary and developmental changes but also changes resulting from psychodynamic psychotherapy.

Lyons-Ruth (2006) argues that at the time Bowlby (1969) was writing, the capacities of the very young human infant for establishing intersubjective communication with a caregiver, was unknown. Bowlby identifies the more visible human attachment behaviours such as clinging, following and crying as the infant's contribution to the attachment relationship during the first year. As these behaviours display the goal-oriented pattern of maintaining physical proximity to the primary caregiver and protesting separation only at the end of the first year, Lyons-Ruth concludes that studies of the infant attachment system have neglected attachment behaviours during the first year of life.

Lyons-Ruth (2006) argues that with the emphasis on the explicit sharing of intentional states in human evolution, the centre of the infant-parent relationship moved from the more visible attachment behaviours to primarily intersubjective processes, such as the exchange of affective cues. The sharing of emotional cues becomes more important than the primate attachment behaviours of clinging, following and close bodily contact. She suggests that a further adjustment to older attachment theory is necessitated as "the human infant's new capacities for continuous intersubjective exchanges means that the regulation of fearful arousal in infancy cannot be understood primarily in terms of mechanisms of the termination or soothing of already aroused fear" (p. 600). It necessitates an ongoing, positive engagement with the infant, which lays the foundation for the infant's overall sense of felt security and stress modulation (Stern, 1985; Trevarthen, 1980).

Lyons-Ruth (2006) points to the convergence on developmental, behavioural, biological and evolutionary arguments for extending the model of the attachment motivational system to include positive components of the infant-caregiver relationship which also down-regulate fearful arousal in early life. Rather than view the attachment system and the intersubjective system as separate motivational systems, Lyons-Ruth (2006) "views the human capacity for intersubjectivity as a condition of our humanity and as an essential function of mind" (p. 602). Lyons-Ruth (2006) states that "the basic intersubjective flow of reading others' states and sharing aspects of our mental lives through the exchange of affective and intentional cues is a condition of our existence and cannot be switched on and off" (p. 602). Based on the findings of the Harvard Family Pathways Study, Lyons-Ruth (2008) contends that "particular deviations in early communication may catalyse a series of further deviations in the infant's understanding of other minds, changes that put the infant on a fundamentally different course of human relationship over time" (p. 215).

### **Implications for the therapeutic relationship**

According to Lyons-Ruth (2006) collaborative communication with the caregiver offers the infant the best opportunity for internalising a dialogue structure that allows for optimal regulation of stressful arousal and flexible exploration of the mental worlds of

self and others. Similarly Ontai and Thompson (2008) suggest that elaborative discourse may offer an important contribution to children's understanding of mental states. Thus the dominant goal of psychodynamic treatment would focus on establishing and expanding areas of collaborative communication in the relationship between patient and therapist rather than that of increasing reflective understanding per se. Target (2006) argues that the presence of closely and carefully contingent communication is of prime importance in the therapeutic action of psychoanalytic therapy. This kind of communication has the potential to help the patient develop emotional awareness and ego strengths and builds a sense of self and personal meaning.

According to Brownlow (2001) treatment is currently construed by many psychoanalysts (Stern, 1985; Hoffman, 1992; Beebe & Lachmann, 1994; Ogden, 1994; Stolorow & Atwood, 1992; Lyons-Ruth, 1999; Ammaniti, 1999) "to be a process that is co-constructed between two subjectivities and that both patient and analyst contribute to the form and content of the interaction" (p. 95). Van der Kolk, Herman and Perry (1988) found that borderline personality disorder patients attributed their improvement to a safe therapeutic relationship in which they felt safe to acknowledge the realities of both their past and their current lives. Kernberg (1984) explains that in treatment of patients with borderline personality disorder the therapist's empathic attitude has elements in common with the empathy of the "good enough" mother (Winnicott, 1960). Herman (2001) writes about the difficulties of both patient and therapist in coming to a working alliance and suggests that when survivors recognise that their psychological difficulties are linked to an abusive childhood, they no longer need to attribute them to an inherent defect of the self. Thus starts the process of creating a new meaning in experience and a new, unstigmatised identity.

## **APPLYING FINDINGS FROM INFANT RESEARCH TO PSYCHOANALYTIC TREATMENT**

Mahler, Pine and Bergman (1975) see the rapprochement sub-phase (from 15/18 to 24 months) during which there is an awareness of separateness, separation anxiety, and an increased need to be with the mother, as the critical period of character formation. This sub-phase is particularly relevant in this study as the main subject of the study was separated from her mother shortly before the commencement of this sub-phase. According to Kramer and Akhtar (1988) the rapprochement sub-phase's crucial conflict between separateness and closeness as well as autonomy and dependence, are repeated throughout development, particularly in periods which accompany loss, illness and drug-induced states. The attachment system seems under particular stress in this sub-phase. The mother's failure to empathically support the child when the child experiences strong ambivalence between autonomy and fusion, will lead to the collapse of the child's omnipotence. This will result in a fixation and jeopardising of the abandonment of omnipotence and the narcissistic enhancement of the self from within, through autonomous activities. Such individuals will have no clear image of themselves or their objects, may wish to avoid or control them or search for symbiosis with a perfect object. Furthermore, they will struggle to tolerate criticisms, setbacks or ambivalence that challenges their view of the other (Mahler et al., 1975; Fonagy, 2001).

This part of Mahler's theory has been extensively used in work with borderline personality disorder patients. "Residues of rapprochement sub-phase conflicts are seen in the borderline group in the form of persistent longings for, and dread of fusion with the mother and in continued splitting of self- and object representations which cumulatively prevent the establishment of object constancy and identity" (Fonagy, 2001, p. 74; Kramer, 1979; Mahler, 1971, 1972b; Mahler & Kaplan, 1977). Fonagy (2001) describes how "the search for an 'all-good' mother persists throughout life" (p. 75). Masterson (1972, 1976), in agreement with Bowlby's (1973) perspective, expanded on Mahler's views of borderline pathology and suggested that the mother of the borderline individual is likely to have been borderline herself, encouraging symbiotic clinging and withdrawing her love when the child strives towards independence. Masterson (1972, 1976) describes the borderline patient's search for a clinging attachment bond with a mother substitute as due to experiencing a deep conflict between the wish for independence and the threat of loss of love.

Mahler emphasises the process of separation-individuation which entails the gradual distancing of the child from the mother and the transition from dependency to independence. According to Mahler et al. (1975) separation refers to the child's emergence from a symbiotic fusion with the mother, whereas individuation consists of the achievements marking the child's assumptions of her/his own individual characteristics. Mahler extends this process to the entire life cycle, which she views as a distancing "from the introjection of the lost symbiotic mother" (Mahler 1972a, p. 130). Blos (1979) and Settlege (1980) concur that separateness underpins the capacity for self-regulation and object relations. In Mahler's framework the separation from attachment is viewed as progress and the enrichment of the self. Blatt and Blass (1990) differentiate between separation and attachment theories and propose that full understanding of psychological development necessitates integration of attachment and separation theories. Fonagy (2001) concludes that it remains an empirical question whether the capacity to maintain a relationship or to separate from it should be regarded as most formative in the development process.

Lyons-Ruth (1991) proposes renaming the separation-individuation development phase (Mahler et al. 1975) to attachment-individuation, consistent with Mahler's idea that symbiotic needs are life-long and Kohut's (1984) proposal that the need for self-object experience is life-long. According to Lachmann (2001) the implication for adult treatment is that attachment and separation work together as the retention of the attachment, rather than the separation from a primary caregiver, leads to the development of independence and self-assertion, and to individuation with a distinct sense of self. This allows for the gradual abstraction of an attachment, which enables the person to form attachments to persons other than their primary caregiver; and for the de-personification of an attachment so that the literal presence of the primary caregiver is less necessary for sustaining the sense of self. Furthermore, Fonagy (2001) contends that Mahler's model explains the nature of aggression better than Bowlby's framework. He views Parens' (1979) observation that aggression begins to emerge in the second sub-phase

of separation-individuation in the service of both separation and individuation, as a helpful growth point for attachment theory.

Lachmann (2001) describes the infant conceived by empirical infant researchers as “the constructionist infant, the infant co-constructing its world in interaction with its environment” (p. 168). He proposes a new view of therapeutic change based on empirical infant research and motivational systems theory. He describes an extraordinarily complex model of the mind, development and treatment that “accounts for simultaneously maintaining a sense of one’s continuity while undergoing continuous transformations” (p. 169). This involved a move “away from the constructs of structure and towards the constructs of processes and systems, of a person and an environment (infant-mother, patient-therapist) that influence and co-construct the experience of the other with the other” (Stolorow, 1997; Lachmann, 1998; Lachmann, 2001, p. 169).

Beebe and Lachmann (1994) and Lachmann and Beebe (1996) identify three organising principles of the infant’s experience in their research on the infant-caregiver dyad, namely ongoing patterns of self- and mutual regulation, disruption and repair of ongoing regulations, and heightened affective moments. The concept of expectancies is central to these three principles with the confirmation of expectancies leading to predictable ‘ongoing’ regulations and the violation of expectancies leading to disruptions that fall on a continuum from playful and pleasurable to traumatic and complicated to repair. The three organising principles and the confirmation and violation of expectancies operate throughout life and can also be applied to the psychoanalytic treatment of adults (Lachmann, 2001).

Lachmann (2001) describes the implications for adult treatment of findings from empirical infant literature as a shift in attention from what went wrong in the patient’s life to the patient’s transformational efforts in a dialectic with repetitive patterns. Vicissitudes of self- and mutual regulation emerges (Beebe, Jaffe & Lachmann, 1992; Lachmann & Beebe, 1996) and transference is understood to encompass the ongoing organisation of the patient’s experience of the analytic relationship (Stolorow & Lachmann, 1984/1985) co-constructed by analyst and patient (Lichtenberg, Lachmann & Fosshage, 1992; Lachmann & Beebe, 1996). Tronick (2001) suggests that like a mother and child, a therapist and patient can co-construct an implicit interactional procedure for being together. This uniquely arises out of their present and past interactions with each other in the therapeutic setting. Lyons-Ruth et al. (1998) describe it as a form of relational knowing. Tronick (2001) emphasises the interaction and the interactional processes whereby each individual is a self-organising system that creates its own state of consciousness, which can be developed into more coherent and complex states in collaboration with another self-organising system.

Kohut (1971) and Bowlby (1969) identify “the quality of attachment to primary caretakers as the enduring prime mover of all relationships” (Brownlow, 2001, p. 95). Lichtenberg et al. (1992) expanded on these ideas after reviewing infant research to include a theory of the self and five motivational systems with a revised theory of affects. Lichtenberg et al. (1992) and Stern (1985) provide a comprehensive account of the child’s developmental

needs based on systematic empirical research and compatible with the basic structures of Kohutian theory.

The five motivational systems are the need for psychic regulation of physiological requirements, the need for attachment and later for affiliation, the need for assertion and exploration, the need for sensual pleasure and sexual excitement, and the need to react aversively through antagonism and/or withdrawal. During infancy each system contributes to self-regulation in interactive regulation with caregivers. Lachmann (2001) contends that the theory of motivational systems provides analysts with a broad map for capturing the patient's experience. The core experience for the infant/patient is the caregiver's/analyst's attention to these five motivational systems. These systems are dynamically related and during the course of treatment there are changes in which system provides motivational dominance for the sense of self. The specific motivations reflect a tendency toward self-organising and self-stabilising in response to the infant's/patient's needs and the caretaker's/analyst's response while providing in these needs. A transformation in self-experience follows from the affect that arises from the understanding of the patient's motivational systems due to the analyst's refined attunement (Lichtenberg et al., 1992; Brownlow, 2001; Lachmann, 2001). Lachmann (2001) states that in combination, the two distinct systems perspectives of self- and interactive regulation and the motivational systems, offer a unique contribution to the treatment of the difficult-to-reach patient.

## **THE ROLE OF ATTACHMENT IN BUILDING A SENSE OF SELF**

### **Self Psychology**

Silver (1983) describes how the approaches of self psychology and infant research inevitably draw together "in that each attempts to evolve a developmental conception of the self" (p. 38). Stern (1985) points out that to fully understand the development of the self, an integration of the two domains of knowledge is required. Furthermore, Brownlow (2001) argues that the therapeutic application of self psychology may be enriched by integrating selected concepts from attachment theory, motivational systems theory and intersubjectivity theory.

### **The self and selfobjects**

Kohut's theory places the self as central. The self is the core personality, which includes an experience of oneself as continuous in time, state and space with a history, a present and a future (Wolf, 1988). The self includes our ambitions for ourselves, our ideals, our sense of having particular talents and skills, our exploratory and creative energy and the affects that influence all of these (Swartz, 2009).

According to Kohut (1971), we are born without a sense of self and depend on responses from our surroundings for a sense of wellbeing. These self-sustaining responses are called selfobject experiences. The term "selfobject" describes the link

between self and other. Bacal and Newman (1990) describe an object as a selfobject “when it is experienced intrapsychically as providing functions in a relationship that evoke, maintain, or positively affect the sense of self” (p. 229). These functions include attunement to affective states, validation of subjective experience, containment of affect, regulation of tension, soothing, restoration of a weakened sense of self due to a selfobject failure, and recognition of uniqueness and creative potential. A selfobject experience is described by Wolf (1988) as an experience that “functions to evoke the structured self (which manifests as an experience of selfhood) or to maintain the continuity of selfhood” (p. 52). The selfobject functions serve in the development and maintenance of a cohesive self which cannot exist apart from these experiences (Wolf, 1988). Bacal and Newman (1990) describe the self as established when the selfobjects and their functions have been transformed into psychological structures consisting of permanent units of relationships.

The core self is built piece by piece beginning with an infant’s interactions with primary caregivers. The parent is the first important selfobject in an infant’s life. If a parent is not empathically attuned to her/his child’s developmental striving, the child’s inborn potential to develop self structure and a vital, cohesive self is hampered. The development begins as a self in relationship. Many theorists agree with the notion that the development of the capacity for intimacy is a complex process that occurs within the infant-caregiver relationship (Fairbairn, 1952; Balint, 1979; Bowlby, 1969; Winnicott, 1960).

### **The idealized parental imago and the grandiose self**

Kohut (1971) identifies the idealized parental imago and the grandiose self as two unconscious structures that are reactivated in the treatment of narcissistic personality disorders. These two structures evolve simultaneously in early development, but the nature and timing of the traumatic events in early life sometimes leads to one being dominant. In the evolution of the idealized parental imago, the psyche assigns perfection to “an archaic, rudimentary (transitional) self-object” (p. 37). The child seeks constant contact with the all powerful idealized object to feel alive and intact, but must eventually reclaim the idealization to prevent interminable dependence. According to Kohut, psychic structures develop when the child gradually withdraws idealizations from her/his caregivers through the processes of re-internalization of the idealizing narcissism and transmuting internalization (Siegel, 1996). These new structures assume the psychological functions previously performed by the idealized object, without the personal qualities of the object. The gradual disillusionment leads to optimal frustration, which cannot be reached in situations of sudden massive disillusionment. Kohut emphasises that the function-providing object is experienced by the child as part of the self, distinct from a true object that is psychologically separate from the self. Thus psychological structures are internalizations of the functions previously performed by the selfobjects, which perform in the absence of the selfobject.

This implies a period of overlap with the findings of Mahler et al. (1975) on the rapprochement sub-phase, starting at 15/18 to 24 months, as a critical period of character transformation. According to Kohut, severe early trauma is usually the result of

an unempathic caretaker and predisposes sufferers to addiction to replace the tension-regulating and self-soothing functions of the missing internal structures (Siegel, 1996). Trauma in the oedipal or early latency period (3-7 years), when the superego is not yet complete, will result in an adult who will have a superego that contains values and standards, but will “forever search for external idealizable objects from who (she) needs to obtain the approval and leadership which (her) insufficiently idealized superego cannot provide” (Kohut, 1971, p. 49).

When the child’s grandiosity is accepted and celebrated by the parents, the expansive demands of the grandiose self become replaced with acceptance of realistic functioning and realistic self-esteem. Trauma or an unempathic caretaker can lead to interference in the optimal development of the grandiose self and inability to integrate the grandiose self into the personality structure. If the mirroring needs are not met, the crude exhibitionistic demands of the grandiose self remain outside of awareness through a vertical split or through repression. This results in a lowered sense of well-being and a diminished self-esteem. The therapeutic process in the working-through of the grandiose self is aimed at “the integration of the grandiose self, with its wish to be known as beautiful, wondrous, admirable and exalted, into the rest of the personality. The humiliating, crude, exhibitionistic narcissism that previously was disavowed modifies and is available to enhance self-esteem” (Siegel, 1996, p. 94).

### **A cohesive or fragmented self**

A self that is fragile due to problems in early relationships with caregivers will be prone to fragmentation. A fragmented self will have diminished vitality, exploratory energy and flexibility (Swartz, 2009). Attachments may be anxious or clingy, or withdrawn or wary. The fragmented state may exhibit a combination of “depression, emptiness, anxiety, or rage, ambivalence, confusion, poor bodily coordination, misperception of the body in time and space, disorganisation, withdrawal, memory loss, mood swings and diminished capacity for creative problem solving” (p. 3). Problems can occur as a result of an individual’s attempts to prevent fragmentation or to overcome experiences of loneliness, emptiness or overwhelming need. These often take the form of “maladaptive self-soothing behaviours and may include addictions, sexual perversions, avoidant behaviour and the pursuit of dangerous activity” (Swartz, 2009, p. 4).

Kohut believed that due to earlier disruptions the child/patient developed compensatory structures in the form of defensive solutions that interfered with their capacities for genuine intimacy. These defensive solutions “are undertaken in the service of psychological survival” (Kohut, 1984, p. 115) and they become the foundation for later character pathology. A cohesive self sees the self as the centre of initiative. In adulthood selfobject experiences continue to serve the role of maintaining and affirming the self. In the development of a cohesive self, there is a dynamic interplay between mirroring and idealizing selfobject needs, even into adulthood. Mirroring needs refer to the need to be affirmed, recognised, accepted and appreciated particularly in relation to displays of the self, while idealizing needs refer to the need to experience oneself as being accepted by and merge into an admired and respected selfobject (Kohut, 1977). Failure to meet

mirroring needs in infancy is linked to later failure in striving to achieve and may manifest in lack of ambitiousness or overambitiousness. When idealizing needs are not met, the self may become overburdened and lack self-soothing structures. Addiction is a possible result of the traumatic failure of an idealized selfobject during early development (Kohut, 1971). Ornstein and Ornstein (1995) suggest that many different selfobject needs are found in each unique interactive dyad, including adversarial, twinship and alterego relationships. Wolf (1988) describes the importance of the twinship relationship – the most basic of the three selfobject experiences (Basch, 1992) – in the acquisition of skills and talents.

### **Empathic attunement**

For Kohut (1982) empathy was the means of collecting information about the inner world of others. He defined empathy as “vicarious introspection”, while Teicholz (1999) explains that empathic responsiveness through vicarious introspection implies the therapist being in touch with her/his own internal world as well as that of the patient. The therapist’s “contact with her(/his) own subjectivity” forms the basis for empathy with the patient’s inner world (Teicholz, 1999, p. 27). The resonant understanding arrived at through vicarious introspection may then be communicated to the patient, which if adequately accurate, will fulfil a selfobject need.

Therapists will occasionally fail to be empathically attuned to their patients in the same way that caregivers necessarily fail in their provision of an empathically attuned environment for their infant. Frustration of need ensures that the infant will develop self-reliance. Kohut (1984) describes two steps in the development of the healthy self. “First, a basic intuneness must exist between the self and its selfobjects. Second, selfobject failures (e.g. responses based on faulty empathy) of a non-traumatic degree must occur” (Kohut, 1984, p. 70). Kohut (1971) describes the process of “transmuting internalisation” whereby optimal frustrations in the course of ordinary development allow the child to disengage gradually from total reliance on the selfobject, and to internalise the self-regulatory functions of the selfobject as part of the self-structure.

The therapy relationship thus follows two steps. Firstly, development of a basic intuneness between therapist and patient which mobilises archaic selfobject needs, experienced as idealizing or mirroring transferences. Secondly, the therapist’s empathic failures will momentarily fracture the gratifying sense of being understood, which causes “a gradual shift from the self relying for its nutriment on archaic modes of contact in the narcissistic sphere... to its ability to be sustained most of the time by the empathic resonance that emanates from the selfobjects of adult life” (Kohut 1984, p. 70).

Kohut (1984) describes the cycle of disruptions to attunement and the processes of understanding the failure and restoration of the transference as intrinsic to cure. Healing involves not only the experience of being understood, but also a sense of authenticity and efficacy in relation to the therapist. The goal of therapy in self psychology is to strengthen the self. This implies decreasing the tendency to fragmentation, while

increasing resilience to threat. The self is strengthened by the experience of being understood through the empathic attunement of the therapist.

More recent research on patterns of mutual regulation between caregiver and infant in early infancy has contributed to understandings of the nature of interaction and the process of change in the therapeutic dyad (Lyons-Ruth et al., 1998; Beebe, Knoblauch, Rustin & Sorter, 1999; Beebe, Jaffe & Lachmann, 2002). Brownlow (2001) proposes “a nonlinear, dynamic systems approach that attempts to shift a patient’s current attachment organisation to create a more coherent self” (p. 95). Thus using attachment concepts in the clinical transference will lead to “deconstructing complex but maladaptive ways of being with, while simultaneously co-constructing more adaptive but equally complex ways of being together” (Lyons-Ruth, 1999, p. 605).

## **INTERGENERATIONAL TRANSMISSION OF ATTACHMENT CLASSIFICATIONS**

Bernier and Dozier (2003) propose that few findings in developmental psychology are as robust as the intergenerational transmission of attachment patterns. Three longitudinal studies have indicated a 68-75% correspondence between attachment classifications in infancy and classifications in adulthood (Hamilton, 1994; Main, 2000; Waters, Merrick, Albersheim & Treboux, 1995). These attest to the significant stability of attachment classifications across the lifespan. Van Ijzendoorn (1995) found that individuals categorised as secure are three or four times more likely to have children with secure attachments to them. Slade, Belsky, Aber and Phelps (1999) concur that secure mothers on the Adult Attachment Interview (AAI) conveyed more joy and pleasure in their relationship with their toddlers than did dismissing and preoccupied mothers.

Van Ijzendoorn (1995) identifies a transmission gap in the study of intergenerational attachment processes as behavioural measures of maternal sensitivity have not explained the strong link between the Adult Attachment Interview and the Strange Situation. Based on his finding that the transmission gap cannot be bridged by maternal sensitivity, several researchers have attempted to explain how it can be reduced.

Van Ijzendoorn (1995) found that the security of an infant’s attachment relationship with a specific caregiver can be reliably predicted from the caregiver’s state of mind regarding attachment. The caregiver’s state of mind influences her/his sensitivity to the child’s signals, which in turn influences the child’s attachment security (Main, Kaplan & Cassidy, 1985; Ainsworth et al., 1985).

A number of theorists have discussed processes underlying the transmission of caregiving across generations. Bowlby (1969, 1982) explains how individuals internalise experiences with their significant caregivers into working models of relationships, which operate largely outside of conscious awareness and are highly resistant to change. Main (1995) contends that parents are likely to respond to their children’s attachment-related needs in a way that preserves their own representations of attachment. There is emerging evidence for the relative stability of internal working models from infancy to young adulthood (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000; Hamilton,

2000; Hazan & Shaver, 1987), as well as across middle adulthood (Klohnen & Bera, 1998; Klohnen & John, 1998). Thus, children can potentially preserve models transmitted to them by their parents well into adulthood and use them to negotiate interactions with romantic partners (Obegi, Morrison & Shaver, 2004). As children develop socially, the dynamics established with their caregivers are likely to become both self-regulating and self-perpetuating (Matas, Arend & Sroufe, 1978; Sroufe, 1989). In adulthood these children may choose relationship partners who further validate their internalised strategies (Caspi, Bem & Elder, 1989) and may establish with their children similar, familiar relationship patterns that by now have become deeply ingrained, core components of their personality (Belsky & Pensky, 1988).

## **Mentalization**

Fonagy and Target (2005) describe the transgenerational transmission of attachment as “an issue that lies at the heart of the question of the social inheritance of mental disorder and personality” (p. 333). They argue that the broader conception of attachment as an organiser of physiological and brain regulation increases the importance of gaining an understanding of the processes that support the transgenerational transmission of attachment. They consider the link between early attachment security and intelligence and the possibility of early attachment relationships as an organiser of attentional systems (Belsky & Fearon, 2002; Fearon & Belsky, 2004) as a background to examine the role of reflective function in the development of attachment and social cognition.

Fonagy and Target (2005) describe reflective functioning as mentalization measured in the context of attachment. Psychologically sharing experiences, information and affects requires the “intentional stance”, treating the person whose behaviour you want to predict as someone with beliefs and desires (Dennett, 1987, p. 15). Mentalization implies our ability to see others as having minds and motivated by thoughts, feelings, wishes, beliefs and desires. Fonagy, Gergely and Target (2007) describe mentalization as a form of mostly preconscious imaginative mental activity which entails perceiving and interpreting human behaviour in terms of intentional mental states (needs, desires, feelings, beliefs, goals and reasons). According to Fonagy and Target (2005) the experience of social interaction with a caregiver determines the capacity for mentalization as “understanding of minds is hard without the experience of having been understood as a person with a mind” (p. 334). According to Fonagy (1999) reflective capacity is acquired transgenerationally: “We think of others in terms of desires and beliefs because, and to the extent that, we were thought of as intentional beings” (p. 8).

In looking for additional mechanisms to help bridge the transmission gap, Bernier and Dozier (2003) describe maternal representations, more specifically her tendency to see the child as an individual with an autonomous mental life, as one element of a multidimensional network of parental influences on the child’s attachment security. These elements interact with one another in complex ways to shape the attachment relationship. Grienberger, Kelly and Slade (2005) propose that their findings assist in clarifying the nature of the transmission gap. These include the close link between maternal reflective functioning and maternal behaviour, and that mentalization appears

to limit breakdowns in affect regulation during times of infant distress. They suggest that mothers with high reflective function are better able to regulate the infant's fear and to interact with the infant without frightening or disorganising the infant. This links mentalization conceptually to Bion's (1962) containment concept. Slade, Grienenberger, Bernbach, Levy and Locker (2005) have possibly closed the transmission gap with a new formulation of adult attachment, linking adult attachment classification and parental reflective functioning about the child into a single model. Fonagy and Target (2005) simplify the findings by Slade et al. (2005) through explaining that the secure attachment history of the mother allows and improves her ability to explore her own mind and encourages a similar enquiring stance towards the mental state of the new infant in her world. She makes use of her awareness of her own mental state to understand her infant, while remaining mindful of her awareness of her child as an independent being. This promotes the infant developing its own sense of mental self, through the dialectic of her/his interactions with the mother (Fonagy & Target, 2005). Slade et al. (2005) describe the disorganisation of attachment as the consequence of an undermining of a mental self, or the disorganisation of the self.

Fonagy and Target (2005) emphasise the profound opportunity for an attachment based intervention and suggest that infant security may be most effectively ensured by limiting frightening or disruptive caregiving behaviour through focused interventions with the objective of improving the mother's mentalization of her child. Fonagy (2000) contends that the ultimate goal of treatment in adult psychotherapy, regarding reflective functioning, is to help the patient find meaning in her/his own and other people's behaviour. This implies that the therapist's technical efforts and therapeutic stance should be aimed at an attempt to help the patient locate her/himself within the mind of the therapist as an intentional being. This leads to the patient experiencing the therapist as someone who thinks about her/him as a thinking and feeling person. The patient's internalisation of the therapist's interest in mental states encourages the patient to learn the contents and mental processes within her/his own mind. Similarly this can be applied to work with parents. The parent-infant or child psychotherapist can demonstrate interest in the mental states of the parent and the mental states of the child. Within the context of a safe and containing relationship, the parent and the therapist can struggle together to understand the child's thoughts, feelings, motivations, intentions and behaviours. The goal is that the therapeutic process itself and the insight that has been gained will be integrated into the patient's personality to be utilised in an ongoing way (Grienenberger, Kelly, et al., 2005; Grienenberger, Popek, et al., 2005).

Similarly, Rosenblum, McDonough, Sameroff and Muzik (2008) suggest that directing attention towards supporting the mother's capacity to effectively mentalize is likely to hold positive consequences for both her mental experience of the child and the relationship, as well as for her behaviour during interaction. Ultimately, enhancing mothers' capacity for reflective parenting also may support children's own relationship security, developing theory of mind, and capacity for effective mentalization. Grienenberger, Kelly, et al. (2005) describe a mother's capacity to understand her child's developing mind as giving the child a sense of her/his own mind. The mother's attachment organisation becomes highly relevant to the child's sense of self and of

her/his relationships to others. Slade et al. (2005) found that reflective functioning plays a decisive role in the intergenerational transmission of attachment. They link the finding that reflective function can serve as a model for the regulation and modulation of experience to Winnicott's (1960) concept of "good enough" mothering. This implies that mentalization serves a modulating function once the mother-infant relationship has been disorganised. This model provides a link to the modern literature on effective processes in psychological therapy and particularly the therapeutic benefits of healing ruptures in the therapeutic alliance.

### **Implications for intersubjectivity**

Lyons-Ruth (2006) predicts "that how attachment-related communications are organised within the family around the most intense and survival-related affects and how those organisations are represented and transmitted intergenerationally will have important implications for the particular ways that intersubjectivity is elaborated at both individual and societal levels" (p. 604). Crowell, Fraley and Shaver (1999) and Grossman, Grossman, Spangler, Suess and Unzner (1985) state that attachment strategies of collaborative communication are associated with more flexible and adaptive ways of relating to others in early development and in the context of romantic relationships. As stressful arousal in humans is mainly caused by other people, the child's ability to explore the human environment and the human mind through sharing with others in a flexible manner is especially important in human development and evolution.

Attachment theorists have argued that conversations are a critical feature of the parent-child relationship that can serve as a process by which security is established, experiences are shared and discussed, and psychological understanding is achieved after infancy – especially if conversations are open and fluid (see Bretherton, 2005, for review). Ontai and Thompson (2002) found that the interaction of elaborative discourse and attachment security at the age of three predicted children's emotional understanding at the age of five, while Ontai and Thompson (2008) found that maternal elaborative discourse is a stronger predictor of children's theory-of-mind understanding than explicit maternal references to the mind. They point out that contrary to previous research (Fonagy, Redfern & Charman, 1997; Meins, Fernyhough & Russell, 1998; Steele, Steele, Croft & Fonagy, 1999) attachment security did not independently predict theory of mind. Their findings suggest that elaborative discourse may offer an important contribution to children's understanding of mental states and their influence on behaviour. Other recent research confirms the importance of elaborative discourse for the growth of psychological understanding in children (Raikes & Thompson, 2006; Reese, 2002; Dunn, 1998).

Collaborative strategies of parent-child communication lead to more effective regulation of the child's stress hormone levels in early development. Freedom from overwhelming fearful arousal allows the child to focus on exploring and learning about the social world, and in particular about intimate, intersubjective relationships. "Therefore, how well the infant-caregiver relationship maintains positive engagement and regulates the infant's fearful arousal will have escalating consequences over development for the organisation of intersubjectivity" (Lyons-Ruth, 2006, p. 604).

Conversely, Van der Kolk and van der Hart (1989) describe how people who are exposed to early neglect come to expect it as a way of life. Subjected to the chronic helplessness of their parents' alternating outbursts of affection and violence, they learn that they themselves have no control. As adults they hope to undo the past by love, competency and exemplary behaviour. When they fail, they blame themselves. In their relationships they alternate between expecting perfect behaviour leading to perfect harmony and a state of helplessness in which all verbal communication seems pointless due to having little experience of nonviolent resolution of conflict. A return to earlier coping mechanisms, such as self-blame and numbing manifesting in emotional withdrawal, or the use of drugs and alcohol, leads to a repetition of the childhood trauma.

### **The influence of contemporary grandmother-mother relationships**

One of the prevailing explanations of parenting is that parents provide care based on their own experience of being parented. Kretchmar and Jacobvitz (2002) found that parents are likely to respond in ways that are consistent with previously experienced family dynamics. They point out that although theoretical, empirical and clinical literature supports this intergenerational hypothesis, most empirical studies have relied on retrospective accounts of caregiving received. Few researchers have examined mothers' current relationships with their own mothers to determine the transmission of caregiving, while even fewer have used direct observation of the contemporary grandmother-mother relationship to examine patterns of continuity across the generations (Kretchmar & Jacobvitz, 2002; Jacobvitz, Morgan, Kretchmar & Morgan, 1991; Wakschlag, Chase-Lansdale & Brooks-Gunn, 1996).

Both attachment and family systems theorists suggest that parents' caregiving is influenced by their own experience of being parented (Boszormenyi-Nagi & Spark, 1973; Bowen, 1978; Bowlby, 1980; Sroufe & Fleeson, 1988) and highlight the balance between intimacy and autonomy as a requirement for healthy relationships. Kretchmar and Jacobvitz (2002) found that "just as mothers' representations of their significant childhood relationships may influence caregiving, it is also likely that mothers' ongoing relationships with their own parents influence caregiving" (p. 352). Mothers whose current relationships with their own mothers were characterised by both closeness and support for independence, seemed to be recreating similar nurturing and autonomy-fostering relationships with their infants. Their findings underscore the emphasis of Wakschlag et al. (1996) on the importance of the combination of intimacy and support for autonomy, as predictors of positive caregiving in the next generation. Furthermore, consistent with Biringen (1990) and Ricks (1985), they found that mothers who reported memories of maternal acceptance during childhood were more sensitive and less intrusive with their infants. Thus, both emotional intimacy and respect for autonomy in the current grandmother-mother relationship along with mothers' memories of acceptance forecast infants' secure attachment with their mothers. Grandmother-mother dynamics and mothers' memories distinguished secure from insecure attachments and between the types of insecurity.

Kretchmar and Jacobvitz (2002) found that few researchers have studied the effects of becoming a mother on a woman's relationship with her own mother. They suggest that instead of carrying forward relationship patterns, establishing an intimate bond with one's own child may motivate mothers to renew close relationships with their mothers or to change old, negative patterns. Fischer (1981) found that mothers and adult daughters were likely to redefine their relationship when daughters become mothers themselves, while Walker, Thompson and Morgan (1987) found that mothers and daughters may become closer due to the role convergence that occurs when daughters become mothers and the shared concerns that accompany this.

Kretchmar and Jacobvitz (2002) obtained correct attachment classifications for over 80% of the infants in their study based on the current grandmother-mother relationship and mothers' memories of acceptance. They caution that transmission of relationship dynamics is not inevitable with some mothers disengaging from their own mothers to provide better care for their children, while a supportive partner may lead to change in a mother's relationship style. They found that "understanding more about parents' current relationships with their own parents may help identify and break dysfunctional cycles" (p. 369). Their findings have implications for interventions as "helping parents to resolve both past and present issues with their own parents will assist them in establishing more optimal relationship dynamics with their own children" (p. 369).

## **THE EFFECTS OF THE MOTHER'S INTELLECTUAL DISABILITY**

### **The challenges of motherhood**

Lyons-Ruth and Spielman (2004) describe the experience of becoming a mother as extremely challenging both physically and psychologically. This is due to the baby's constant neediness and expressing of distress in strong, but often hard-to-read ways. The mother, who has experienced relationships of harm and fear in her own early development, can find the responsibility of caring for another to be particularly overwhelming. The new mother's response to her baby's distress can be influenced by her own memories of insensitive responses or abandonment by her own parents. Similarly Grienberger, Kelly, et al. (2005) describe the parenting of infants and young children as "a puzzling enterprise" (p. 309) in which parents must struggle to respond in sensitive ways to their child's behaviours and communications, and to understand the mind of their child. The parent is challenged to try to understand the child but also in terms of self-reflection.

Infant security is dependent on the quality of maternal care. Secure attachment in infancy is based on sensitive caregiving, which predicts superior capacity to understand the nature of mental states (Isabella & Belsky, 1991; Fonagy, 2001). Benoit and Parker (1994) also describe quality of parenting as an important determinant of the child's attachment classification, while Steele et al. (1999) found that contextual factors such as life events, experience, social support, marital relationship, psychopathology and personality also influence the child's attachment classification.

Followers of Mahler (1972a) identified the specific tasks of parenting in the second year of life that transcend the attachment literature's generic endorsement of sensitivity. Settlege (1977) identified eight developmental tasks of the rapprochement sub-phase including mastery of intensified separation anxiety and affirmation of basic trust. During the second year the mother must be emotionally available but gently start pushing towards independence. An excessive push towards independence, or lack thereof, limits the child's potential to explore the environment or could impair her/his pleasure and confidence in her/his own functioning.

## **Parentification**

Parents are not equally prepared to meet the psychological burdens of parenthood, which can lead to role reversal whereby parent-child interactions can be dominated by the emotional needs of the parents versus those of the child (Macfie, Mcelwain, Houts & Cox, 2005). Similarly Lyons-Ruth (2006) found that disrupted forms of parental responsiveness can lead to role reversal. According to Bowlby (1969) a parent who tries to seek security from a child usually manifests other signs of psychological disorder which may generate disorder in the child. Klein (1990) found that children of mentally disturbed parents tend to develop coping strategies that indicate exaggerated independence, autonomy and self reliance relative to their developmental stage.

Minuchin (1974) emphasises the importance of clear but flexible boundaries between the generations i.e. between the parent and child subsystems for healthy family functioning. Similarly Burkett (1991) found that a diffuse boundary between parent and child subsystems results in inadequate role distinctions between the generations. When parents act like dependent children, while children are assigned and assume adult roles, their children's social development could be compromised, especially regarding their future adult relationships and their parenting behaviours.

Research on the developmental consequences of parentification have linked memories of these boundary violations to compulsive caregiving (Valleau, Bergner & Horton, 1995; West & Keller, 1991), depression, anxiety and low self-esteem (Jacobvitz & Bush, 1996); and to problems in identity exploration in young adulthood (Fullinwider-Bush & Jacobvitz, 1993).

## **Intellectually disabled parents**

Perkins, Holburn, Deaux, Flory and Vietze (2002) found that little research has been conducted on children of parents with intellectual disabilities. A review by Holburn, Perkins and Vietze (2001) revealed that research on parent-child interactions with an intellectually disabled mother has typically been conducted with infants, focused on the mother during mother-child interactions and aimed to compare some quality of the mothers' parenting to mothers without intellectual disabilities. In South Africa intellectual disability has received scant research attention (Adnams, 2009), although Petersen (2004) found in a study focusing on a psychological referral service at primary level care

in South Africa that almost half of the presenting problems related to intellectual disability and/or scholastic problems.

Similarly, children's perceptions of their intellectually disabled parents and how these influence the child's relationship with the parent or the child's sense of well-being has received limited attention. Furthermore, these studies found that little is known about school-age children of mothers with intellectual disabilities. It is suggested that research may provide valuable information about the needs of children in families with intellectually disabled caregiver(s) and how these children cope with threats to self-esteem. This could inform practitioners and educators of ways of strengthening the mother-child relationship (Coates, Vietze & Gray, 1985).

While only a few studies have examined the emotional outcomes among the children of intellectually disabled mothers (e.g. Nichols, 1989; Booth & Booth, 1997; Feldman & Walton-Allen, 1997), none was found that quantitatively assessed interpersonal aspects of the mother-child relationship such as attachment, caregiving or possible coping mechanisms of children with intellectually disabled mothers. Qualitative studies include Denfeld's (1998) account of a daughter whose parents and brother have intellectual disabilities and Ronai's (1997) account of being the daughter of a mother with intellectual disability. Ronai (1997) found little empirical research on mentally retarded parenting and no studies focusing on the experience of the child of a parent with mental retardation. Ronai writes: "At the heart of the problem is the painful, shame filled, humiliating silence that still pervades the issue of mentally retarded parenting. Without dialogue there are no opportunities to construct the necessary formulas and recipes which enable interaction and problem solving; specifically, no opportunities for understanding on the part of researchers, policy makers, and the public" (p. 43).

Perkins et al. (2002) found that children of intellectually disabled mothers feel the stigma associated with the disability and may even feel stigmatised themselves, which could result in the child feeling less attached to her/his mother. However, the child's perception of the mother's caregiving style may have a positive influence on the child's attachment. According to Collins and Read (1990) adults who had warm caregivers were more trusting and experienced more love in their adult relationships. Biringen et al. (2000) indicate that maternal education is perhaps one of the most important contextual predictors of maternal sensitivity, while Valenzuela (1997) shows that this association remains valid in contexts that are characterised by particularly high psychosocial risk. Rosenblum et al. (2008) found that mothers with higher levels of education were more reflective and engaged in more mind-minded commenting. Similarly mothers' education was related to more sensitive behavioural interactions.

Feldman and Walton-Allen (1997) and Feldman (2002) note that children of intellectually disabled parents are at risk of neglect and developmental and behavioural problems. They concede that parenthood can be stressful for any person, regardless of the level of cognitive functioning, but found that intellectually disabled mothers have extremely high stress levels that increased as the child reached school age (Feldman, Le'ger & Walton-Allen, 1997). Maternal stress can disrupt optimal parenting practices and has been

associated with lack of warmth and responsiveness (Belsky 1984), negative parent-child interactions (Lempers, Clark-Lempers & Simons, 1989) and behaviour problems (Patterson, DeBaryshe & Ramsey, 1989). Furthermore, Crittenden and Bonvillian (1984), Seagull and Scheurer (1986) and Feldman and Walton-Allen (1997) report finding problems caused by elevated parental stress in families where the parents have intellectual disabilities.

Perkins et al. (2002) suggest that social service agencies can help the child of an intellectually disabled mother to understand the realities of the mother's limitations and abilities and create ways of working with the mother to teach warm caregiving. For example, Golden (1999) has taught parents at risk of child abuse, skills of listening, accepting, comforting and supporting their children. Several studies demonstrate that intellectually disabled mothers can be taught to increase their affection, contingent praise, imitation of child vocalisations, descriptive and reflective statements, stimulating conversations, and behaviour management skills (Feldman et al., 1986; Feldman, Case, Rincover, Towns & Betel, 1989; Ducharme & Feldman, 1990; Peterson, Robinson & Littman, 1983; Slater, 1986; Tymchuk & Andron, 1988).

Feldman, Varghese, Ramsay and Rajska (2002) describe how intellectually disabled mothers are likely to be highly stressed and socially isolated. They suggest that social support and parent education, specifically designed for parents with intellectual disabilities, may prevent the adverse effects of parental stress. Based on the influence of maternal representations of the child on child security, Bernier and Dozier (2003) propose that interventions should be aimed at helping parents develop an age-appropriate understanding of their child's level of functioning. Since attachment state of mind is stable and resistant to intervention efforts, an education approach whereby parents are assisted to better understand their child as a distinct and autonomous person, holds promise for intervention efforts.

Regarding the difficulties inherent in intervention efforts, Crandell et al. (1997) found that parents most in need of intervention were the least likely to identify themselves as in need, as insecure mothers reported as much confidence in their parenting abilities as secure mothers. In their view this supports the assumption that insecure attachment representations are highly organised internal models that operate outside of conscious awareness, which increases the risk of intergenerational transmission. They found that many of the insecure mothers were cognitively aware of the difficulties they experienced with their own parents, but were split off from the affect associated with these memories. Although mothers often vow not to repeat the same mistakes in parenting their children, and they did possibly provide improved parenting, they were found to be engaged in problematic interactional patterns with their children. They emphasise intervention efforts such as longer term psychotherapy as repression, isolation or absorption in painful affect are linked with repetition of these patterns with one's own children, while accessing and integrating childhood pain is a powerful deterrent against repeating parenting mistakes.

In conclusion, this section reviewed the integration of selected concepts of attachment theory, self psychology, motivational systems theory and intersubjectivity theory. This overview forms the background for presenting a patient suffering from a general sense of interpersonal incompetence resulting from complex relational disturbance caused by disorganised attachments in her early life.

## CHAPTER THREE

### METHODOLOGY

The use of single case study research methodology in this study is aimed at therapeutic progress through gaining new knowledge. Freud laid out very clearly what he considered to be the appropriate methodology for the exploration of psychoanalytic ideas. "In psychoanalysis", he wrote: ". . . there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured" (Freud, 1927, p. 256).

The process of psychoanalytic understanding entails "to risk testing our organizing principles in dialogue with a text or a person (which) makes possible a new meaning" (Orange, 1995, p. 73). Yin (1994) states that the single case study is not aimed at directly proving theory or giving decisive test to hypotheses, while Kazdin (1980) maintains that it allows clinicians to generate hypotheses around new therapeutic techniques which may emerge during the course of their work and enables them to extend given techniques to a new problem or a new patient population.

Mackay and Poser (2004) argue that the kind of effort involved in writing a case study is probably the best possible way of understanding what is going on in the treatment. Similarly, Stake (1995) views the case study as "the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (Stake, 1995, p. xi). He describes the qualitative case study as highly personal research whereby the persons studied are studied in depth and researchers are encouraged to include their own personal perspectives in the interpretation. It presumes a unique way of interaction between the case and the researcher. Furthermore, the quality and utility of the research is based on whether the meanings generated by the researcher or the reader, are valued.

Erickson (1986) points out that the most distinctive characteristic of qualitative research is its emphasis on interpretation. At the same time he highlights the ambiguity regarding whether the researcher's interpretations or those of the people being studied is emphasised. Stake (1995) concludes that although "the interpretations of the researcher are likely to be emphasised more than the interpretations of those people studied, ...the qualitative researcher tries to preserve the *multiple realities*, the different and even contradictory views of what is happening" (Stake, 1995, p. 12). My choice of a qualitative paradigm in this research allowed me to emphasise "episodes of nuance, the sequentiality of happenings in context, the wholeness of the individual" (Stake, 1995, p. xii).

While the single case study has been widely criticised as a research approach, Midgley (2006) points out its valuable contribution to clinical practice, the development of new ideas and teaching. Midgley (2004) describes the last twenty years as a period of relative pluralism in which the dominance of statistical methods has begun to be challenged in the social science research field. He writes about a renaissance of case study approaches. These more recent works (Bromley, 1986; Gomm, Hammersley & Foster, 2000; Kazdin, 1982; Stake, 1995; Yin, 1994) argue that the case study is a legitimate method within social science research which needs to be assessed by criteria suitable to its own methods and not those of experimental research. Furthermore, they argue that single case studies are often the most relevant way of studying causal influences and mechanisms; they provide a basis for moving towards a gradually wider level of understanding; they are often more clinically meaningful; and therefore are significantly helpful in bridging the gap between research and clinical practice. Spellman and Ross (1987) concur that the single case study uniquely enables practicing clinical psychologists to bridge the scientist-practitioner gap.

The case study as a research method has not been without controversy. Midgley (2006) categorises the criticisms of the clinical case study into three main areas: Firstly, the unreliability of the data. Secondly, the way in which the basic observations are analysed and reported lack validity and do not provide for the evaluation of the truth or accuracy of any particular interpretation or hypothesis. Lastly, the limited value of the approach due to it not being possible to generalise beyond the particular case, is criticised.

Acknowledging the controversy surrounding the case study in some parts of the scientific world, Denzin and Lincoln (2000) argue that the case study is a special, perhaps non-scientific, means of investigation that yields a special kind of knowledge belonging to a domain separate from orthodox scientific knowledge.

Yin (1984) defines the case study research method as “an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used” (Yin, 1984, p. 23). Fonagy and Moran (1993) argue that the belief that knowledge based upon groups of individuals is somehow more likely to be generalisable (that is, applicable beyond the specific locus of its discovery) than is the case for knowledge based upon individual cases, is fatally flawed as problems of sampling and questions of generalisability apply equally or even more to group designs.

MacKay and Poser (2004) argue that the scientific function of the analytic case study implies a form for its reporting. It should be systematic, to give readers access to the maximum amount of information about the case; transparent, which requires that the reported facts and the inferential processes of the researcher should be clear and explicit and the concepts used to link the material to the concepts should be clearly defined; and self-critical, which requires that the researcher should argue for the theoretical approach taken in explaining the case and justify what she/he does against

other possible explanations and other conceivable inferences that the material might imply.

In conclusion, the single case study is chosen in this study as it provides for the systematic illustration of theory in clinical material. Treating the case study as an illustration addresses the main controversies over its legitimacy as a research method and uniquely suits the needs of clinical training. The single-case study “is aimed at supporting theory by exemplifying it in a case and by showing that theory can bring coherence to the apparently disparate elements of patient behaviour and symptoms” (Mackay & Poser, 2004, p. 174).

## **Overview of the case**

### **Procedure**

In this study a patient is presented who was brought to the Child Guidance Clinic by her mother and maternal grandmother initially as a way of addressing her recent failure at school. The study is based on 15 sessions with Melanie and her family. In the first session I spent an hour with Melanie, her mother and her grandmother and a further 30 minutes individually with Melanie. Thereafter, most sessions were spent individually with Melanie, although her mother attended one individual session and her mother and/or grandmother were occasionally included for short parts of sessions. Two sessions were used for career guidance purposes. Towards the end of the process, Melanie’s mother was referred to one of my colleagues at the Clinic.

The primary data consists of verbatim transcriptions of the videotapes of the first two sessions, two case presentations on the case, the therapist’s own notes recorded soon after the session, based on the therapist’s own memory of what happened during the hour and the therapist’s notes on countertransference issues. Note-taking during the session was found to disturb the rapport between therapist and patient. Melanie Klein addresses criticism of and justifies this approach as follows:

“I took fairly extensive notes, but I could of course not always be sure of the sequence, nor quote literally the patient’s associations and my interpretations. This difficulty is one of a general nature in reporting on case material. To give verbatim accounts could only be done if the analyst were to take notes during the session; this would disturb the patient considerably and break the unhindered flow of associations, as well as divert the analyst’s attention from the course of the analysis . . . For all these reasons I am sure that notes taken as soon as possible after each session provide the best picture of the day-to-day happenings in the analysis, and therefore of the course of the analysis” (Klein, 1961 p. 11).

While Midgley (2006) acknowledges the many advantages to the use of audio and video-recordings, he points out that Wallerstein and Sampson (1971) found that it is not always an improvement even when considered purely from a research perspective. They referred to the real danger of data overload when dealing with transcripts of psychotherapy sessions with the consequent possibility of getting so lost in the detail that one is unable to see the bigger picture. Klein (1961) describes the use of a recording machine as “absolutely against the fundamental principles on which psychoanalysis rests, namely the exclusion of any audience during an analytic session”.

Midgley (2006) found that the myth of “absolute completeness” and the myth of “absolute exactness” that audio- and video-recording seems to support, is just a myth. He argues that deciding on whether such recordings are better or worse than case notes as the basic observations of clinical research should be based on what type of data is best for what kind of research questions.

### **Analysis of material**

As the issues being investigated can only be understood from within the context of the subjective world of the individual, including the individual's personal history, meaning is sought through close personal interaction with the ‘subject’ of study. This enabled an empathic immersion into her perspective and leads to understanding of her internal world. Kohut (1977) introduced the concept of empathy as a mode of data collection by which the therapist attempts to understand the patient from within the patient's subjective reality (Wolf, 1988). Fielding (2003) found that “the gradual development of understanding of the individual's psychological life arises from an intersubjective process, involving the interplay between the subjective worlds of both the individual under analysis and the investigator” (p. 19).

Stake (1995) describes two strategies used by qualitative researchers to make a case understandable, namely direct interpretation of the individual instance and aggregation of instances until something can be said about them as a class. Stake further explained that his quantitative side emphasised the meaning gained from repetition of phenomena, while his qualitative side looked for the emergence of meaning in the single instance. Stake (1995) states that “the search for meaning is often a search for patterns, for consistency within certain conditions, which we call ‘correspondence’ ” (p. 78) and that “both categorical aggregation and direct interpretation depend greatly on the search for patterns” (p. 78).

According to Stake (1995) “...there is much art and much intuitive processing to the search for meaning (p. 72)”. In analysing the data, I commenced by immersing myself in the literature and clinical material. Thereafter the analysis was driven by the major categories identified in the attachment literature.

## **Ethical considerations**

The Child Guidance Clinic informs all patients that it is a training and research institute and patients are asked to sign a form granting permission for material to be used for these purposes. At the initial interview, the family was informed that we were being observed by colleagues, qualified professionals and fellow trainees, from behind a one-way mirror and that sessions could be videotaped or audio-taped.

In deciding to present this family in a case study, I carefully considered the impact of asking more direct permission on both daughter and mother. According to Goldberg (1997) securing the patient's consent for publication may place an unnecessary burden on the patient as well as the analyst. Gabbard (2000, p. 1078) states that "once the analyst has introduced the idea that the patient will appear in a publication, it inevitably affects the subsequent course of the analysis".

Gabbard (2000) raises the profound ethical issue of causing a devastating or harmful impact on patients by asking for consent and suggests that "every decision about the method of protecting patient privacy must be based on a clinical judgement that is unique to the patient and the situation" (p. 1082). After careful deliberations with my clinical and research supervisors, we concluded that asking further consent would not be in the best interest of my patient and the family.

I have protected my patients' confidentiality by changing the names of the family members and some of the historical facts. These changes have no direct impact on the nature or meaning of the case material. I have only included the background information really necessary for providing clarity to the material being discussed. In this process I experienced the tension described by Aron (2000) that exists for clinicians in striving to protect the privacy of their patients while simultaneously attempting to accurately convey the particular circumstances that contribute to the phenomenon being studied.

## **Limitations and challenges**

The limitations to this case study are the inevitable gaps in the history, compounded by the intellectual disability of the mother and the limited time available for therapy due to the requirements of the training. A longer intervention might have offered a richer understanding of the impact of Melanie's early life on her attachment patterns.

Furthermore, I was challenged by having to fulfil the dual roles of both researcher and clinician with the research guided by Melanie's needs in therapy. In this process I was guided by clinical and research supervision.

## CHAPTER FOUR

### THE CASE HISTORY AND FORMULATION

#### The Case History

##### Introduction to the family

I met Melanie when she was aged seventeen and seven months, her mother Diane, aged 37, and her maternal grandmother Jackie, aged 51, in a family intake interview at the Child Guidance Clinic of the University of Cape Town in March 2009. Although her grandmother's attendance was unexpected, it soon became evident that her absence would have resulted in large gaps in the family history. The grandmother provided pertinent information regarding Melanie's early separation from her parents, her parents' alcohol abuse and Melanie's later separations from the family during high school. Accompanying the family to the therapy room, I had a sense of something amiss with Diane as she took longer than usual to fill out the information forms and needed assistance from her mother and daughter.

Melanie was brought to the clinic by her grandmother because she had failed Grade 11 and wanted to leave school. The grandmother was concerned about Melanie's lack of motivation and her plans to study art at a college, which the family could not afford.

Melanie presented as a neatly dressed, petite and very thin girl. She appeared calm and seated herself between her mother and grandmother, on the edge of the chair closer towards her grandmother. Her grandmother was well groomed, while her mother appeared overweight and unkempt. During the interview Melanie spoke easily and was forthcoming when asked questions. Her grandmother looked at Melanie when she spoke, but her mother did not look at either of them. Melanie and her grandmother communicated easily, while her mother was very quiet and at times seemed uninterested in the proceedings. The grandmother offered information elucidating Diane's responses, which often lacked detail. Melanie often corrected her mother with a note of impatience in her voice and occasionally interrupted her grandmother's narrative to clarify or add her views. Diane's limited engagement and her responses to my questions contributed to my suspicion that she might be intellectually disabled.

When asked why they came to the clinic, Melanie reported that she had no idea why she was there, but thought it was "to take a multiple choice test". Diane responded as follows: "Assess Melanie's ability, schoolwork, at home. Her friends are talking about her problems, the way she was brought up, like a counselling session". The grandmother said: "Melanie has academically not say struggled, not being able to apply herself fully because of home conditions".

## **Family and developmental history**

### **The grandmother**

Diane's mother, Jackie, was one of six siblings who were subjected to their parents' alcohol abuse and domestic violence. She was reportedly not close to her mother and left home at a young age. Diane was born when her mother was fourteen years old. Jackie never married Diane's father and Diane never knew him. Diane's mother subsequently married a violent man and they both abused alcohol. Another daughter was born when Diane was five years old. Diane reported that her mother and stepfather fought all the time and the marriage did not last long.

Jackie subsequently re-married and had two children now close in age to her granddaughter Melanie. It seemed that Jackie's present husband is unsupportive of her efforts to assist Diane and Melanie and that they perceived him to be critical of them. Jackie's family of origin experienced mental health problems with three of her siblings having schizophrenia and she herself reported suffering from depression.

### **The parents**

Melanie's mother, Diane, was socially isolated, depressed, overweight, hypertensive and alcoholic, while her father, Ronald, was immature, substance dependent, unreliable and mostly absent. He refused to take part in the process from the start.

Melanie's parents met when Diane was fifteen and Ronald was twenty. Diane was in the remedial class at a mainstream primary school from Grade 3 and attended a high school for learners with special educational needs where she completed Grade 10. The high school caters for learners not coping in mainstream schooling because their IQ falls below the average range. The results of a recent work assessment indicated that Diane is unable to work as a library assistant as she would be unable to categorise books alphabetically. This information confirmed my suspicion that Diane might be intellectually disabled.

Ronald worked as a plumber, but was regularly unemployed, while Diane occasionally worked as a home based carer. Diane fell pregnant four years after they met, but they never married and stayed together only "on odd occasion" according to Diane. The grandmother reported that Ronald came and went at his convenience and that Diane was never part of his social life. Ronald has two brothers and two half-brothers. One of his brothers supported him financially while he was unemployed and the three brothers worked together for periods of time. Ronald's mother passed away when Melanie was born and his father subsequently remarried.

## Melanie

Being totally unsupported in school and with a disorganised and chaotic home environment in a small one-bedroom council house with drinking and quarrelling parents, it was unsurprising that Melanie failed Grade 11. She hated school and wanted to go to college to study art. She came into treatment unmotivated and without any prospects for a better life.

Melanie experienced a number of traumatic events during her early childhood starting with her mother's heavy drinking during pregnancy, which caused strife between her parents as her father criticised her mother's behaviour. When Melanie was one year old, she was separated from her parents and placed in the care of her paternal grandfather and his wife, who had two young children at the time. Significantly, Diane did not provide any information about this early separation. When I asked about Melanie's developmental milestones towards the end of the interview, Diane responded by saying "everything normal". At this point the grandmother interceded: "The only thing that did happen when Melanie was one, which I think has quite a bearing. Diane and Ronald decided that Melanie should stay with her (grandfather)..." When I asked if the separation happened due to the situation at home, Diane said: "Yes, I had to work. My house was too small". Melanie then remarked that "you were too busy to look after me". It later emerged that social services were involved in the decision to remove Melanie from her parents' care which raised suspicions regarding the level of care they provided.

It later emerged that during the time Melanie was away, up to fifteen people at a time were staying with Diane and Ronald in their small one-bed-roomed house. When asked how often she saw Melanie during this period, Diane reported that she saw Melanie on her days off every second week. It seemed as if social services demanded supervised visits during this time. Melanie could not recall missing her parents during the separation and only remembered her father "coming in and he'd leave some money on the table". When I asked whether she could recall her grandfather's wife she responded that "they're very fond of me", "I call her granny" and "I don't see her (anymore)" as her grandfather and his wife were subsequently divorced.

After four years Melanie was returned to her mother's care, abruptly severing Melanie's ties with her substitute caregivers and their young children after a dispute about whether they would adopt her. This was likely due to uncertainty regarding the level of care that her mother could provide. When I asked about the adjustment after Melanie returned to stay with her, Diane said "it took a long time for her to realise that we were her parents, about a year". Melanie remarked that she called them Diane and Ronald.

After her return she witnessed frequent verbal arguments and physical violence between her parents. Her mother was abusing alcohol and her father was abusing alcohol and drugs, such as tik (methamphetamine). Her parents were regularly unemployed and were supported financially by extended family members. During this time Ronald

continued his pattern of coming and going. When I asked Melanie how she experienced his transient presence, she said “I don’t even know how I handled it. I don’t even think of it anymore”. While Melanie was in primary school, her father physically abused her mother while under the influence of tik and alcohol. Her mother would also engage in physical altercations with him. Melanie described her parents’ incessant fighting: “They’ll both pick on each other. They irritate each other...They’re like two little children going at each other. It’s very irritating”.

When Melanie went to high school, she started “coming and going as she pleased”, often staying over with friends for long periods. Her mother was often not aware of her whereabouts and she was regularly absent from school. Melanie reported not liking high school and that she decided to live with the wife and children of her father’s brother from the beginning of Grade 9 “to get away from the fighting”. This move occurred during a particularly disrupted period in the family’s life when Melanie and Diane moved in with the grandmother, while Diane’s sister stayed in their house and Melanie was spending weekends living with her homeless and substance addicted father in his car. This information was gained in a meeting with the social worker at Melanie’s school, who intervened at the time. She informed me about Ronald’s drug abuse, which was not mentioned during the intake interview. In an individual session with Diane, while speaking about the difficult times she went through with Ronald, she said: “It was difficult. When he was on drugs he stayed in his car for 8 months. I didn’t allow him back then”. Diane did not mention that Melanie spent weekends staying with him in his car.

When I asked what the reason was for Melanie going to stay with her father’s brother, Melanie said: “They used to fight” and Diane said “I thought it would be better for her, settled in easier” while the grandmother said: “The big reason was they said they would send her to a private school”. Melanie reiterated: “I went there to get away from the fighting”. After 6 months she returned to her mother. She reported that it was her decision to return as she was not happy staying there because she did not get along with her uncle’s wife and most of their children.

The grandmother explained that since being in high school, Melanie has “lived independently and which is quite distressing having her moving around independently and not knowing where she is”. Melanie used to stay with friends and she was often absent from school during these periods. During Grade 10 she often stayed with her best friend, sometimes for up to two weeks and she missed 27 days of school. During her first year in Grade 11 she moved in with her new best friend’s family and stayed there for six months. Her grandmother explained that “a family took her in for half a year”. She was absent from school for 38 days and Diane reported that she was contacted by the social worker after Melanie missed a month of school. Melanie described living independently as helping her to stand on her own two feet, while her grandmother agreed that it made her more resilient.

During the intake interview the grandmother reported that since the year before therapy commenced, Ronald moved in with Diane and Melanie and that things had been better, although Diane and Ronald would regularly argue about small things without ever

resolving these. When I tried to gain an understanding of why Melanie went to stay with her best friend Michelle for six months after her father moved in with them and things were “better”, Melanie explained: “No, it was like building up to get better. Sometimes it would like fall out, but sometimes it would be really good, but now it’s been quite good, but sometimes they do have their fights...I just don’t like to get involved in it cause it just stresses me out so I rather stay away, but I’m glad I did stay away most of that year because ever since then they’ve gotten on much better. I noticed that me being away got them to like understand each other much better...it opened their eyes as well”. Her grandmother added: “maybe Melanie did that intentionally. I think I heard Melanie saying, they cared more about each other, than they cared about her. They cared more about this dysfunctional relationship”. Melanie said about the time she was away: “They never used to like be, where’s Melanie, and only after I told them. They never phoned me to find out where I am and stuff. And only like ever since I mentioned it”.

Shortly after the commencement of therapy she expressed wanting to stay with her grandmother for the midyear examination to have peace for studying. She reported that her grandmother’s husband “does provoke her, but I’ll be busy, so I won’t react”. She felt that her mother will miss her while she is away and said: “she’ll realise all I do if I go to stay at my gran. It was better after I went to Brackenfell” (the 6 months spent at her father’s brother’s wife). During the later weeks of therapy Melanie often spent weekends at her aunt to escape her parents’ drinking.

Refer to the appendix for the case formulation.

## CHAPTER FIVE

### ANALYSIS OF ILLUSTRATIVE MATERIAL AND DISCUSSION

In this section illustrative material drawn from therapy sessions is used to elucidate the attachment difficulties Melanie experienced during late adolescence, her symptoms of disorganised attachment and the intergenerational transmission of attachment difficulties. The analysis section ends with a discussion of observations on the conclusion of the therapy process.

#### ATTACHMENT DIFFICULTIES IN LATE ADOLESCENCE

An understanding of Melanie's attachment difficulties in late adolescence necessitates an overview of her early attachment history which includes the severing of her attachments, the ongoing neglect she experienced during her childhood, her experience of home life, and her assumption of a parentified role to compensate for her parents' lack of parenting ability.

#### Melanie's early attachment history

Melanie's attachment history is viewed in the context of her environment with specific emphasis on the influence of her mother's intellectual disability. From the details available, it is very unlikely that she had a secure base during infancy. Given her mother's inability to provide details regarding Melanie's early infancy, it is hypothesised that Melanie's attachment to her mother in infancy is likely to have been either anxious avoidant or disorganised/disoriented. As an infant, Melanie could not be sure of her mother's accessibility or responsiveness because of her mother's insecure attachment history, her unsupportive partner and her intellectual disability, which resulted in her lack of reflective capacity. The anxious avoidant pattern of attachment indicates the infant's lack of confidence in the caregiver's availability, leading to a strategy of down-regulating emotional arousal, to show little distress during separation and definite disinterest at reunion (Ainsworth et al. 1978). Melanie would have learnt to 'defend against' intimacy and develop relationship strategies that make her less vulnerable, like seeking closeness when she is not distressed (Ainsworth et al., 1978; Bowlby, 1973; Main & Weston, 1982). The disorganised/disoriented infant displays strange and disoriented behaviour when seeking proximity to the mother (Main & Solomon, 1990).

When Melanie was born, Diane was a young, unmarried mother in a volatile relationship with an immature partner, ill-equipped to commit to fatherhood. Both Diane and Ronald drank regularly and were financially insecure. Rather than being a supportive partner who could assist Diane to break a dysfunctional cycle (Egeland et al., 1988), it is likely that Ronald's transient presence in Diane's life caused her to focus her attention on the needs of her partner rather than on the needs of her infant in an effort to retain his affection or material help (Crandell et al., 1997).

Diane's intellectual disability compounded the physical and psychological challenges of motherhood described by Lyons-Ruth and Spielman (2004). Considering the circumstances of Melanie's first year and the separation from her mother, it is likely that Diane was deemed to be a not "good enough" mother (Winnicott, 1960) by her family, in-laws and social services. The removal of Melanie from her mother's care is seen as evidence that the quality of Diane's parenting was insufficient to ensure attachment security (Benoit & Parker, 1994). Furthermore, it is likely that due to her intellectual disability, Diane experienced Melanie's return after four years and the threat of adoption as particularly stressful (Feldman & Walton-Allen, 1997).

However, based on Melanie's memories of her "granny", it seems likely that she formed a secure attachment with her substitute caregiver during the period of separation from her mother. It is likely that neither her mother nor her father was able to fulfil her mirroring or idealizing needs before or after this separation. Melanie was further subjected to contextual factors such as a turbulent parental relationship, her parents' psychopathology and lack of social support, described by Steele et al. (1999) as influencing the child's attachment classification.

### **The severing of attachments**

Melanie was separated from her primary attachment figures twice before the age of five and she witnessed violent altercations between her parents after being reunited with her mother. It was difficult to infer Diane's feelings about the separation and whether she experienced it as traumatic, because of her reticence. However, as she refrained from reporting this important aspect in Melanie's development, it seemed likely that she was shamed by what had occurred during her early history as a mother. Melanie conveyed her sense that she was not a priority in her parents' lives by saying "you were too busy to look after me".

Bowlby (1979) writes about the link between prolonged or repeated disruptions of the mother-child bond during the first five years of life and later personality disorders, notably sociopathology and psychopathology, although studies on separation typically focused on shorter separations. The prolonged separation that Melanie experienced would have compromised the successful completion of the development tasks of the rapprochement sub-phase (Settlage, 1977). On her return, Melanie faced the formidable developmental task of finding a way to develop a sense of basic trust and safety with untrustworthy and unsafe caretakers (Herman, 2001). She had to develop a sense of self in relation to a helpless and occasionally uncaring mother and a father who was mostly unavailable.

The impact of her disrupted early attachment history emerges clearly in Melanie's behaviour during adolescence. When she started high school she regularly left home to stay with friends. It appears that at these times her parents were often unsure about her whereabouts or whether she was attending school. While discussing Melanie's staying with a friend for six months in the year before therapy commenced, her grandmother said: "She moved in with the family and stayed there and we didn't ever really

communicate. I only went after, at the end of the year to speak about (it)" and "Melanie did tend to go off".

When I asked Diane how she handled Melanie staying with friends for long periods, she responded "a lot distressing, because I felt when I need to get hold of her I didn't know where she was or I thought she was by her friend. Most of the time it was like an orphan. I didn't know if she was going to school". When I enquired about Ronald's reaction to Melanie's absence, Melanie said: "I don't really know", while Diane said: "He didn't really like it. He would come to me and question me, why's the child doing this".

Melanie's coming and going during her adolescence illustrates her struggle with the crucial conflict between separateness and closeness, autonomy and dependency of the rapprochement sub-phase, which are repeated throughout development (Mahler et al., 1975). During adolescence Melanie engaged in an ongoing search for selfobjects who could offer her the security her parents were unable to offer her. These selfobjects repeatedly became unavailable to her after a short while. Finally the termination of the therapy, necessitated by the training requirements also led to my unavailability.

## **Neglect**

Melanie experienced a pattern of neglect starting at conception. Her mother jeopardised Melanie's safety in utero by abusing alcohol while pregnant. During the intake interview, Melanie relayed her sense that her parents and grandmother were not concerned about her needs and neither did they care much about her whereabouts. She felt that her parents were always preoccupied with their problematic relationship and consequently not concerned about her wellbeing (Jekielek, 1998; Kelly, 1998). Their lack of commitment to her wellbeing was evident in their disclosures during the interview. When I asked Melanie how she experienced her father coming and going, her grandmother answered for her by stating that "I wouldn't say he's alcoholic. They drink socially, they drink. Diane is not so much of a problem now as it has been in the past, but it's been very difficult for Melanie. Their social lives have taken precedence over Melanie. Although they are concerned about Melanie, but not enough to make enough sacrifices for her wellbeing. They've had big anger issues..." She further reported that "they tussled for her favour. They would give her things as compensation for lack of nurturing, which was problematic for Melanie because then she would want compensation".

During the therapy it emerged that the pattern of neglect was ongoing. For example, in session 2 Melanie arrived visibly agitated and reported that she had an argument with her mother on the way because she was hungry and her mother only buys polony and does not make her sandwiches for school: Melanie said: "She's too lazy. She doesn't take the time to think about stuff like that (to buy the right kind of food). She'd rather worry about stuff on her plate (problems). That's also why I became very independent over the years. She did usually make my lunch (when Melanie was younger)". Subsequently Diane reported that she no longer makes Melanie's sandwiches for school as this leads to arguments and that Melanie's old enough to do it herself. Diane reported sleeping at her mother's house while working night shifts and said: I don't cook for them

(Melanie and Ronald), they can do it. I'm tired". It was evident that Diane was withdrawing from her parental responsibilities as Melanie matured.

Fonagy (2001) explains how neglect of the child in turn leads to the child's disavowal of reflection and rejection of mentalization as an adaptation that helps the child to attain some distance from a traumatising situation. In accordance with the findings of Biringer et al. (2000) and Rosenblum et al. (2008) it is likely that Diane was less able to exhibit maternal sensitivity towards Melanie due to her intellectual disability and resultant lower level of education.

## **Home life**

An overview of Melanie's home situation crystallises the attachment patterns in her nuclear family. Melanie paints a picture of her home as a lonely and stressful place. In stark contrast, she describes her best friend Michelle's house as "an interesting place, at my house it's very quiet", although at other times she describes her home as very noisy when her parents are fighting and when they drink with their friends. During session 1 when I spent time alone with her, she said about spending time at Michelle's house: "I look at them as all my brothers and sisters and I like it at their house". In session 2 she said: "It felt like I had my own brothers and sisters around me" and "Michelle's parents are very understanding. I can sit down and have a proper conversation with her father and her mother as if they were my own parents".

When I asked her whether she feels lonely at home, she responded "Not really. I'll talk to my parents whenever they talk to me or whatever. I don't like sit down and have quality time with them all the time. Sometimes I'll sit next to them, but most of the time I'll just go to my room.....(at Michelle) we're like a whole big family, we just all get along with each other. At home we don't have real conversations, like we don't talk about real things. At Michelle we'll talk about stuff that happened in the world, like politics, interesting things. But at home it's just money and alcohol basically. My dad just keeps quiet when he gets home so my mom doesn't fight. He just minds his own business. I prefer it at Michelle. It's an interesting place and I learn interesting things all the time".

Importantly, Melanie referred to sitting "next to" her parents rather than "with them". This seems to indicate that the individual family members had not yet adjusted to their roles as part of a family following Ronald's return to live with them. Melanie seemed not to know where she fits in and was unsure whether her father's return would be permanent. She did not view their new configuration as a "real" family in contrast with her perceptions of Michelle's family, where everyone knows their roles and feels comfortable. Melanie indicated an awareness of how disorganised her own home life is, by stating: "we have curfews and rules there (at Michelle's house)". Further evidence of their inability to maintain a cohesive family unit was that Diane seemed to be excluded from Ronald and Melanie's social lives. When I asked what the family does for fun, Diane said: "we don't do much things, but when she's home, she enjoys being around her dad". When I asked Melanie what she and her father did for fun, she said "well, not really anything. We like each other's company". She described how her father always

used to go to the neighbour: “He’ll go out, get drunk” and “he’ll just pass out”. Melanie reported occasionally joining her father and his friends and that he included her in his conversations.

In session 2 when I asked about her parents’ drinking she disclosed that her parents became violent in the past: “Bad thing, they’d get violent with each other. Years ago my father used to hit on my mom. My mom would provoke it as well. She’d start the fight and my dad was on drugs also and with the drinking it made him violent. She’d hit him and then he’d hit her and then it would become a big thing. He’d win because he’s bigger. Then eventually it stopped”. In reference to the current situation she said that “now they’ll throw threats at each other, but they won’t do anything.” It is hypothesised that Melanie’s anticipation of her mother’s unavailability during periods of domestic violence could have been exacerbated by her early experience of being separated from her mother (Davies & Cummings, 1998).

Another facet to Melanie’s experience of home life was her shame and frustration regarding her parent’s unconcern about the state of their home: “I don’t like people coming to the house, because I don’t like the way my parents look after it, cause they don’t take pride in it, they don’t really care. They’ll throw things around in the garden and stuff. I’ll be the one to pick it up. I do care how my house looks.... They (father and neighbour) used to throw beer bottles over (the fence)”. She related how she tries to keep the house tidy only to have it “messed up” by her parents and their drinking friends: “When I get home, the whole place is a mess with broken glass lying around and it smells of alcohol – I hate the smell” and “my mom lets them lie on my bed and she can’t understand that it makes me angry”.

Melanie described both home and school as stressful: “School stressed me out and then I’d go home and there’d be more stress. I’d hear my parents fight in the morning.” When I asked her how she coped with this, she responded. “I don’t even know. I just decided to keep strong”. When I asked Melanie whether her parents help her with schoolwork, her response was: “No, my dad will if I ask him. I know that he can, he’s really smart and he can, but a lot of the stuff is different to what they used to learn and they won’t really know how to do it. My mom, I never even ask her, because she’s not interested, so I don’t even try. I rather do it myself”.

## **Parentification**

It is postulated that neither Diane or Ronald were able to cope with the psychological burdens of parenthood described by Grienerberger, Kelly et al. (2005), which led to their emotional needs being foregrounded and subsequent role reversal (Macfie, et al., 2005). Melanie related various incidents of parentified behaviour and incidents where her mother acted like a child. Melanie spoke about her mother’s irresponsibility, feeling “like she’s the parent” and having to take responsibility. She described how her father would give her the money when she and her mother went grocery shopping. On these occasions Melanie would have to prevent her mother from filling the trolley with unnecessary items, which led to scenes reminiscent of a toddler having a temper tantrum when not getting what she/he wants. Ronai (1997) similarly describes her

intellectually disabled mother making "scenes, which include foot stomping, yelling, fist pounding, and pouting" (p. 3).

Melanie spoke about being burdened with things that "a little girl" should not be concerned about. On more than one occasion she voiced her concern about her mother's wellbeing with regard to her weight, diet, high blood pressure and alcohol abuse. She said "I don't want something to happen to her" and "I don't want to have to think about everything she should be doing. She doesn't take her blood pressure medication". When we discussed the incidents of domestic violence, she mentioned telling her father that she would call the police if he became violent, which she felt put an end to his violent behaviour.

Furthermore Melanie often discussed her frustration at having to take charge of the domestic chores while her mom messes and doesn't clean: "I just get on with the cleaning. My mom doesn't do it", "If I clean up, my dad does too, but then my mom messes". I suggested that we discuss with her mother that Melanie needed more time for studying during examination time and that they could negotiate who is responsible for certain chores, but Melanie was unenthusiastic. It seemed as if she had little hope that any intervention would make a difference.

The role reversal is further evident in the way Diane looks to Melanie for selfobject experiences. Melanie described twinship experiences (Wolf, 1988) in which her mother learns from her. She said: "she is doing things (household chores), but sometimes I just laugh when I see how she messes. But she watches me, like when I make pancakes ... I clean up as I go along and then she watches this and also does it".

During the therapy process it clearly emerged that Diane was finding parenting Melanie difficult. In telephonic conversations, Diane for example reported that Melanie had inserted a tongue ring against her express wishes; and that she was "stressed out" by Melanie wanting two foster children to stay with them. It was evident that she experienced difficulties in setting boundaries for Melanie. Diane's inability to effectively parent Melanie was confirmed when I was contacted by the school social worker when Melanie had been caught "bunking school and smoking dope in the park with the two foster children" and had allegedly supplied them with cannabis at school. This confirmed my sense gained in the early contact with the family that I might be expected to assume her mother's responsibilities.

After reviewing Melanie's attachment difficulties in adolescence, the next section focuses on her symptoms of disorganised attachment.

## **SYMPTOMS OF DISORGANISED ATTACHMENT**

During adolescence Melanie's attachment difficulties manifest in her ongoing search for selfobjects; her repeated efforts to escape her home situation; significant affect regulation difficulties; problematic relationships and her perception that others view her as being "bad".

## Searching for selfobjects

In accordance with Ainsworth's (1989) findings, Melanie engaged in seeking the closeness that would result in feeling secure and comfortable from a variety of potential attachment figures, following the massive failure of her initial attachment figures to be attuned to her basic idealizing needs. When applying Ainsworth's criterion of security, none of Melanie's affectional bonds can be classified as an attachment. Melanie's ongoing search for selfobjects is consistent with Kohut's (1971) findings that the traumatic loss of an idealized parent leads to an interminable search for external idealizable objects and Fonagy's (2001) findings on borderline personality disorder patients who search for an "all good mother" throughout life. In accordance with Herman's (2001) findings Melanie is unable to develop a secure sense of independence and continues to seek desperately and indiscriminately for someone to depend on. Her relationships are driven by the hunger for protection and care and haunted by the fear of abandonment.

Melanie's compensatory selfobjects include her grandmother, her previous best friend's sister, her present best friend's parents and her maternal aunt. Although Melanie is drawn by the security and stability these selfobjects could potentially offer her, they are never available to her for long. She described her maternal grandmother as "a very strong woman" and speaking about her future, she said: "I just want to get there, because of my past life and stuff. I'm gonna work for it. I'm gonna make it, like my granny does". Although her grandmother could potentially fulfil her idealizing and mirroring selfobject needs, she was unavailable to Melanie because of her own attachment history, her responsibilities toward her younger children, a demanding career and her husband's lack of support of her efforts to support Diane and Melanie.

Melanie reported that when she was fifteen she viewed her best friend Cecile's sister as "a very nice person, I used to look up at her". She often stayed with Cecile, possibly to ensure proximity to her sister, but three years later her friendship with Cecile ended when Melanie started a new friendship and Cecile left the school. She subsequently viewed her new best friend Michelle's parents as potential selfobjects. Melanie said: "Michelle and I got really close. I used to go to her house and then her parents would talk about my whole life situation and everything, my schooling and stuff and they would help me through it, speak to me and motivate me and including Michelle, she helped me with my schoolwork. And we got very close and they helped me through a lot of things. We're very close. They're very fond of me; I'm like a child to them". The social worker at her school reported that Melanie often sought the company of Michelle's father, who she described as a "stable and understanding person".

In keeping with the pattern, Michelle's parents eventually also became unavailable. After living with the family for six months she had very little contact with them thereafter. Melanie explained: "I have not had time to spend at Michelle..... They are very busy,

Michelle's in Matric, they also have a foster child there and money is tight". During the later stages of therapy, Melanie attempted to satisfy her selfobject needs through a relationship with her maternal aunt. She reported that she was able to discuss her situation with her aunt and that she liked spending weekends there as "things were calm" and allowed her to get away from her parents' drinking and the chaos at home. After speaking to her aunt about her mother's drinking, her aunt confronted her mother, who blamed everything on Ronald. She mentioned that her grandmother and mother felt that she was spending too much time at her aunt. It later emerged that there was a dispute between the sisters concerning her aunt wanting Diane to pay for Melanie's keep. As with the other potential selfobjects, her aunt was only fleetingly available to Melanie due to the demands of her two-year old son and young baby, her partner and her career.

The pattern of selfobjects becoming unavailable was re-enacted in our therapy. Melanie seemed to perceive me as unavailable when her mother was referred to see a colleague at the Child Guidance Clinic. This followed reports from Melanie and her grandmother that Diane seemed depressed. In retrospect, although this intervention seemed to contribute to an improvement in the relationship between Melanie and Diane, it also created the opportunity for Melanie to withdraw from therapy. It seemed that offering Diane therapy was viewed by Melanie as my acknowledgement of her mother being the patient, which allowed her to step back. This can be seen as a repetition of the earlier trauma when Melanie was removed from the care of her mother and confirmation of the inevitable unavailability of her selfobjects. Furthermore, this confirmed that for Melanie and Diane as a dyad, interventions were doomed to fail as only one at a time could be helped.

In accordance with Van der Kolk and van der Hart's (1989) findings, Melanie compulsively but seemingly unconsciously exposed herself to situations reminiscent of her early separations in her ongoing search for selfobjects. Although these efforts provide a temporary sense of mastery or even pleasure, they eventually contribute to her chronic feelings of helplessness. The inevitable unavailability of the selfobjects repeatedly reinforced her sense of being unacceptable and bad. Her lack of strong attachments, deprive her of the security to explore her life experiences and to address the inner or social isolation that compels her to repeat these experiences.

### **Getting away**

The family members individually displayed behaviour aimed at "escaping" the reality of their home life. Melanie repeatedly leaves home to stay with friends especially when she is upset by her parent's fighting, while Diane "goes to a friend to get out when Melanie fights". Ronald haphazardly came and went for years and since staying with the family, he routinely goes out to drink on weekends or has friends over who drink with him. Diane reported: "Last weekend Ronald was stranded in Hermanus (a coastal town 1½ hours from Cape Town). I didn't know where he was, he only came back the Sunday. Usually he sleeps at home".

The motif of “getting away” from her parents’ incessant fighting was echoed regularly in sessions with Melanie. She related her fantasies about things being better after periods of absence when her mother would realise how much she does around the house and appreciate her on her return. Melanie viewed leaving school as a possible new beginning and said: “I want to start somewhere new. Start new with my ways”.

### **Affect regulation difficulties**

Melanie is unable to regulate her affect on her own in accordance with Fonagy’s (2001) findings that attachment difficulties are linked to problems in affect regulation and social cognitive skills. She reported talking to people such as her best friend’s mother and her maternal aunt about her ongoing problems with her parents and referred to them as “helping me deal with my situation”. Melanie often spoke about people calming her down: “If something hectic happens at home, I’ll go there (to Michelle’s house) or they’ll fetch me, they’ll calm me down”. She said that after a fight with her drunken father, “I went to Michelle and her mom ran me a nice bath with candles and read a story to me and I fell asleep on the bed and I was fine after that”.

Van der Kolk and van der Hart (1989) found that childhood neglect may cause a long-term vulnerability to be hyperaroused which manifests as a decreased ability to modulate strong affect states. Due to the absence of a familiar attachment figure, who modulates physiologic arousal, by providing a balance between soothing and stimulation, the infant experiences psychological disorganising extremes of under and overarousal. In accordance with Van der Kolk and van der Hart’s (1989) and Gunnar and Donazella’s (2002) findings, Melanie exhibits a decreased ability to regulate affect because of the unavailability of a sensitive caregiver in her infancy.

When I asked if being stressed at home and at school influenced her mood, she said: “Yes, I’d get very irritated and annoyed. That’s why I have a very bad temper cause of the fighting I see all the time. Then I get very irritated with it and I just want to shout so that they can stop”. In accordance with the findings of Kelly (1998) Melanie often ascribed her aggression to her witnessing of parental conflict. In accordance with the findings of Amato et al. (1995) on children from high-conflict homes, Melanie also lacked social skills such as compromise and negotiation.

During the intake interview, Melanie spoke about her temper and being shy. She reported that she became less shy “when I got to high school. Everybody is so loud and disruptive, it rubs off on a person. Also it rubbed off on my ways. I have a very bad temper, my parent’s fighting and including people at school and stuff. So a lot of it has rubbed off on me. Made me decide not to keep quiet much. I decided to open up a little”. The social worker reported that Melanie had problems controlling her anger at school and an incident when she was “very cheeky to a teacher”. She described Melanie’s behaviour problems including truancy, cheekiness and being disrespectful towards teachers. She spoke about Melanie as being “passive-aggressive”. Furthermore, she stated that Melanie was “not engaging and aggressive in her second year of high school”.

As the therapy progressed, Melanie's difficulty in comfortably experiencing her affects continued. She did not feel safe experiencing sadness or elation, but I sensed her underlying anger. When her mother or grandmother was present she could often barely contain her irritation with them. Ronai (1997) poses the question "so why is it that when I am with my mother I am just barely able to keep my anger in check and unable to restrain myself from correcting her speech and behaviour?" (p. 14). Similarly Melanie's irritation and anger towards her mother was evident in sessions they attended together, when she often corrected or disagreed with her mother's statements. When speaking to her mother, her voice changed to become tense, tight and irritated. Using this tone, she said in session 11: "It's difficult when the house is messy. I can't concentrate because I think of the mess outside and then I want to clean that first". Turning to her mom, she said further: "If you could clean first, pack away your things, then I can clean properly, afterwards". At this time Diane was picking at her nails, her face turning red.

In session 12 Melanie expressed her view that she should not be seen as the problem and that it would solve her problems if her mother could get help. When her grandmother refuted this on joining us later in the session, Melanie became highly agitated and stormed out at the end of the session. I was left feeling unsure whether she would return.

### **Relationship difficulties**

Significantly, despite acknowledging her anger problems, Melanie described her relationships as mainly good and said: "I get on with people". However her relationship with her mother was a theme discussed in every session. She commented on their relationship as follows: "We don't get along, most of the time we're at each other's throats"; "We were very close when I was younger, but we eventually fell apart". This is in accordance with Ronai's (1997) experience of growing apart from her intellectually disabled mother as she grew older. Both Melanie and Diane individually spoke about how their relationship was better when Melanie was in primary school. In session 1 Melanie said "(we were) very close when I was younger". When I asked Diane in an individual session whether she had a different relationship with Melanie now to when she was younger, Diane replied: "Yes, it was easier then. Difficult now that she's big. Almost eighteen".

The motif of her mother "not being interested" was often echoed in sessions. I made sense of this as Melanie's way of understanding her mother's inability to understand her. When I asked Melanie when that feeling that her mother was not interested had begun, she said "all the time, all the time". When I asked: "even when you were younger?" she responded "Uhm, well we used to have a close relationship, but as soon as we started falling apart when I finally got independent, she never started worrying about anything, and then it started coming". When I asked how that feels for her, the feeling that her mother is not interested, she related a feeling of hopelessness by saying: "I tried to get used to it, but I know that part of me hates it. I'd love my mommy to be interested, she just doesn't try. I can't do anything about it". Melanie often expressed her need to be

cared for and wanting her mother to care. Similarly Ronai (1997) writes "I still need a mommy and I'll never have one. All I have is her" and describes how humiliated she was by how much she needed her mother: "I am a gaping chasm of dependency and I hate it, HATE IT, HATE IT. . ." (p. 34).

The effects of her mother's intellectual disability seemingly became more pronounced as Melanie reached adolescence. Diane often seemed baffled by Melanie's behaviour and unsure about what to expect next. She said: "Melanie's belly ring and tongue rings. Got infected. I didn't expect it of her. Don't know what to expect. Maybe a tattoo. I know about these things, but didn't expect it from her". In an individual session with Diane, she spoke about wanting Melanie to tell her things: "I think she has a boyfriend. I want her to tell me about it. I want her to tell me things".

Similarly Melanie described not being able to have "a proper conversation" with her mother as "she doesn't join in conversation, is withdrawn and lacks confidence". She stated that she wants Diane to think "what's my point of view" and that she would like Diane to be like "a best friend and mom" and "I want her to care". She further spoke about wanting her mother to be open minded and being able to speak with her dad about sex, but not with her mom. These statements seemed indicative of Melanie's awareness of her mother's lack of mentalizing capability. It was evident that both mother and daughter wanted a closer relationship, but had no idea how to accomplish this.

During sessions with Melanie her mother's intellectual disability was not overtly discussed, but it was alluded to in different ways. The only direct mention was that Melanie stated in session 4: "I know my mom was in a special school, but she doesn't try". Diane reported that she always struggled at school, but that she did not receive assistance from her mother with schoolwork. Melanie spoke about her mother "not knowing what is necessary to do with children". For example: "She said she won't buy me tampons, what kind of mother does that?" Conversely she referred to her mother's sister knowing "what must be done, she's good with kids" and her mother getting irritated with her sister for telling her what to do for Melanie.

Melanie's comments revealed much about her relationships with her parents, for example: "When I talk to her, my mom never listens. She stresses more about my father". It was evident that Melanie felt deprived of parental affection and that her parents never prioritised her needs, being more concerned about each other than about her. When I asked Melanie in Session 3 how it feels coming here (to therapy), she responded: "good to speak about things, to have someone to talk to. I can't talk to my mom".

In session 3 both Diane and Melanie individually reported that things were "very bad" between them. Diane spoke about the last two weeks as bad with Melanie shouting and swearing at her, while Melanie said that "my mom shouts and screams at me" and described her mom as lazy. She said: "I clean the house while my mom is at work and then my mom messes when she gets home and I must clean up again. My mom's drinking irritates me". She often spoke about her mother's drinking and how "she never

listens when I tell her to stop". In contrast she seemed accepting of her father's weekend drinking binges. She resented her mother spending money on wine, which they could not afford. She related how her mother borrows money to buy wine and hides it from Melanie, although she could always find it. Melanie reported that her father said that he would stop drinking for her, even though he was drunk at the time. However, she felt that her mother would thwart his good intentions by always initiating more drinking. Conversely, when I asked whether her mother might attend Alcoholics Anonymous, she said her mother would not, unless her father attended and that he never would.

In session 4 Melanie reported that her mom was "fighting with me all the time about the house and money". When I asked Melanie whether she is willing to work on the relationship with her mom, she responded, "yes, but my mom must do the most work as she is in the wrong". Hereafter her grandmother informed me telephonically that "Melanie doesn't really want to work on the relationship with her mom". In session 5 Melanie seemed down and stated that "It won't work with my mom. I've thought about it and it will just be a waste of time". Melanie's hopelessness deepened as she repeated that "nothing is going to change if my mother doesn't change".

In session 6, two and a half months after the intake interview, Melanie described things at home as quiet and "my mom is leaving me alone, but drinking a lot". In Session 10 she said the situation was "better, she leaves me alone". In session 11, shortly before Diane was to join us in the session, I asked whether there was anything specific Melanie would like me to discuss with her mother and she said: "On the way here she asked if I say bad things about her". It was evident that Melanie realised how fragile her mother's self esteem is.

In session 12 Melanie reported that her mother often "threw hurtful things" at her, for example that "she never wanted to have me". When Melanie retorted by saying hurtful things back, her mother would report this to her grandmother without "ever owning up" to the hurtful things she herself had said. Melanie felt that this contributed to her being seen as "the bad one" by her extended family.

The problematic relationship between mother and daughter had implications for therapy with Melanie. In the early stages of therapy Diane contacted me telephonically a number of times before sessions to tell me that "Melanie was being difficult". Before Melanie started travelling to sessions on her own by train, sessions were often cancelled when Diane and Melanie could not agree about walking or taking a taxi to the station. Furthermore, Diane's intellectual disability influenced the therapy process as her disability precluded Diane and I from meaningfully struggling together to understand Melanie's thoughts, feelings, motivations, intentions and behaviours, as suggested by Fonagy (2000) and Grienenberger, Kelly et al. (2005).

As therapy progressed it emerged that Melanie was not ready to be the patient. She spent the greater part of two sessions talking about how things would change for her if her mother received help. She feared that her mother's disruptive influence would make it impossible for her to pass Grade 11. She asserted herself by increasingly presenting

her mother as the cause of all of her problems and the one who should be the patient. Outside of therapy she guarded against the ever present risk of injury with anger outbursts and escaping her home environment.

Termination with Melanie was also influenced by her mother. Melanie returned to therapy after a break of seven weeks during which time her mother attended four sessions with a colleague at the Child Guidance Clinic. Unbeknownst to me, this turned out to be our last session, which lasted only 20 minutes as Melanie arrived late.

At the start of the session, she asked me when last I saw her mom, as though she was under the impression that I was her mother's therapist. It was clear that mother and daughter were not communicating about their respective therapies.

Melanie reflected on her progress in our last session. She said: "I'm handling my mom better. I just keep quiet, don't provoke her. I've improved a lot with that." She spoke about her parents "still drinking a lot" and how the friend who accompanied her to the session, went with her to fetch her mother when she was drunk recently.

Melanie's relationship with her father was characterised by frequent separations. Her grandmother reported a change in their relationship since Ronald had moved in with Diane and Melanie the previous year as "he has come to realise that being a father, a relationship with Melanie has value to him". Melanie consistently reported having a good relationship with her father and often attempted to defend his behaviour even when it seemed to be inexcusable. She said about her father: "I started getting closer to my dad", "My dad listens to me" and "I can talk to my dad, but I don't, I rather talk to Michelle's parents". "If I had to tell my mom I was having sex, she would freak out, but if I had to tell my dad I was having sex, he'd like talk to me about it. Tell me to use condoms". During session 2 Melanie described an incident with her father: "We had a fight on Saturday. He was drinking, he misunderstood what I was talking about.... because he was drinking he wasn't listening to what I was saying. I ended up crying".

In accordance with Herman's (2001) findings that abused children often idealize the abusive parent and displace all their rage on the non-offending parent, Melanie often spoke about her close bond to her father and that he understood her and "could look at things from her point of view". For example, she reported that her father said: "He knows I'll never do drugs. If you ever want to try out drugs, you can sit down and do it with me". Although Melanie seemed to appreciate the freedom her father allowed her, his approach to parenting was viewed as permissive by Diane and the social worker at school. While defending her father's behaviour while drunk or on drugs, she had little patience with her mother who she described as lazy and only interested in drinking and shopping. She viewed her mother as the source of all her problems: "If she can go for help, then it will help me, then I won't get so stressed" and "If she can be sorted out, it will take a lot of pressure off me and my dad". She spoke reproachfully about her mother not working and her father having to support all three of them financially while her mother spends money on unnecessary things. Her father's prior unavailability possibly contributed to her determination to keep him in her life during her adolescence at a time

when she was increasingly distancing herself from her mother. Now that she was older her father had become the dominant and valued parent.

The effect of Melanie's disorganised attachments was evident in her relationships with peers. She spoke about her home life being different from that of other children and said that she had not discussed details about her parents with her friends. Similarly Ronai (1997) writes about the difficulty of talking about her mother's intellectual disability: "no one talks publicly about the experience of having a mentally retarded parent, thus there exists no common repository of knowledge for dealing with the situation as it arises within any social context" (p. 2). When I asked Melanie whether she had discussed our first session with her grandmother, she reported that "she asked me today if it's like helped and if I thought about it. It's good that I did speak about my past and stuff because I never ever do". I then asked her if speaking about it upset her and she responded: "No, I felt really fine that I told someone about (it). I felt clear of things. My friends do know about it but I haven't explained, said that my mom and my father and stuff like that, that my mom is not interested in a lot of things and my father doesn't participate in things. I haven't spoken about stuff like that. That's basically what bothers me – that my mom is not interested, mainly that my mom's not interested".

Diane mentioned in Session 1 that "Melanie's friends are talking about her problems, the way she was brought up". When I asked Melanie about her relationships with friends, she described herself as being a shy child in primary school who only started making friends in Grade 3, although she had more friends in pre-primary school. In high school she was less shy because the children were so loud and disruptive. She reported that currently she had very close friendships ("like sisters") with girls and that she had boyfriends before. She said that she knew she would get married one day, but that she did not want serious relationships at present. When her friendship with a friend who she was very close to for three years ended, she said she was depressed for two weeks "but then eventually I just got over it". It seemed that based on her experience with the unavailability of her selfobjects, she learnt to expect her friendships to end.

### **Being bad**

Melanie came into treatment feeling a failure due to failing Grade 11. She often spoke about being good, although she felt that her extended family saw her as "bad". She reported that she was taught to have manners during her early separation from her mother: "I was very obedient and I listened and I knew my respect and my boundaries, because I was brought up like that when I stayed by my granny up to the age of four, that's where I learnt my manners and stuff like that. So when I came home my parents were fine with me".

In session 13 Melanie said: "I'm like the bad one at family gatherings.... they all think I'm so bad, do bad things". She felt that her mom always expects the worst of her, and ascribed this to her mother expecting that Melanie would do the things Diane did as an adolescent, such as drinking with her cousin. She spoke about how her grandmother still perceives her father as "bad" due to his behaviour in the past when he was taking drugs.

She felt that they saw her as bad like her father, because she was so much like him. She relayed her sense of unfairness at this perception and said: "I don't do drugs and alcohol, I hate the smell. I dress fine. I don't have cleavage showing. I don't act like a whore....I don't come home pregnant. I don't do naughty things."

Herman (2001) writes about the abused child's conviction of inner badness, which manifests in the child's ongoing attempts to be good and taking on caretaking and household tasks with perfectionist zeal. Melanie took on the responsibility of housekeeping from a young age and Diane remarked on this in an individual session: "Melanie's a perfectionist. She wants everything neat. I'm tired after shifts".

Similar to Herman's (2001) findings on traumatised children, Melanie displayed ongoing attempts to be good and felt very frustrated by being perceived as doing bad things by her family members. For example, she felt that her anger was misconstrued by her grandmother as her being bad rather than being recognised as her frustration with her mother's inadequate mothering.

## **INTERGENERATIONAL TRANSMISSION OF ATTACHMENT DIFFICULTIES**

Consistent with Bowlby's (1969, 1982) findings on the internalisation of experiences with significant caregivers into working models of relationships and Kohut's (1971) findings on the lifelong needs for selfobject experiences, it was evident that neither grandmother, daughter or granddaughter's selfobject needs were met in their relationships with their respective primary caregivers. The attachments of grandmother, daughter and granddaughter can be described as disorganised due to their lack of an attuned selfobject relationship in infancy. The family's relationships reflect the intergenerational influence of mental health problems including intellectual disability, depression and substance abuse, as well as domestic violence and absent fathers. The family members yearn for close relationships but are unable to establish these.

The grandmother, Jackie, left home at a young age to escape the conflict between her parents. After Diane's birth, Jackie perpetuated the intergenerational cycle of abuse by marrying a man who was violent and abused alcohol. As an adolescent, Diane often used to go out at night, riding on a motorbike and drinking with her cousin from the age of twelve, without her mother's knowledge. Diane explained that she got nurturance in the form of food from her cousin's family. Like her mother before her and her daughter at present, Diane wanted to "get away" from the fighting in her house.

Consistent with the findings of Caspi et al. (1989) both Jackie and Diane chose violent and alcoholic relationship partners similar to their father figures. Diane met Ronald at the age of fifteen and became a mother at the age of twenty after an unplanned pregnancy. Diane wanted Melanie to know her father because of her own experience of never knowing her own father. Both Jackie and Diane established familiar relationships with their children which according to Belsky and Pensky (1988) had become deeply ingrained, core components of their personalities. Jackie reported current difficulties

communicating with her 21 year old son who like herself, suffers from depression. Her husband has not demonstrated acceptance of her depression.

Significantly, neither grandmother and mother, nor daughter described themselves as being close to their mother. Furthermore, themes of helplessness were evident in both Melanie and Diane's references to their relationships with their mothers. They individually spoke of having done enough and that their mother should do something to salvage the relationship. They both spoke about wanting to be close to their mother and the reasons they are not. In an individual session with Diane, I asked her if she and her mother are close and she responded: "No, they always tell me to stop drinking and she and Dennis (mother's husband) were always telling me I'm a bad mother to Melanie". When I asked if they were close when she was a child, she responded: "No, my stepfather was violent. They used to fight all the time. They both drank. Also because of her past". She said "I would like to be close to my mom, but she's so busy" and "My mom must do something now. I have done enough". She also reported her mother's lack of affection toward her and that she never hugged her.

Diane relayed her sense of being socially isolated in an individual session: "I don't have friends, they just use me" (hereafter she started crying). She further related how she was excluded from family gatherings, for example when she was not invited to a dinner to celebrate Melanie's 18<sup>th</sup> birthday by her mother and sister. Diane often reported how stressful she finds parenting Melanie and not knowing what to expect next. Diane's experience of social isolation, being easily stressed and subjected to domestic violence and abuse are consistent with research findings on intellectually disabled people (Feldman et al., 2002; Stimpson & Best, 1991; Feldman et al., 1997).

About the relationship between her mother and her partner, Diane said: "My mom and Ronald don't really get on. I can't do much about it, they're both adults". When I asked Diane whether she is close to her second-eldest half-sister, she said: "No, we fight all the time". Furthermore, Diane clearly felt criticised by her immediate and extended family. She mentioned that "Melanie tells me to stop drinking and that I'm an alcoholic. Ronald also. I tell them that I don't drink every day. Alcoholics drink seven days a week" and "I enjoy having a drink. Everyone has one little thing they do. I go next door for a few beers. I enjoy it".

Melanie echoed the sense of helplessness about her relationship with her mother: "I'd love her to be interested, she just doesn't try. I can't do anything about it." It is postulated that due to their intergenerational transferred attachment organisations, both Jackie and Diane lacked the reflective functioning that could serve as a model for the regulation and modulation of experience to ensure that they would be "good enough" mothers (Slade et al., 2005; Winnicott, 1960). The question that arises is whether it will be possible for Melanie to escape being a not "good enough" mother if she becomes a mother in future.

Furthermore, it was evident that the relationship between Jackie and Diane lacked the balance between intimacy and autonomy, described by family and attachment theorists

as a requirement for healthy relationships (Kretchmar & Jacobvitz, 2002). It is posited that Diane's intellectual disability inhibited the process of separation-individuation with her own mother, described by Mahler et al. (1975), which entails the gradual distancing of the child from the mother and the transition from dependency to independence. Mahler extends this process to the entire life cycle, which she views as a distancing "from the introjection of the lost symbiotic mother" (Mahler 1972a, p. 130). Diane often depended on Jackie to take responsibility for mothering tasks. The fact that the maternal grandmother did not step in to provide care for Melanie when Diane and Ronald proved unable to adequately care for Melanie as an infant, is perhaps indicative of their troubled mother-daughter relationship. Furthermore, Jackie initiated the process of bringing Melanie to treatment and also accepted the financial responsibility for the therapy. On more than one occasion Jackie spoke about the ongoing burden of being responsible for Diane's family as well as her own. It is unlikely that the relationship between mother and daughter was redefined and strengthened by Diane becoming a mother in accordance with the findings of Fischer (1981) and Walker et al. (1987). Diane's intellectual disability more likely contributed to Jackie viewing Melanie's birth as adding to her burden of supporting Diane.

Kretchmar and Jacobvitz's (2002) findings that "just as mothers' representations of their significant childhood relationships may influence caregiving, it is also likely that mothers' ongoing relationships with their own parents influence caregiving" (p. 352) finds resonance with this family. Diane's current relationship with her mother is not characterised by emotional intimacy and support for independence, which according to Kretchmar and Jacobvitz (2002) leads to similar nurturing and autonomy-fostering relationships between mothers and infants. Due to her intellectual disability, Diane is still largely dependent on her mother for emotional and financial support at the age of 37. It seems as though she defers to her mother in most decisions regarding her daughter's welfare. She lacks the agency to make changes in her life and is constantly trying to please her mother, but continually feels criticised and consequently like a not "good enough" mother. Furthermore, Diane does not have memories of acceptance by her mother which is a further predictor of insecure attachment with her own infant.

In speaking about her relationship with Melanie, Diane revealed her feelings of inadequacy in her relationships. She said that she wanted Melanie to tell her about things. When I commented that Melanie would like Diane to talk to her about things and wants to know that she cares, she remarked that "Ronald also doesn't know how to show love, also because of his family. To me or Melanie". When we discussed how she felt about Melanie seeing me, she stated "I like her to come. It's good that she talks to you. She doesn't tell me about it". This disclosure reinforced my initial feeling of having to be cautious not to further erode Diane's fragile self-esteem. In therapy with Melanie, I was mindful of not adding to Diane's perception of herself as a not "good enough" mother by expressing criticism of her mothering.

In accordance with the findings of Crandell et al. (1997) on mothers with insecure attachment histories, Melanie expressed her wish not to make the same mistakes with her children. When I asked her about her future and where she sees herself, she

responded: "I see myself as a successful, independent woman on my own feet. I know whether I'm married or not, I'll still stand alone. I'd like to have my own things. If my husband divorced me I don't want to be left with nothing. I'd rather have my own things and still be with him. I'm gonna work. Everything is gonna be set up perfectly. And my kids are going to private schools. I don't like these public schools. My kids are going to be brought up so well. I'm gonna work hard, so I can get where I want to be. No matter how hard, I'm still gonna do it, I just want to get there. Because of my past life and stuff. I haven't like, I'm not where the other child is, like they're happy with their homes and stuff and I'm not. So I'd rather have everything go well for me by myself, let myself do it all alone. No one else is gonna help, I'm gonna work for it, I'm gonna make it like my granny does". Melanie clearly understood that she, like her grandmother and mother before her, could not depend on anyone and that she was on her own.

Melanie's unmodulated grandiosity, as a result of the early failure of her selfobjects to meet her mirroring and idealising needs, was evident in her aspirations for her future and her shorter term goal for studying art at college. However, her major problems in the area of her attachment motivational system impacted on her exploratory motivational system so that she made no concrete plans to realise her goals. My belief in her realistic abilities and a joint evaluation of career prospects helped her to begin to face the greater challenges, although the sense of hopelessness prevailed due to any plans for her future being dependent on her parents' or grandmother's financial assistance.

### **Concluding therapy**

The last time I saw Melanie, she was looking well and happy, with a new zest for life. In my fervour to assist her to make a difference in her life, I was tempted to ascribe her happiness to the therapy over the preceding months, but I have to concede that more likely it had much to do with her tall and good looking new boyfriend I met in the foyer while saying goodbye to Melanie.

In our last session she seemed proud about her recent school results which were a great improvement on the preceding two terms. She spoke about her matric dance the next year, indicating that she was resigned to staying at school, contrary to her determination to leave school at the start of the therapy process.

During the short time of therapy with Melanie, she seemed to accept that her mother was not going to change, her parents were not going to stop drinking, and that her grandmother or someone else was not going to step in to change her situation. I concluded the therapy with Melanie, my first ever patient, knowing that we had merely reached the beginning of a journey, which she would continue without me.

## CHAPTER SIX

### CONCLUSION

This research paper has illustrated the implications for Melanie's life of the intergenerational transmission of attachment difficulties and the added impact of her mother's intellectual disability. In addition implications for her future therapy and areas warranting further research were identified.

#### **The implications for Melanie's life**

The implications of the intergenerational transmission of attachment difficulties and her mother's intellectual disability emerged during therapy with Melanie. It seems almost inevitable that the dynamics established with her caregivers will become self-regulating and self-perpetuating in Melanie's life, compelling her to follow in the footsteps of her mother and grandmother in her choice of relationship partners and leading to the establishment of similar familiar relationship patterns with her future children (Matas et al., 1978; Sroufe, 1989; Caspi et al., 1989; Belsky & Pensky, 1988).

The question posed is whether this cycle can be interrupted to ensure that Melanie establishes a functional romantic relationship and is able to become a "good enough" mother. The possibility is underscored by Kretchmar and Jacobvitz's (2002) findings that transmission of relationship dynamics is not inevitable with some mothers disengaging from their own mothers to provide better care for their children. Furthermore, they found that a supportive partner may lead to change in a mother's relationship style and emphasised the link between choosing the right partner and being able to be a "good enough" mother.

During our therapy Melanie had seemed to begin the process of disengagement from her mother. While speaking about not wanting to make the same mistakes with her children, she fantasised about altering the trajectory of her life. She felt this would be possible through hard work and because she would know how to rear her own children based on her experience of inadequate parenting. Furthermore, Crandell et al. (1997) found that longer term psychotherapy in which childhood pain can be accessed and integrated could be a powerful deterrent against repeating parenting mistakes. However, in our short time of therapy this process was only started. Melanie related a sense of massive disappointment in the malignant mother who refuses to mirror back any of the omnipotent self. However, giving up on her mother meant that Melanie must renounce all hope in the relationship and the possibility that she can be received or understood by others. In this process she has to become responsible for saving herself, she has to become the patient. This, she seemed not yet ready for.

## **The implications for future therapy**

Although it was not possible to circumvent the intergenerational transmission of disorganised attachment to Melanie, it is hoped that this short-term intervention will lead to her seeking longer term therapy in future. This will assist her in developing capacities for regulating emotional processes and prevent her from repeating similar patterns of parenting with her future children. In essence, the goal of our therapy was to give her an experience of therapy to which she will someday return.

The goal of therapy in self psychology is to strengthen the self. The focus falls on decreasing the tendency to fragmentation while increasing resilience to threat. It involves enhancing the person's capacity for self-soothing in flexible and creative ways; the person's ability to seek out affirming selfobject experiences and to actualise her/his potential. The central component in strengthening the self is the experience of being understood, through the empathic attunement of the therapist.

Kohut (1971) places the idealizing transference, set in motion by the therapeutic reactivation of the idealized parental imago, at the centre of the deficient psychological structures and describes this as the essence of the analytic work. Due to Melanie's experience of early and later trauma she presents a complicated clinical picture. Her early trauma caused by her mother's unempathic attunement, along with the sudden severing of their bond, subjects Melanie to suffering a broad, diffuse vulnerability to narcissistic injury which makes it difficult for her to restore balance when her self-esteem is upset. She will look to the idealized analyst to provide the soothing and tension-regulating functions she lacks.

Conversely, the later trauma when she was abruptly removed from the new caregiver led to sudden massive de-idealization due to the loss of the idealized object. Thus the yearning for attachment to an omnipotent object, an expression of the idealized parental imago, remains hidden. The superego is deprived of its idealizations and an endless search for idealized objects with whom to unite ensues (Siegel, 1996).

Kohut (1971) divides clinical work with the narcissistic disorders into the period when the transference is being established and the period of working through after its formation. In accordance with Kohut's description of the development of the healthy self, therapy was aimed at developing a basic intuneness between Melanie and I which allows for the mobilisation of her archaic selfobject needs. Due to the time constraints imposed by the training, I was only afforded the opportunity to attempt work in the first period. Uncertain about Melanie's internal world and her ability to manage affects, I did not want the treatment to stimulate an intense regression. The first stage of our work uncovered the resistances to the mobilisation of the idealizing transference evidenced in Melanie's unwillingness, as the therapy progressed, to accept that she is the patient and not her mother. I further sensed that Melanie harboured an element of fear of losing her personality in the emergence of her wish to merge with me (the idealized object). I experienced her as aloof, probably as a result of her numerous disappointments in

efforts to establish a selfobject bond. I suspect that as an inexperienced therapist trying to create a therapeutic alliance I transgressed in being too friendly, something Kohut (1971) specifically warned against. Melanie and I seemingly partially reached narcissistic equilibrium, with Melanie feeling well, whole, attractive and creative enough to convince herself that she is not the patient.

However, we did not reach the stage of working through and its prerequisite disruption of the narcissistic bond. I did experience some of what would await me in a session when Melanie directed her despondence, rage and coldness at her grandmother when she tried to get the message across that “the problem is not me. My mom needs help”. Kohut (1971) describes the essential part of the working through process: “... (it) concerns the ego’s reaction to the loss of the narcissistically experienced object.... The essential working-through process, however, aims at the gradual withdrawal of the narcissistic libido from the narcissistically invested, archaic, object: it leads to the acquisition of new psychological structures and functions as the cathexes shift from the representation of the object, and its activities to the psychic apparatus and its functions” (pp. 94-96).

The objective of working through is the development of psychic structure and an increased tolerance for the tension associated with the analyst’s absence. We did not have the opportunity to work through self object failures in the therapy which would provide for moving away from total reliance on the therapist as selfobject to internalisation of the self-regulatory functions of the selfobject as part of the self structure.

### **The implications for future research**

In acknowledgement of the identification of the intergenerational transmission of attachment as “an issue that lies at the heart of the question of the social inheritance of mental disorder and personality” (Fonagy & Target, 2005, p. 333), further research is indicated. This research study proposes parenting interventions, including specific interventions for intellectually disabled parents and adolescent parents, aimed at preventing the intergenerational transmission of disorganised attachment in the context of South African society, as an area for future research.

Ronai (1997) highlights the need for research on intellectually disabled parents, while Adnams (2009) points out the paucity of research on intellectual disability in general in South Africa. Coates et al. (1985) suggest that research may provide valuable information about the needs of children in families with intellectually disabled caregiver(s) and how these children cope with threats to self-esteem, which could inform practitioners and educators of ways of strengthening the mother-child relationship.

A number of researchers have made suggestions regarding parenting interventions, which could guide research into the suitability of these interventions in the South African context. Firstly, Fonagy and Target (2005) emphasise the profound opportunity for an attachment based intervention and suggest that infant security may be most effectively ensured by limiting frightening or disruptive caregiving behaviour through focused

interventions with the objective of improving the mother's mentalization of her child. Fonagy (2000) contends that the concept of mentalization can be applied to work with parents. The parent-infant or child psychotherapist can demonstrate interest in the mental states of the parent and the mental states of the child. Within the context of a safe and containing relationship, the parent and the therapist can struggle together to understand the child's thoughts, feelings, motivations, intentions and behaviours. Similarly Rosenblum et al. (2008) suggest that directing attention towards supporting the mother's capacity to effectively mentalize is likely to hold positive consequences for both her mental experience of the child and the relationship, as well as for her behaviour during interaction. Ultimately, enhancing mothers' capacity for reflective parenting also may support children's own relationship security, developing theory of mind, and capacity for effective mentalization. This is in accordance with suggestions made about focused interventions aimed at improving the mother's mentalization of her child, based on the findings of Grienenberg, Kelly et al. (2005). Furthermore, findings by Ontai and Thompson (2008), Raikes and Thompson (2006), Reese (2002) and Dunn (1998) suggest that further exploration of the influence of maternal elaborative discourse on the development of young children's understanding of mental states is warranted.

Secondly, Bernier and Dozier (2003) propose that interventions should be aimed at helping parents develop an age-appropriate understanding of their child's level of functioning. They found that an education approach whereby parents are assisted to better understand their child as a distinct and autonomous person holds promise for intervention efforts. This could prove to be particularly meaningful in the South African context which is characterised by high rates of adolescent parents and child-headed households due to HIV/AIDS.

Thirdly, Kretchmar and Jacobvitz (2002) found that "understanding more about parents' current relationships with their own parents may help identify and break dysfunctional cycles" (p. 369) which has implications for interventions as "helping parents to resolve both past and present issues with their own parents will assist them in establishing more optimal relationship dynamics with their own children" (p. 369).

Fourthly, following their findings that intellectually disabled mothers are likely to be highly stressed and socially isolated, Feldman et al. (2002) suggest that social support and parent education, specifically designed for parents with intellectual disabilities, may prevent the adverse effects of parental stress.

Based on these suggestions it is contended that research on implementing parenting interventions aimed at developing parents' capacity to mentalize at the primary health care level could spearhead the much needed addressing of the problem of intergenerational transmission of disorganised attachment in South African communities. Clinical psychologists completing their compulsory community service could be well placed in pilot parent training programmes, which could be extended to the general population by including other mental health professionals, such as social workers and registered counsellors in the training programmes. Given the realities of the South African situation regarding the unavailability of mental health services to the broader

population, research should focus on cost effective interventions, including group interventions and short term individual therapy, with patients suffering the effects of intergenerational transmission of disorganised attachment.

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## Appendix

### CASE FORMULATION - MELANIE

#### Diagnosis

In terms of the American Psychiatric Association's (1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR), Melanie was diagnosed as follows:

Axis I: 313.81 Oppositional Defiant Disorder  
V61.20 Parent-Child Relational Problem

Axis II: Traits of Borderline Personality Disorder (301.83)

Axis III: None

Axis IV: V61.21 Neglect of child  
V62.3 Academic problem

Axis V: GAF= 51

Other diagnoses on Axis I that were considered, but ruled out were Conduct disorder 312.82, Dysthymic disorder 300.4, Anorexia Nervosa 307.1 and Reactive Attachment disorder 313.89. A diagnosis of Borderline Personality Disorder (301.83) was deferred on Axis II. Melanie displayed symptoms of a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation and inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper) and an unstable attachment.

In accordance with the findings of the Harvard Family Pathways Study Melanie displayed features of borderline and antisocial behaviour such as impulsive behaviour, unstable relationships, illegal acts such as frequent truanting, and aggressiveness in late adolescence (Lyons-Ruth, 2008). Similar to the subjects in this study, the quality of Melanie's early care was questioned and she experienced early maternal withdrawal. It is hypothesised that Diane was unable to respond adequately to her infant's attachment cues due to her intellectual disability and lack of support. Furthermore, Melanie reported being very shy and not having friends in the first three grades of school.

Melanie displayed traits of borderline personality disorder. She has inner images of self and others that are split into extremes of good and bad, characteristic of patients with borderline personality disorder. She also has an unstable sense of self, which is one of the major diagnostic criteria for borderline personality disorder (Kernberg, 1967). A large body of research underlies the link between early withdrawal of the caregiver and later borderline symptoms (Lyons-Ruth, 2006; Target, 2006; Csibra & Gergely,

2006). Melanie's early childhood experiences predisposed her to later psychopathology and particularly borderline personality disorder symptoms.

### **Aetiological formulation**

This formulation accounts for eighteen year old Melanie's affect regulation difficulties which manifest in frequent anger outbursts, oppositional behaviour and problematic relationships; and her academic failure. Melanie's traumatic early experiences predisposed her to the difficulties she is experiencing in maintaining a coherent, continuous and unified sense of self. Her mother's alcohol abuse while pregnant with Melanie, initiated a pattern of caregiving characterised by pervasive neglect. Her mother's intellectual disability further compromised her ability to be empathically attuned to the reflections of the rhythms of Melanie's internal state.

As an alcoholic and anxious first time mother, preoccupied with ensuring Melanie's father's presence in their lives also because she never knew her own father, Melanie's mother was unattuned to the physical and emotional rhythms of her child. Her need to be mirrored herself, never met by her own fourteen year old mother, prevented her from celebrating Melanie's developmental achievements in order to provide her with stable self-esteem. The extent of Melanie's neglect is evident from the fact that she was removed from her mother's care at the age of one and placed in the care of her paternal grandfather and his wife. After four years she was reunited with her mother and subjected to a chaotic home environment characterised by neglect, unemployment, poverty, substance abuse, parental strife and domestic violence.

Melanie's current difficulties were precipitated by a number of factors. On reaching adolescence she was required to take on a parentified role as her depressed mother gradually relinquished her mothering role. Her intellectually disabled mother struggled to understand her maturing daughter, which led to deterioration in their previously "good" relationship. Both of her parents were unsupportive of her school career and unconcerned about her whereabouts, which resulted in Melanie's frequent absenteeism and ongoing academic problems. She engaged in an ongoing quest for relationships which would offer her the safety and support she was unable to obtain from her parents.

Melanie's problems were maintained by her disruptive home environment and her parents' enmeshed conflictual relationship. However, Melanie's resilience and her ability to take a degree of charge in her family have served as protective factors in her life. Her ability to seek soothing in times of crisis by sharing her burden with people she views as stable, has also helped her.

## **Therapeutic formulation**

Although Melanie presents as a confident young girl, proud of her resilience in the face of her adverse childhood experiences, she acknowledges the extent of her neglect and an awareness of the discrepancies between her home situation and that of her peers, indicating her vulnerability to feelings of shame. Melanie has a fragile self prone to disintegration. Rage and denial are mobilised to protect a vulnerable self. Although she speaks about "making it one day like my granny did", her overriding sense of hopelessness and lack of exploratory energy is indicative of an empty depleted self. Her early relationship with a substitute soothing caregiver would account for the degree to which she was able to maintain cohesion.

Melanie's early attachment experiences had an indelible influence on the trajectory of her self. She was deprived of a growth-facilitating emotional environment required for the evolvment of an efficient self system that can adaptively regulate affect, cognition and behaviour. While optimal attachment experiences allow for the emergence of self-awareness and the adaptive capacity to sense, attend to and reflect upon the dynamic changes of one's subjective self states, traumatic attachments in childhood lead to self-modulation of painful affect by directing attention away from internal emotional states.

Melanie has been deprived of a core psychological structure, which would enable her to build a viable sense of self, by her parents' lack of reflective functioning. She suffered disturbances in the idealized parental imago in the early pre-oedipal period due to her mother's lack of empathic attunement to her emotional needs. This is evidenced in her tendency to have angry outbursts because of her lack of tension-regulating and self-soothing functions. This also makes her vulnerable to maladaptive self-soothing behaviours such as substance abuse and illegal activities. It is likely that her mother's lack of empathic attunement caused Melanie to turn in a compensatory way toward her father during her first year. His physical and emotional unavailability because of his substance abuse and failure to commit to fatherhood would be likely to have thwarted Melanie's second chance at structure building, leaving her with a broad vulnerability.

A self psychologically informed understanding of Melanie's problems suggests that she suffered from a developmental arrest in two areas. One area related to her broad difficulty in understanding affects because of the failure of her mother to be empathically attuned to Melanie's emotional life and her inability to help Melanie with managing her affects and tension regulation. This left Melanie with a diffuse narcissistic vulnerability in the management of her internal life. The other area related to an arrest in the grandiose self, evidenced in Melanie's sense of inadequacy and low self-esteem. Melanie's parents were unable to accept and celebrate her grandiosity which resulted in her inability to integrate her grandiose self into her personality structure, leading to split-off grandiosity coupled with low self-esteem.

Melanie's obvious care for her body and her ability to take charge of her family's household indicated that her physiological regulatory motivational system was not a major source of difficulty. Her attachment motivational system seems to be the focus of

her problems. Her ongoing efforts to find a selfobject are continually thwarted, leaving her frustrated and angry. She longs for affection and care, but continually feels neglected. The dominance of her attachment system impacted on her exploratory motivational system. Although she voiced her unwillingness to stay in her present school and planned to study art at a college, she did not take steps or utilise opportunities to implement change. She defended against ever present risk of injury with rage (fight) especially towards her mother and denial (flight) that she was the patient, insisting that her mother was the patient in need of treatment.

Melanie may have suffered trauma when she was suddenly removed from the care of her parents at the age of one. Although details about her life with the substitute caregiver are scant, it is likely that this caregiver became the stabilising idealized selfobject she required. However, Melanie experienced the sudden and massive deidealization of the compensatory caregiver during the oedipal and early latency period when she was returned to her mother's care at the age of four. Once again, her mother's unempathic attunement would be likely to have turned Melanie to her father, who in turn failed as the idealized parental imago. These early experiences prevented the development of necessary psychological structures through gradual internalisations and left her dependent on transference relationships with selfobjects to compensate for the missing psychic structure. She was dependent on outside sources for soothing and tension regulation. During adolescence Melanie engaged in an ongoing search for external idealizable objects which her insufficiently idealized superego could not provide.

It was evident that Melanie needed her mirroring and idealizing needs to be met in the therapeutic relationship. Intersubjectively, our emotional relationship needed to cover the deficiency caused by the lack of emotional relations in her early childhood and through the provision of regulatory self-selfobject experiences to provide the particular intersubjective experiences that evoke the emergence and maintenance of the self. Ideally this process would allow for the restoration of right hemisphere activity to fulfil its function of maintaining a coherent continuous and unified sense of self. I needed to fulfil the function of shoring up the self but to allow for mutual recognition. Melanie's self had to develop to be the recipient but also the giver of empathy. The development of Melanie's responsiveness, empathy and concern needed to be tracked and not just my sufficiency or failure. She needed to achieve self-regulation by regulating the other. It is likely that this would need a lengthy intervention to be successful.

## **Treatment Plan**

In terms of management, it was decided that Melanie would attend weekly therapy sessions. Diane would be included for the last 10 to 15 minutes of a session once a month for feedback and discussion to ensure her involvement in the process. During the early stages Diane was seen in an individual session to assess her emotional state as it was suspected that she was depressed. In my first contact with Diane to arrange the intake interview, she emphatically stated that Melanie's father would not attend any sessions.

In therapy with Melanie I was guided by Kohut's (1975) belief that the ideal of psychoanalysis would shift from truth-seeking to empathic understanding which "involves profound acceptance of our intersubjective vulnerabilities, and a receptive willingness to learn about these vulnerabilities from each other, especially from our patients" (Orange, 2009, p. 9). The goal in therapy with Melanie was to strengthen the self through the experience of being understood by means of the empathic attunement of the therapist. This required the establishment of a therapeutic relationship with Melanie in which she could experience a safe, reliable and containing environment for the mobilisation of her thwarted selfobject needs. It was hoped that through an adequate and responsive selfobject relationship, Melanie's "self" would experience greater cohesion and her symptomatic behaviour would be able to be explored and dealt with therapeutically.

The disarray of Melanie's life suggested a chaotic internal world. Due to her early separation a question remains over whether her substitute caregiver provided the stabilising idealised object she required, which would have intensified the trauma of the separation from this selfobject. This raised the diagnostic question of whether the internal objects were insufficiently structured which would account for her borderline symptoms or whether the substitute idealised parental imago was stable but frozen in an early developmental form. If the latter, then growth in the arrested sector could resume through the remobilisation of the stable transferences in a therapeutic situation. However, if the internal objects were insufficiently structured then the transferences would not be stable and growth could not easily resume. The therapeutic goals would then be to support defences and prevent overstimulating experiences (Siegel, 1996).

In the early stages of the therapeutic relationship, I accepted that her defensive solutions ensured her psychological survival and considered whether her resistance might be a healthy defence against the premature uncovering of the self. Furthermore, I was aware that Melanie had no recourse to any other supportive relationships. I anticipated that in the early stages of therapy the experience of having her inner world heard and understood may be all that she could bear. My sense was that the interpretation of the origin and problems of that inner world would follow later.

The additional knowledge of motivational systems (Lichtenberg et al., 1992) allowed me to use sustained empathic inquiry to understand "which goal-directed motivation was dominant within a mutually designed context" (Brownlow, 2001, p. 92). At times our emphasis was determined by her family's and specifically her grandmother's expectations regarding career guidance. In concrete terms the therapy had the following goals: Firstly, the main goal was for Melanie to have a consistent adult in her life, who would help her structure her relationships with her family. It was envisaged that the provision of supportive relationships and interpersonal learning experiences may assist her with developing capacities for regulating emotional processes, which in turn may lead to more competent social behaviour. The second goal was to assist her with gaining independence from her family, which included providing her with career guidance. The third goal was working towards improving the relationship between

Melanie and her mother, while other goals focused on anger management, communication and problem solving.

As Melanie's problems were rooted in the family system, I undertook to work closely with her mother and grandmother. I visited her school where I met with the social worker who had contact with the family since Melanie went to high school. This collateral provided me with a more nuanced perspective on the family situation.

As Melanie's grandmother described Melanie's academic problems and her need for career guidance as the main reasons for bringing Melanie to the clinic, psychometric testing and aptitude tests were offered to Melanie. The WAIS III, an aptitude test and an emotions profile index were administered. Predisposing Melanie to possible intellectual disability were her mother's intellectual disability and the possibility that Melanie might be suffering from fetal alcohol spectrum disorder (FASD) as her facial features resembled those of FASD sufferers and it was suspected, and later confirmed, that her mother drank heavily during her pregnancy. I was relieved to find that Melanie's IQ score confirmed her ability to complete her schooling.

Furthermore, I collaborated with her grandmother to organise art lessons for Melanie, as she was very disappointed that she could not take Art at school and planned to pursue this at a College. It was envisaged that a creative outlet would serve the dual purpose of reducing her frustration and providing goals for a future career.

Regarding her parents' needs, it was evident from the outset that her mother needed assistance in her relationship with Melanie and was not fulfilling a parental role towards her. Diane's intellectual disability presented specific challenges in the mother-daughter relationship and therapy was also aimed at strengthening this relationship. Her father was presented as an immature individual who usually placed his own needs foremost. I realised that I would have to fulfil a parental role, but be mindful of threatening Diane's position. I felt empathic towards Diane and did not want her to feel inadequate due to my interventions.