Representation, Symbolization, and Affect Regulation in the Concomitant Treatment of a Mother and Child: Attachment Theory and Psychotherapy

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As evidenced by the present issue, the decades' old standoff between psychoanalysis and attachment theory has in recent years slowly begun to give way to mutually enriching dialogue between psychoanalysts and attachment researchers (Slade and Aber, 1992; Diamond and Blatt, 1994; Osofsky, 1995; Fonagy and Target, 1998; Slade, 1999). This is manifest, on the one hand, in psychoanalysts' increasing interest in the relevance of attachment theory to developmental theory and clinical process and, on the other, in attachment researchers' increasing attention to psychopathology, diagnosis, and developmental deviation. Although there are many ways to understand the softening of the impasse that for so long impeded integration of these two perspectives, there can be little doubt that the work of Mary Main (Main, Kaplan, and Cassidy, 1985: Main, 1990, 1991, 1995a, b) and Peter Fonagy (Fonagy et al., 1993, 1995; Fonagy and Target, 1996; Target and Fonagy, 1996; Fonagy and Target, 1998) has been central to this rapprochement. In particular, Main's work on metacognitive monitoring and Fonagy's related work on reflective functioning have been fundamental to forging links between psychoanalysis and attachment theory and, in particular, to transforming attachment research and attachment theory in ways that make its applicability to the basic concerns of psychoanalysis clear and tangible. Their work also has direct and significant application to clinical work with both children and adults. In the present paper, I will consider the role of representation, particularly shifts in metacognitive monitoring, reflective functioning, and mentalization in the intensive treatment of a young child and his mother.

Representational Processes in Attachment Theory and Research

Adult Attachment Representations

The story of attachment theory begins with John Bowlby (1969, 1973, 1980, 1988); the story of attachment research begins with Mary Ainsworth (Ainsworth et al., 1978), who described three major patterns of infant attachment: the secure, insecure-avoidant and insecure-resistant patterns. These three modes of responding to separation and reunion were seen by Ainsworth as organized and motivated patterns of attachment that emerged as a function of the history of the mother—child relationship. When mothers were responsive to children's needs for comfort and security, able to provide the child with what Ainsworth referred to as a "secure base," such needs were expressed easily and openly; when mothers ignored, rejected, or somehow distorted their children's needs, children developed less functional and adaptive means of communicating their needs to their parents when distressed and seeking comfort (see also Belsky and Cassidy, 1994; Karen, 1997). In the decades since Ainsworth published her original research, secure attachment in infancy has been found by scores of researchers to provide a kind of "protective factor" in later development and has been linked to a wide range of social skills and positive socioemotional development (Belsky and Cassidy, 1994). From a clinical perspective, secure children have established...
resilient and flexible emotional relationships with their primary love objects; preoedipal development proceeds smoothly from a core sense of self and of security in basic relationships (Slade, 1996).

Mary Main (Main et al., 1985) set the stage for the next revolution in attachment research by introducing the theoretical constructs and measures that have become central to the “representational era” in attachment research. On the basis of mothers’ and fathers’ narrative descriptions of their experience of early relationships (George, Kaplan, and Main, 1985), Main was able to discern three patterns of adult attachment: the secure/autonomous pattern, the dismissing pattern, and the preoccupied pattern (Main et al., 1985). She described a fourth pattern several years later, which she labelled unresolved in relation to loss or trauma (Main and Hesse, 1990). Attachment classification was based on the quality of parental narratives, which were distinguished not by their content or by specific childhood events (loss, rejection, or trauma), but by patterns of thinking, remembering, and talking about past relationships. Some parents were able to discuss their childhood experiences openly and to remember in a coherent and affectively vivid way the central emotional events and relationships in their lives, whereas others were either unable to remember early relationships and unable to describe their emotional effects or were quite overwhelmed and preoccupied with the negative effects of early family relationships.

Main discovered that the quality of a mother's narrative description of her own early attachment experiences was strongly associated with her infant's attachment classification (Main et al., 1985); this was later replicated by a number of researchers (Fonagy, Steele, & Steele, 1991; Zeanah, et al., 1993; Benoit and Parker, 1994; Ward & Carlson, 1995). Meta-analytic studies have also confirmed this link (van IJzendoorn, 1995; van IJzendoorn and Bakermans-Kranenburg, 1996). Mothers who were flexible and balanced in their capacity to remember and describe early attachment experiences and the feelings attendant to these experiences were likely to have children who were freely able to express their needs for comfort and nurture following separation and to seek proximity upon reunion. Mothers who were either guarded against the memory and power of early childhood experience (the dismissing pattern) or who had remained overwhelmed by such memories and feelings (the preoccupied pattern) had children who disguised their needs for comfort or became so overcome by their distress that they were unable to separate or explore.

Parental Representations of the Child

Thus, the first wave of research in the “representational era” emphasized the powerful relationship between the quality of a mother's representation of her own early attachment experiences and the quality or security of her own child's attachment. Recent research suggests that a second emergent representational system may well play an equally important role in determining the parent's response to the child and the child's subsequent security, namely, the mother's representation of her relationship with her child (Zeanah et al., 1995; Stern, 1995; George and Solomon, 1996; Slade et al., 1997). As has been well-described by psychoanalysts, especially Benedek (1959), Bibring (Bibring et al., 1961), Stern (1995), and Winnicott (1965), mothers (and fathers) begin developing representations of their children early in pregnancy. These representations become increasingly complex and textured over the course of development and reflect an amalgam of the parent's perceptions and fantasies about who the child is, how he functions, and what he feels. Naturally, such representations include conscious, preconscious, and unconscious aspects and are powerfully affected by the parent's own early object relationships and attachment experiences. These representations of the child and complementary representations of the self as parent are a critical and fundamental aspect of the parent—child relationship and, indeed, may function as a means of regulating his or her response to the child (Lieberman, 1997; Slade et al., 1996; Solomon and George, 1996).

During pregnancy, such representations are based almost entirely upon fantasy because little is actually known about the baby (except, perhaps, its gender and the parents' own interpretations of the child's activity level). Here, perhaps more than at any time during the child's life, the parent's representations of past relationships are creating a template of expectations. However, once the baby is born, the baby's actual characteristics, as well as the feelings they actually generate, are increasingly incorporated into the parents' representation of the child and into their representation of themselves as parents. Recent research suggests that parental representations of the child are linked to the parents' own attachment representations; thus, a secure mother is most likely to have a balanced, coherent, and flexible representation of the child and to conceive of herself as providing a secure base for the child, whereas insecure mothers see their children in either limited or distorted ways and represent themselves as detached from their children or as helpless to engage with and contain them (Zeanah et al., 1995; George and Solomon, 1996). Security and balance in the parents' representation of the child have also been found to predict the quality of infant attachment (Zeanah et al., 1995; George and Solomon, 1996). Preliminary research evidence indicates that the mother's representation of her relationship with her child may be as important a factor in determining maternal sensitivity as is her representation of her relationship with her own parents.
Metacognition, Mentalization, and the Mother—Child Relationship

Taken together, the research findings described above make evident the link between the quality and coherence of parental narratives and the child's capacities for affect regulation and symbolization. The clinical ramifications of this link are extensive and will be addressed below. First, however, let us turn to an examination of the mechanisms believed by attachment theorists to account for the relationship between adult and child representational processes, namely metacognitive monitoring, reflective functioning, and mentalization. Mary Main was the first attachment theorist to consider attachment processes in light of the capacity for what she termed “metacognitive monitoring.” This refers to the individual's capacity to “step back and consider his or her own cognitive processes as objects of thought or reflection” (1991, p. 35). In Main's view, the clarity and coherence of an adult's attachment representations reflect the capacity to think about one's thinking and to—as a consequence—represent the complexity of emotion and memory without distortion. A “secure” representation, in Main's terms, is based upon a “singular” model of attachment; in such a model, both negative and positive aspects of current or past attachment relationships are integrated into an internally consistent, believable, succinct, emotionally real, and coherent representation of attachment (Main, 1991). Narrative clarity and emotional “truth” reflect the relative absence of defensive attempts to keep intolerable affects and memories at bay; attachment memories and thoughts, along with naturally occurring inconsistencies and contradictions, can be considered and reflected upon (Main, 1995a, b).

Bowlby (1988) suggested that, when children are traumatized, neglected, or in some way hurt by their parents, they form multiple and inherently contradictory models of the same reality. Main (1991) suggests that such multiple models are typical of the “insecure” models of adult attachment and stem from early failures to integrate contradictory and painful information into attachment representations. Thus, unintegrated and sometimes unacknowledged “knowledge” remains unmetabolized and distinct in consciousness from more idealized or banal descriptions of the relationship. These are evidenced linguistically in disruptions in the narrative and other linguistic inconsistencies such as logical and factual contradictions, losing track of the narrative, slips of the tongue, anomalous intrusions into the narrative, and so on. (Main, 1991). Insecure models also compromise parents' ability to respond to their children's attachment needs in a sensitive way. Children's longing for comfort, their need to be held and safe, and their fears and anger are intolerably evocative and painful to a parent who has had to deny such feelings in her own early relationships, for they threaten to make the parent feel what they struggle not to feel and remember what they struggle to forget. The affect evoked by children's needs and demands will lead insecure parents to respond to manifestations of their children's need by either turning away from and minimizing their children's emotional expression or by heightening or maximizing them to diminish their own fears of loss and abandonment (Cassidy, 1994; Cassidy and Berlin, 1994; Main, 1995a, b). In either case, basic emotional reactions, thoughts, and memories must be denied in order for the child to maintain his connection to the caregiver; this begins the cycle of multiple models and insecure attachment representations in the child.

Peter Fonagy and his colleagues (Fonagy et al., 1991, 1995; Fonagy and Target, 1998) suggest that above and beyond signalling the adult's capacity to think about her thinking, metacognitive monitoring indicates the capacity to reflect on internal, particularly affective, experience in a complex and dynamic fashion. He describes this as the “reflective function,” the capacity to reflect on internal experience; to know, imagine, and represent inner life and mental states in the self; and to recognize and represent these same states in others. For Fonagy, reflective functioning is vital to making sense of the personal and interpersonal universe: to making sense of one's own feelings and behavior and to making sense of others' behavior and motivations. It is how we come to label and regulate our own affective experience and how we come to know what goes on in others' minds. As such, it may well provide protection against the damaging effects of abuse and trauma (Fonagy et al., 1995).

Fonagy views the reflective function as an “intrapsychic and interpersonal achievement that emerges fully only in the context of a secure attachment relationship.” In insecure relationships, it is, along with other high-level cognitive processes, “subject to the vicissitudes of conflict and anxiety and consequent defensive disruption” (Fonagy et al., 1995, p. 251). A secure mother will be able to make sense of and make known her child's internal experience, as a function of her capacity to reflect upon her own affective experience. The child is thus able to “find himself in the other as a mentalizing individual” (1995, p. 257). The mother's recognition of the child's desires, feelings, and intentions allows him to see himself as thinking, feeling, and
belonging. Indeed, Fonagy reports that mothers and fathers rated high in reflective functioning were more likely to have children who were secure.

A mother's capacity for reflective functioning and metacognitive monitoring is necessarily linked to her capacity to regulate, modulate and ultimately symbolize affective experience, which will in turn allow her to contain and bind by her infant's affect expression. Because emotions and their exigencies are familiar and known to her, she can recognize and respond to them as coherent, organized, and meaningful communications. By contrast, mothers who are insecure may well have more difficulty symbolizing experience for their children and making sense of their children's communications, both because they have found it difficult to make sense of and integrate their own emotional experience and because they are disregulated by their child's emotions. Dismissing parents appear to be unable to symbolize or acknowledge their children's dependency needs, desire for comfort, or anger; these feelings are thus not represented or known to the self and therefore cannot be represented in the relationship with the child. Preoccupied mothers seem to acknowledge and symbolize their own negative affects in the extreme, although such acknowledgment is highly enactive (Diamond and Blatt, 1994) in that it stimulates feeling and memory, rather than creates a bounded symbolic context for such feeling and memory. Maternal failures to bind or contain the infant's affective experience thus lead to infant failures of regulation and integration.

Taken together, the research findings presented in the preceding sections, coupled with the theoretical advances in understanding metacognitive monitoring and reflective functioning described above, make it evident that mothers who are able to reflect on their own attachment experiences and on their developing relationship with the child, to tolerate and regulate their own affective experience, and to express their experience in ways that are at once coherent and verbally mediated are more likely to have children who have begun to regulate and contain their own affective experience, who can express the range of their needs and feelings in clear and meaningful ways, who have begun to be aware of their own and others' mental states, and who rely upon increasingly symbolic forms of self-expression as they enter middle childhood.

These findings have a direct bearing on a conceptualization of the aims of child psychoanalysis. Fonagy and Target (1998) suggest that child analysis, and particularly the activity of playing with a therapist or analyst who provides a secure base for the child's mind, implicitly affirms and recognizes the child as a “mentalizing” being, and leads to shifts in the capacity to use their awareness of their own and other people's thoughts and feelings. In children, the mentalizing capacity is “crucially linked with children's ability to label and find meaningful their own psychic experiences, an ability which underlies the capacities for affect regulation, impulse control, self-monitoring, and the experience of self-agency” (1998, p. 92). However, as will be described in the sections that follow, because the child's representation of himself and of his inner experience must be seen as a direct function of his parents' capacity to represent and imagine his mind, and thus provide a secure base for him as a “mentalizing being,” understanding the interface of the child's mind with the minds of his attachment figures is necessarily central focus to the therapeutic or analytic process. And in many instances, understanding and ultimately transforming the parent's conception of the child and of the child's mind and separating such awareness from projections and distortions will be central to the child's progress (see too Stern, 1995).

It is this conception of a link between the mother's capacity to recognize and represent her child and the child's recognition of himself as a thinking and feeling person that is at the heart of this paper and that guided the “concomitant” work described in this paper, which began as a dyadic, mother–infant psychotherapy. From its inception in the late 1960s, when first introduced by Margaret Mahler in her work with psychotic children and their mothers (1968), and its later development by Selma Fraiberg (1980), dyadic or (with infants and toddlers) infant–parent psychotherapy (Stern-Bruschweiler and Stern, 1989; Lieberman, 1992; Lieberman and Pawl, 1993; Stern, 1995) has assumed that change in the child depends upon change in the mother's representation of the child, as well as her representation of their relationship. In the work that is described here, that notion is expanded to encompass what becomes an individual child treatment, concomitant with ongoing individual work with his mother, focused specifically upon the mother's representation of the child and of herself in relation to attachment. Since Anna Freud and her colleagues introduced what was to become the “child guidance” model of child psychotherapy (1965), virtually all child treatments have included ancillary work with parents. Indeed, Bowlby himself suggested in 1940 that a “weekly interview in which... problems are approached analytically and traced back to childhood has sometimes been remarkably effective” for mothers who are struggling in relationship to their children (1940, p. 23). However, the aims of such ancillary work were usually loosely, if not poorly, defined and often included “education” of parents, keeping the therapist abreast of events in the child's life, developing in the parents a better understanding of the child, and—
occasionally—working toward developing the parents' capacity to understand the genesis of their own neurotic and distorting responses to the child. Typically, however, the latter kinds of interpretive and insight-oriented work have been relegated to a separate venue, namely the parents' own individual and, hence, separate psychotherapy. As will be described here, the work with Michael and Julie reflected my attempt to adapt the principles of infant–parent psychotherapy and attachment theory to the treatment of an older child, for whom dyadic work was no longer appropriate. (See, too, Oram, in press.)

This work is best described in terms of three phases: the consultation and evaluation phase (2 months), the dyadic phase (4 months), and phase of concomitant individual work with Michael and Julie (ongoing, 2+ years). Discussion of the latter phase is the primary focus of this paper.

**Representation, Symbolization, and Psychotherapy: Michael and Julie**

**The Evaluation Phase**

Michael had just turned 3 when his parents came to see me in consultation. They were referred for evaluation by the child's pediatrician because of excessive and unremitting temper tantrums, extreme demandingness, and separation anxiety. The developmental history suggested that, from the beginning, Michael had few resources for regulating his affective experiences; his mother reported that, from his first days in the hospital, he was awake for long periods of time and was soothed only by nursing. His unremitting crying, wakefulness, and irritability did not diminish over time; by the time he was a year old, he was having full-blown temper tantrums that would last for an hour or two. He was a very poor sleeper, often waking up as many as seven or eight times a night during his infancy. He was also hypersensitive to smells, tastes, and sounds and would react very negatively to any that seemed unpleasant to him. At the time of the evaluation, his regulatory upsets were quite extreme: his anger and anxiety would escalate rapidly and intensely and would last for a very long time. These tantrums were very difficult to curtail, and even Michael himself would sometimes cry: “I can't stop! I can't stop!” When his mother would try to hold or physically contain him, he would scream at her: “Don't touch me! You're not fair! You're mean! You're going to hurt me!” Michael's emerging sense of his own “badness” and differentness was already beginning to crystallize: he knew there was something wrong; he knew he had a problem that made his and others' lives very painful, and he didn't know why or what it was. Too young to understand the trouble as anything but the totality of who he was, he incorporated the badness into his sense of himself.

Michael lived with his mother, Julie, his father, Andy, and his sister, Lucy, who was 25 months his junior. Andy worked long hours as an engineer, and Julie—who herself had professional training as a respiratory therapist—stayed home with the children full-time. She worked one day a week at a local hospital and went out one evening a week for choir practice. During these times, Michael and Lucy were care for by her mother, who lived nearby, or by Andy. Michael found these infrequent separations nearly intolerable; he would anticipate them anxiously for days and would beg her not to leave. When home with his father, he would cry bitterly as he awaited his mother's return. His efforts to control Julie naturally extended beyond separation; he worked to command her attention and do his bidding throughout the day, especially when she was involved in caring for Lucy. If she resisted any of his efforts to control her or refused any of his wishes, his tantrums were unrelenting. Unsurprisingly, he was unable to tolerate playdates or family gatherings and would rapidly spiral out of control in these situations.

When I met him, Michael was an adorable, compact, and extremely neat little boy who assiduously avoided eye contact with me and who moved from the waiting room to the playroom in such a wide arc as to avoid any physical proximity to me. In the playroom, he shrank away and looked furtively to his mother if I spoke to him; I had to keep a distance of at least 5 feet, or he would immediately become anxious and move to his mother's side. His tremendous dependency upon her manifested itself in other ways as well: he was extremely reticent to explore the room and asked his mother to take the toys that interested him out of the cabinet. When I asked a question of him, he would direct her to answer it and avoid looking at me. He initiated games in a weak and tentative way and needed her active involvement and initiation to carry the game forward. His play was fairly ritualistic; for the most part he simply lined up figures and animals and was intensely interested in their clothes and other accessories. He would become
fixed on details, such as the Playmobil® catalog, the number and placement of weapons on a figure, and so on. At this point, he had no words for his play. His affect was somber, and only rarely did he smile, except in occasional moments of playful exchange with his mother.

In describing Michael diagnostically, it is important to address the various substrates of his functioning. Basic to any discussion of his diagnosis is a severe regulatory disturbance; Michael's capacity for affect regulation and containment were remarkably limited, even for a 3-year-old (Zero to Three, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, 1994). Like many hypersensitive (Greenspan, 1995) or difficult children (Turecki and Tonner, 1989; Lieberman, 1994), he was tremendously reactive to shifts in both external and internal stimulation. Concomitant to this biological vulnerability (and likely as a consequence of it), he manifested symptoms of a severe anxiety disorder; this included separation and other forms of generalized anxiety. From the perspective of psychoanalytic developmental theory (Freud, 1965; Mahler et al., 1975), Michael would be seen as a child whose progress along any number of developmental lines was severely impeded: he was functioning like a tormented rapprochement-age child, with no friends, constricted affect, poorly developed symbolic play, and few resources for coping with his emotions; there was little evidence of more mature oedipal development.

From the perspective of attachment theory, Michael would be characterized as insecure in his attachment to his mother; because of his inability to derive comfort from the soothing and contact he so desperately and continuously sought, he would be classified as insecure/resistant in his attachment. Michael's attachment to his father was less tormented, certainly, but it nevertheless felt rather tenuous and unsatisfying; his mother was the center of his universe, and his father was a temporary and disappointing substitute. In terms of conceptualizing the relation between his underlying biological disturbance and his attachment security, I saw Michael as a child who had particular difficulties feeling safe and deriving comfort from his caregivers because of the extent of his biologically driven anxiety and disregulation. That is, his capacity to develop a secure attachment to his mother might well have been compromised even under the best of circumstances by his hypersensitivity and overarousal. Of course, it is also possible that his biological vulnerabilities had the long-lasting effects they did because his mother found it so difficult to regulate his affective experience or provide both a sense of security and a bridge to autonomy and separateness (Schore, 1994; van den Boom, 1994; Belsky, Hsieh, and Crnic, 1998).

When I met Julie during the evaluation phase, she was the consummate “historian,” providing clear and highly detailed descriptions of Michael's early years, of his disregulation and her inability to regulate him. An attractive, athletic, and lively woman with a direct and somewhat prickly demeanor, Julie tried hard to minimize the sense of desperation and loss of control that lay beneath her every word. Contained and highly organized in her everyday life, the situation with Michael was quite intolerable to her. She described herself as frustrated and despairing, unable to calm him, unable to understand him, and unable to come to grips with what she realized was a very serious problem. And she was very worried and pained for Michael, whose suffering was quite tangible for her.

Andy, a quiet, passive, and gentle man, provided a vivid contrast to Julie. Although clearly worried about Michael and quite able to talk and think about the situation in an intelligent and thoughtful way, it was evident that he kept himself emotionally and physically detached from the situation. His affect was constricted, and he seemed fairly withdrawn from the emotional exigencies of his life; he found dealing with Michael taxing and difficult and often avoided helping Julie in the evenings, despite realizing that this would be very helpful for both her and Michael. As might be expected, this was a constant source of conflict between them: Julie felt abandoned and unsupported, and Andy felt criticized and unappreciated for what he did do. Although both Julie and Andy participated in the evaluation process, it quickly became clear that I would be working most directly with Julie; this was reinforced numerous times over the course of the treatment when I tried—for the most part unsuccessfully—to engage Andy in the work we were doing.

In relation to Michael, Julie seemed most comfortable with the idea that he had a “biological” problem, that he had been born with difficulties in regulation and modulation that left him prone to the kinds of upheavals and tantrums that were disrupting their lives. But she seemed to have little sense of—at a psychological level—what made him tick. She was very sad for him, but she did not understand him. She did not understand why he became disregulated, how her efforts at control made him feel, why he was angry, or why he had so much difficulty with separation: as an emotional being, he was a mystery to her. She had equally little sense of her own feelings; she did not recognize her anger nor could she appreciate the extent of her own rigidity and need to control Michael. She had little understanding of or even interest in her own childhood history: she described her childhood as “fine” and “normal,” despite multiple moves, separations, and upheavals. And it was nearly impossible for her to think about...
the meaning Michael had for her, why she had reacted to him in some of the ways she had, how her history had informed some of her reactions, and so on. Like many parents of disturbed children, Julie harbored the fear that she was somehow responsible for his condition and felt enormous guilt at what she imagined she must have caused. Any exploration of her role in his psychology came too close to these feelings and had to be curtailed. From an attachment perspective, Julie’s limited capacity to remember or reflect upon her own childhood attachment experiences, her affective experience, or her current relationships would lead to a classification of dismissing of attachment. Clearly, her capacity for reflective functioning was also extremely low.

Diagnostically speaking, there was no evidence in Julie of major psychiatric or biological disturbance; however, Andy was diagnosed with a depressive disorder following Michael's evaluation and was placed on Zoloft. In addition, there was a history of severe obsessive—compulsive disorder in his family and evidence of compulsive behavior in his clinical picture. Unfortunately, he declined psychotherapy, despite the fact that both the treating psychiatrist and I strongly encouraged it.

My first meetings with Julie and Andy served as consultation as well as evaluation; I confirmed their sense that this was a biologically disregulated child and emphasized that they had not “created” this level of difficulty by mishandling him. On the other hand, I made it clear that his difficulties could be much better contained if they were able to be more attuned to his needs and feelings and so made a number of concrete suggestions about managing his behavior while remaining sensitive to his feelings. I tried to describe to them what I imagined it felt like to be Michael and what it felt like to live in his skin (a first step in helping mentalize his, as well as their own, experience of him). Julie and Andy were eager to enroll Michael in nursery school, which I discouraged. Nevertheless, Julie was so stressed by the difficulties of caring for him full-time and by managing his jealousy of Lucy that she was determined to give it a try. We agreed that they would try my suggestions, try nursery school, and be back in touch if the need arose.

Dyadic Treatment Phase

About 6 months later, I received a call from Julie. The nursery school experiment had been a dismal failure—largely because of Michael's separation anxiety—and she was about to withdraw him. Because Michael was unable to separate from his mother and come comfortably to the playroom, I began by treating them dyadically and saw Julie for intermittent individual sessions. Individual sessions with Julie focused on Michael and the upheavals that continued to dominate their daily life. It soon became clear that Julie needed these sessions on a regular basis because we were hampered in the fullness of our discussions by Michael's presence in dyadic sessions. I began meeting with Julie twice a month, in addition to weekly dyadic sessions.

Dyadic sessions began with Michael turned away from me and toward his Mom, as if ignoring me would make me disappear. As long as he could ignore my presence, Michael seemed comfortable and happy with his mother; he giggled, his eyes twinkled, and he molded to her easily. Indeed, given the level of both of their difficulties, it was surprising to see how sensitive and responsive she was in these sessions. They seemed to enjoy each other, and she picked up on cues readily and comfortably. Her voice betrayed little of the anger that she was beginning to openly acknowledge in individual sessions, and she seemed physically comfortable with him and readily available. The only clue to her anger in these sessions was the subtle aggression that would sometimes emerge in her play, when she would playfully wipe out his army. But he seemed to enjoy this and retaliated in kind. He was also enormously sensitive to her attempts to get him to take initiative; as soon as she pushed him to do something on his own, he would move toward her and cling to her. Michael's play was evidently symbolic or imaginary, although he used absolutely no language to set the stage or give voice to the figures he had chosen; occasionally, he would have his characters speak in a kind of modulated gibberish, but otherwise, his play was, for the most part, silent exploration and enactment. Stories and voices, so typical in children his age, were notably absent.

Because of Julie's remarkably limited capacity to reflect on her inner life or on her relationships, I had very little clear sense at the outset of what had gone so wrong between them (other than to speculate on the obvious effects of her emotional distance). So in our individual sessions I began by first trying to make Michael's experience meaningful to her, identifying the cycles of regulation and disregulation, the link between his symptomatology and his anxiety the cues to his becoming overwhelmed and frightened. And as he began to make sense to her and she began to be able to represent and understand his experience, she became more sensitive to his affective experience and to the nuances of his biological disregulation. She became more containing and empathic and less abandoning and rigid during his tantrums; she began to recognize the situations that would trigger his distress and try to modify them or at least help him anticipate them. She became, in essence, more of a secure base. During this phase, it was simply not possible to explore the deeper levels of her own feelings about Michael; she
could not yet imagine that his difficulties had any connection to her feelings toward him or were in any sense a response to aspects of her inner life that were unconscious or unacknowledged.

Despite the fact that Michael was so avoidant of me at first, he slowly warmed up to me over the first few months of our work; he gradually began to look at me and to answer my questions and allowed me to participate in the play, albeit at some remove. One day, he happily brought in his favorite pirate books to show me, as well as his toy gun collection. As time passed, I encouraged Julie to move slowly to the edge of the playroom, and Michael slowly allowed me to replace her as his play partner. She gradually moved to the other side of my consultation room and finally moved downstairs to the waiting room. His time alone with me became very important to Michael, and

Indeed one day when Julie came upstairs with us to talk to me briefly, Michael waited for a few minutes and then looked at her with twinkling eyes and said, “I think it's time for you to go, Buster!”

During the period of transitioning from dyadic treatment to individual treatment, despite changes in Julie's sensitivity and responsiveness, Michael's separation anxiety continued unabated, and he began to show a number of tics and obsessive preoccupations. He would insist upon changing all of his clothes if so much as a drop of water touched him, he washed his hands ritualistically if he got at all dirty or messy, and he would repeatedly tuck his clothes in and look at himself in a rigid, stereotyped way. Consecutive obsessions—cowboys, pirates—dominated his play. Shortly after his fourth birthday, he was evaluated by a child psychiatrist who diagnosed severe and early onset obsessive—compulsive disorder (OCD), as well as a generalized anxiety disorder. Medication was recommended, and Michael began on 10 mg of Prozac daily, which was increased to 20 mg when he was four and a half. This is the standard psychopharmacological treatment of OCD. Increased individual therapy was also recommended, as was a cognitive behavioral training program to be carried out at a local clinic that specialized in OCD. I increased Michael's individual sessions to twice a week and scheduled Julie to see me every other week. During this same period, continuing for several months until Michael was four and a half, Julie, Andy, and Michael intermittently attended cognitive behavioral therapy sessions aimed at helping Michael manage the anxiety that was thought to trigger his obsessional symptoms.

**Concomitant Treatment Phase**

By the time of Michael's fourth birthday, we had begun the phase of what I have termed “concomitant treatment,” where I worked individually with both Michael and Julie. I use the term *concomitant* because I thought of the sessions with both Michael and Julie as invariably interlinked and intertwined; I used the work I did with Michael to inform my work with Julie and the work with Julie to help me in my work with Michael. Michael's play began to change once we began individual sessions and changed dramatically when we moved to twice a week. The compulsive and rather stereotypic play of his early sessions gave way to a number of age-appropriate symbolic games:

A turning point in Michael's beginning to really play symbolically followed my deciding to enact a set of play scenarios related to his obsessions with cleanliness and separation. I initiated these scenarios because the cognitive—behavior therapist had encouraged his mother to “practice” anxiety-provoking situations with him; however, these practice sessions felt silly and unsuccessful to her, largely because he was too young to understand the function of practicing control over his anxiety. I decided to transform the idea of practice into the realm of make-believe, which I thought might be more suited to his age and needs. I also thought it might help him develop ways of representing or imagining the things that most troubled him. I made up three pretend scenarios; in each a soldier lost control when faced with sticky mud, separation, or something that made him angry, but eventually calmed himself down. Michael was absolutely fascinated watching me act these out and, in fact, summoned his mother over from the far side of the room to watch (she had not yet moved downstairs at this point): “Hey, Mom, look what Dr. Slade's doing!” We played these scenes over many times the following months, and he played them at home with his mother. And, although the specific scenarios eventually dropped from his repertoire, his symbolic play gradually became rich and expressive. Increasingly, he found symbolic expression for his experience of deregulation, rage, and loss.
During the fall and winter following Michael's fourth birthday, we continued the schedule of concomitant treatment with Michael and Julie, and intermittent cognitive—behavioral sessions for Andy and Julie. It was now a year since Michael had left nursery school, and the child psychiatrist and I felt it was time to try again. Michael had calmed down a great deal at home and was tolerating separation much more easily. As a function of treatment and medication, he was also considerably less angry and controlling, although he and his mother still had their moments of great conflict. Plans were made to begin Michael in a preschool classroom in local private school, where the teachers and staff had been apprised of Michael's difficulties and were willing to work him into the school program at his own pace. Up to this point, my work with Julie had been limited to helping her think about and understand Michael's experience, with the result that she was increasingly sensitive to his fears and the triggers to his becoming overaroused. Nevertheless, the work had not progressed to the deeper level that seemed so very essential to her understanding of why she responded the way she did and why Michael continued to struggle with anger and anxiety; she was still closed and defensive whenever I probed about her own history of separation anxiety and the reasons for her emotional distance and anger.

Finally, nearly 2 years into my work with this family, as Michael began school and approached his fifth birthday, a remarkable shift occurred in a session with Julie. She had shown signs of increasingly overt anxiety as the date for his beginning school approached. She worried that his classmates would be mean to him, that the teachers wouldn't understand him, that they'd force her to leave the class before Michael was ready, and so on. But none of these fears were being realized: Michael loved school. And Julie was allowed to stay in the classroom. But soon it would be time for her to leave, to let him cope without her, and this was what frightened her. What would happen if he were to fall apart and she weren't there to help him? Would he go crazy? Would the teachers know what to do? Would he recover? As he began outlining her many fears of his decompensating should she leave, I said to her, “Now, we are about to encounter your separation anxiety!” The tears began to flow, and finally, after so many months, Julie was able to tell me how, from the day of Michael's birth, she had been afraid of losing him. He was too special to her. From his first moments in the hospital, she felt the nurses took him away from her too quickly and for too long; she was the only one who could care for him. She was exquisitely concerned for his physical well-being, even before his temperamental difficulties became apparent. Once they did, her anger and disappointment became viciously entangled with her fear of losing him. As she told me this, I could finally begin to understand how her fear of losing him, coupled with her anger at his biological vulnerability, made it very difficult for her to regulate his affective experience or facilitate his autonomy. Instead, she and Michael remained enmeshed in an angry dependency.

This began a slow and painstaking process of Julie tentatively beginning to explore her own history and particularly her relationship with her own mother. At each milestone in Michael's emerging autonomy—his first class session without her in the classroom, his first “meltdown” in class while she was absent, his first day of a full classroom program—Julie was beset with fear and anxiety. And she slowly began to understand that his growing away from her made her anxious about his survival and that this somehow had to do with her early fears and her mother's unavailability to soothe and comfort her. When Julie was 3, she and her two brothers and parents moved to rural Austria, where her father was to run a small business. Her father's company was an hour away, and Julie was herself enrolled in a local preschool. A year later, she was enrolled in a school that was an hour's bus ride away. Julie has no conscious memory of anxiety during this period or during any of the other multiple moves and upheavals that characterized her childhood. But we have reconstructed a situation in which her mother, put in full charge of relocating her family, coping with her husband's long absences in a foreign culture, simply “copeed” and expected her children to do the same. There was no room for distress.

One day, Julie came into a session and plopped down into her chair. She was on the verge of tears as she recounted an incident with her mother that spoke volumes to both of us. Michael was now attending school on a regular basis, and Lucy had started school, too. Julie was beset with anxiety, as she had been every morning since the children began school. On the morning of our session, Julie had been unburdening herself to her mother, recounting her anxiety and fear for the children. To her surprise and profound upset, her mother told her simply to “just deal with it, and get on with your life.” Up until that moment, Julie had never realized how little tolerance her mother had
for her feelings, particularly her anger and her anxiety. Only now could she begin to understand why she had had to bury her own feelings and worries time and time again. Until Michael was born, she had been the ultimate “coper.” Only in her representations of his emotional experience could she allow herself to feel the anxiety she had not been allowed to feel and to respond to him in the way she had never been responded to by her own mother. His difficult temperament undoubtedly set the stage for this reenactment, because it made it easy for Julie to see him as vulnerable and in desperate need of her comfort. Unfortunately, because these representations and feelings were unconscious, her projections severely limited and distorted Michael's autonomy and likely worsened his biological vulnerabilities.

As Julie began to reflect on the complexities of her relationship with her parents and her capacity to tolerate and understand her own emotional experience, there were fascinating shifts in Michael's play and in his understanding of the world. Despite his obvious intelligence and evidence within our sessions of his rich and vivid imagination, Michael—even at 5—had remained somewhat confused by the distinction between what Fonagy and Target (1996) term the appearance/reality distinction. In his interactions with playmates and with his parents, he would become frightened and upset by the boundary transgressions and violations that are part of normal social intercourse. He would often take his playmates' “tall tales” as truths (Colin's house really burned down last night) and had difficulty, particularly in the absence of visual cues, recognizing humor and teasing. Unless there was a smile or linguistic marker to indicate humor or teasing, he would remain lost to the subtle and less evident meanings of the exchange. To him, what was was. However, as his and his mother's treatment progressed, he began actively grappling with the distinction between reality and pretend. This manifested itself both at a verbal and symbolic level.

In our sessions and at home with his mother, he asked numerous questions about the difference between real and pretend. “Is that real? Is that pretend?” When his mother took him to a performance of the musical Oliver, he was both agitated and fascinated. He had to work very hard to keep the awareness that this was fiction and play and, throughout the play, asked his mother whether these were actors,

whether this was really happening. A fascinating corollary to his struggling to distinguish between real and pretend was his attention to others' subjective experience. Often, he had the squirrels “watch” an episode of particularly violent play; their role was to comment, observe, and reflect on what was going on. In all of his interactions, he became more attuned to the connection between affect displays and internal experience. He began to understand and appreciate that his parents and other children had emotional experiences that were both similar to and different from his. He would ask his mother, “Did that happen to you too, Mommy?” and took close note of his playmates' emotional reactions and upsets. Seeing that they, too, got upset during a routine school day, had fights, lost control, and so on, he became more confident and more social. It seemed as if he felt less and less “different,” more a part of the human world.

The disentangling of real and pretend and particularly the capacity to pretend to “play” with reality emerged vividly in his symbolic and imaginary play. One day Michael was playing with the Magic 8 Ball, a fortune-telling toy that provides yes or no answers to hypothetical questions. Michael had been playfully asking it a series of silly questions when he shook it too vigorously and bopped himself in the mouth. He looked transiently worried and then insisted he was alright. When I gently told him he was bleeding a little and that we needed to put some cold water on his lip, he disintegrated. I brought him sobbing to Julie, who was waiting downstairs. He insisted on looking at his wound in the mirror and demanded to be taken right home. As his mother held him in her arms, I said goodbye to Michael and reminded him I'd see him in several days. In the meantime, I

pleasure, pride, and mischief. Now the Magic 8 Ball had a bloody lip, too. He'd gotten that Magic 8 Ball back!

These events took place during a time in Michael's treatment when he was continuously moving back and forth between enacting battle scenarios in his play and drawing tanks, guns, and other instruments of war. At times, he would pull out the toy guns, and we would play robber and space battle. At others, however, he would just sit down and draw. He would draw picture after picture, as if trying to symbolize that which he had previously only been able to enact. One day, I remarked that he seemed to be very interested in all the “stuff” of war and the like. “Oh, I'd never want to be in a real war!” he said, “I'd be too scared!” Symbolization was—for the first time—providing him with the means to contain his anger and his fears and conquer them,
using his imagination. In Diamond and Blatt’s (1994) terms, he was moving from the enactive to the lexical mode. And when he retaliated against the Magic 8 Ball first in action and then in fantasy, he was making several vital developmental leaps, all at once. He was representing his hurt and anger, his wish to retaliate and cause hurt, and his desire to take action, within the context of play.

Michael is now about to enter first grade and seems happy and comfortable at school. He is a full and appreciated member of his class, with friends, playdates, and a range of interests and enthusiasms. He has begun learning to write, spell, and read and is a voracious consumer of fact and information. His obsessional symptoms as well as his anxiety, have diminished considerably and tend to emerge primarily when he is stressed or upset. And, although holidays and other times of great excitement can disregulate him, he is usually even and content. He still has flare-ups with his sister, along with areas of rigidity and fragility that get in his way. And, although his oedipal development will necessarily be limited by his father's passivity and inaccessibility, he has developed a stronger and more resilient connection to his father. He is no longer “different” in the way he once was, and even his biological vulnerabilities are contained and less disruptive. Most striking, however, is the change in the relationship between Michael and his mother. The anger, disappointment, and anxiety that had infiltrated their closeness is greatly diminished and in its place is a growing delight and understanding.

**Discussion**

What emerged over the course of my work with Michael and his mother was a kind of “hybrid” treatment that combined aspects of infant-parent psychotherapy (Fraiberg, 1980; Stern-Bruschweiler and Stern, 1989; Lieberman, 1992, 1997, this issue; Lieberman and Pawl, 1993; Stern, 1995), play therapy for Michael, and insight-oriented supportive psychotherapy for Julie. These kinds of flexible and evolving treatments are not unusual in day-to-day psychoanalytically oriented work with young children. Indeed, I am hardly suggesting that I happened upon a “new” approach to child treatment; rather, I am trying to understand what often happens naturally in child work in light of current developments in the study of attachment and related processes. Concomitant work with mother and child allowed me to address intertwined and interacting representational worlds simultaneously: Julie's representation of Michael and of their relationship, Julie's representation of herself in relation to attachment, and Michael's representation of himself and others. Changes in both the mother's capacity for self-reflection and in the child's capacity for symbolic expression were linked to changes both in the quality of their relationship and of their attachment, as well as to changes in Michael's overall functioning, despite ongoing biological disruptions to his adaptation. As Julie's treatment progressed, Michael's way of being began to make emotional sense to her, and her understanding made it possible for her to “recognize” him and thus contain and regulate his emotional experience. And as Michael's treatment progressed, he began to be able to reflect on, organize, and play about his inner experience: slowly, it became possible for him to describe and reflect on his own feelings, as well as on the feelings of others; to contain and symbolize what had been overwhelming experiences of dysregulation and distress; and to distinguish between pretend and real in increasingly complex and differentiated ways. Indeed, differentiation proceeded on all fronts. As Stern (1995) points out in his recent discussion of the interdependent, dynamic, and mutually influencing nature of the parent-child relationship and of infant-parent psychotherapy, “a successful therapeutic action that changes any one element will end up changing all the separate elements” (p. 16)

**Within the framework of child psychoanalysis, the development of Michael's capacity to play within the clinical situation, to give voice to his inner life—via symbolic play—would be seen as central to his improvement. Indeed, there can be no question that the emergence of symbolization within the context of an ongoing treatment relationship was intrinsic to his progress (Slade, 1994) and specifically to the development of mentalizing abilities (Fonagy and Target, 1998) and what we might speculate was a more differentiated and integrated sense of self (Mahler et al., 1975). Shifts in reflective functioning, which Fonagy would attribute to Michael's developing “theory of mind,” were linked directly and explicitly to diminution in his separation anxiety, obsessional symptoms, and temper tantrums, and to his developing increasing spheres of competence and mastery. However, what I believe was equally—if not more—central to his improvement and to the improvement in his relationship to his mother were the changes in Julie's representation of herself and of Michael that emerged as a function of my concomitant work with her.

The child's mentalizing abilities emerge most fully within the context of a secure relationship; however, secure communication between Michael and Julie was severely limited not only by his biological vulnerabilities, but by Julie's inability to recognize and be sensitive to his needs. Although she could be quite sensitive to him when he was calm and playful, she withdrew from him and became controlling and angry when he was anxious or angry. It seems likely that even as early as the neonatal period, Michael's naturally occurring distress—which may or may not have been extreme—was profoundly
disregulating for Julie. And just as her mother withdrew emotionally and abandoned her when she was frightened and angry as a child, Julie's only recourse was to withdraw from Michael and his distress; by the time of the family's initial consultation, Julie clearly felt helpless and in its grip. When he was born, she consciously feared losing him, and she feared that harm would befall him. But in a sense, her fears for his safety reflected her awareness that she could not meet his needs or contain him because the anxiety elicited by his distress and need for her was intolerable; she was losing him because she found closeness to him terrifying and impossible. And so she withdrew from him; she did not have the resources to do otherwise.

Coming to “know” Michael through the course of treatment allowed Julie to begin to master and contain the anxiety she felt in the face of his distress and needs for intimacy. Seeing him more clearly and in a more differentiated fashion allowed her to experience his needs—not as terrifying and overwhelming, but as comprehensible and containable—was intrinsic to her beginning to provide a secure base for his emotional experience. And it was intrinsic to Michael's emergent security, and sense of separateness, as well as to his beginning to imagine, understand and regulate his own inner experience. Julie's ability to make meaning of Michael and their relationship allowed her to meet his needs and make them meaningful for him; her coming to know and recognize him led to his becoming known to himself. These changes were at the center of his being able to become a more differentiated, coherent, and representational person and were at the heart of their developing a healthy and joyful intimacy.

In many ways, these formulations are reminiscent of Winnicott's (1965) thinking about the true and false self. In his view, the infant's sense of the self as real and separate arises from the mother's recognition of the infant as real and separate; it is this capacity to know the self as separate that leads to the development of the symbol. “It is an essential part of my theory that the True Self does not become a living reality except as a result of the mother's repeated success in meeting the infant's spontaneous gesture …. It is the infant's gesture … that is made real, and the capacity of the infant to use a symbol is the result” (p. 145). For Winnicott, the mother's capacity to know, represent and reflect the infant's experience back to him is intrinsic to the infant's capacity to represent and symbolize his inner life. The mother provides the means of the child coming to know and represent his own experience; the child's sense of subjective reality, as well as his capacity to symbolize, is linked to the “mediating” (Mitchell, 1988) effects of the mother's consciousness.

The work with Julie moved from disentangling and making sense of the aspects of Michael and her relationship with him that were least threatening and disorganizing to those that were deeply upsetting and quite unconscious. I began by making sense of Michael's biological disregulation, imagining with her what it was like for Michael to be emotionally disregulated and fly out of control, what it was like for him to experience such profound sensitivity to change and to environmental stimulation. I suggested ways that she might describe Michael's experience to him in words, so that he could begin to make sense of what was happening to him and between them. His arousal cycles, his episodes of disregulation, and his consequent obsessions, his rages, his panics, began to make sense to her, and she could clearly understand them as a reaction to his biological difficulties. The chaos of his temperament and emotional reactivity began to take on a shape and a reason to her, and began to be differentiated from the complexity of her response to his biological difficulties. She began to understand what set him off; at long last, she had words to describe it, to herself as well as to him. This allowed her to mirror and “mark” Michael's affective experience (Gergely and Watson, 1996).

This led directly to our trying to make sense of his emotional experience, as distinct and differentiated from her own. Children who are biologically vulnerable, which he clearly was, live in an emotional universe that is fraught with the fear of disregulation and anger at its effects. For the hypersensitive child who reacts to every touch, sound, or change as if it were an earthquake, life and maintaining a sense of internal regulation are continual challenges. These children, more than most, are enormously reliant upon their “self-regulating others” (Stern, 1985) for containment, modulation, and organization. Julie was too angry, disappointed, and separation anxious to recognize Michael's separate experience; as a consequence, his biological and emotional needs remained mysterious to her, and she was an erratic and poor self-regulating other. Once she began to recognize these needs, it was possible for her to remain both emotionally available and emotionally containing for him. And, at long last, it became possible for her to experience real pleasure and delight in their relationship.

Intrinsic to realizing how Michael felt was realizing how her feelings affected him. It took Julie a long time to acknowledge that her feelings, her rage, her sadness, her separation anxiety, and so on had an effect on Michael. Acknowledging such feelings meant acknowledging the tremendous guilt she felt about his condition (which she had few resources to handle), and it meant acknowledging that she too had had feelings her mother had been unresponsive to. In a sense, our work proceeded from reworking aspects of her conscious representation of Michael (i.e., her conscious recognition of his biological difficulties) to her less articulated representation of his inner life, to

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her even less conscious awareness of his response to her affective experience. Finally, we began to address the relationship between her representations of her own parents and those of Michael and their relationship.

The shift in their relationship that resulted from changes in her capacity to understand and make sense of his emotional experience was, from my perspective, probably the most important catalyst to change in the dyad and likely most healing for Michael. Had Julie been in treatment with a separate therapist, she might have changed considerably, and Michael might have benefited considerably from his own psychotherapy, but it is very unlikely that their relationship would have changed the way it did or that either of them would have changed as much or as fully as they did. By becoming the intermediary between them, I had access to two profoundly complementary and interacting representational systems and emotional worlds. This made the potential for individual and dyadic therapeutic change and growth all the greater.

Whereas the articulation of Michael's and Julie's feelings, intentions, and motivations enhanced mentalization for both, it was the creation of shared illusions through play within the context of the therapeutic relationship that enhanced Michael's symbolic capacity (D. Diamond, personal communication, June 24, 1997). When Michael began treatment, he had little capacity to play. However, coincident with his mother's emerging capacity to imagine and contain his experience, his developing relationship with me, and my specific efforts to imagine and represent his experience, both in play and in words, he began to play, to symbolize, and to distinguish between pretense and reality. He began by telling stories in his play, enacting the panoply of his anxiety and rage; over time, he shifted to drawing and to words. As his play came gradually to express his anger and his fear, his anger and fear came under his control for the first time in his life. His play and his words richly expressed his emerging understanding of the world, of pretense and reality, and his wish to make sense of the content of others' minds. As he began to make sense of himself and the contents of his mind could be imagined by his mother, it became possible for him to imagine the contents of others' minds, as well as his own. He began to experience himself as "known" and thus, separate. These changes in consolidation and regulation were accompanied by dramatic shifts in affect expression. His somber mood gradually gave way to exuberance, delight, and true pleasure in the world around him.

I believe that my concretely "playing out" aspects of Michael's experience during our sessions contributed to his feelings of being understood and provided him with a means to regulate his anxiety. I made up play scenarios of soldiers getting dirty, messy, and wet and then found ways to "solve" their upset and discomfort. Quite a bit later in our work, I composed stories about experiences that I knew had upset or troubled Michael and "imagined" how he might have felt about them. These are both examples of how play provides a window into internal experience; by imagining Michael's experience through play, I helped him begin to imagine and understand it. I made it real for him through play. In a certain sense, I think that "playing" about his obsessional symptoms may also have provided him the means of containing his fears so that his compulsions became less necessary. In other words, my play brought the experience to a level that allowed it to be symbolized, rather than enacted (Schimek, 1975; Diamond and Blatt, 1994).

Before closing, I would like to briefly consider the role of what I have been calling Michael's "biological vulnerabilities" in derailing or complicating the early mother—child relationship. Certainly by the time I met him, Michael would have been described as a "difficult" child. But to what extent were these qualities intrinsic to Michael, and to what extent did they emerge as a function of the mother—child relationship? Given Julie's description of her early relationship with Michael, it seems possible, if not likely, that whatever temperamental difficulties he brought to their relationship, they were greatly exacerbated by the extent to which she felt overwhelmed, fearful, and angry in her earliest relationship to him. Negative temperament does not—in and of itself—predict either insecure attachment or later emotional disturbance. Insensitive parenting in combination with difficult temperament does (van den Boom, 1994; Belsky, et al., 1998); these children may be particularly susceptible to rearing influence (Belsky, in press). Julie's likely inability to respond sensitively to Michael in his earliest months may well have left him susceptible to extremes of emotional disregulation that—had she been able to regulate his affective experience and remain emotionally available to him—would have rapidly been integrated and contained and leading to a more normal developmental course.

Recent evidence from the domain of neuroscience suggests that the structures of the brain and of regulatory systems are profoundly influenced by the quality of the early relationship (Schore, 1994; Hofer, 1995, 1996), and by the mother's presence...
as regulator of basic physiological systems. Most fascinating is Hofer's (1995) recent report that when 2-week-old infant rat pups are separated from their mothers, there is widespread evidence of disregulation across a number of physiological systems, suggesting the profound import of maternal regulatory functions in the formation of attachment, even in earliest infancy. In particular, infant rats manifest an increase in attachment behaviors, specifically rates of “separation crying” and proximity seeking. These same behaviors, which Hofer suggests are the most evident manifestation of the first anxiety state, are powerfully reduced by a number of antianxiety drugs, including serotonin reuptake inhibitors such as Prozac. Thus, we can speculate that Julie's withdrawal from Michael and her inability to regulate and contain the earliest and what might well have been normally occurring manifestations of attachment and, specifically, the need for proximity, led to a failure of regulation at a biological, systemic level. The neural systems responsible for down-regulating his anxiety and regulating the production of certain neurotransmitters functioned poorly, if at all. As a result of Julie's inability to regulate his earliest anxiety, he was stuck, both behaviorally and neuroanatomically, in a perpetual “separation cry”. Medication, specifically a serotonin reuptake inhibitor, biologically reduced the extremity of Michael's disregulation and made it possible for Julie to approach him and ultimately understand him.

For children like Michael, more flexible approaches to individual therapy, as well as more direct work with parents, are vital to promoting change in the attachment system, as well as in the individual mother and child, even though—as Stern (1995) points out, such situations often seem theoretically and technically complex, if not messy and certainly “impure.” However, as Selma Fraiberg once described so brilliantly, the child's presence in infant—parent psychotherapy brings the child's experience will provide healing and intimacy of yet another order. Representing the child's experience in a way that makes sense to the parent invariably enhances and strengthens the attachment between them because the parents' emergent and differentiated representation increases sensitivity and genuine attunement and thus makes it possible for the child to trust the parent and express himself in an open and clear way.

References


