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Negative Maternal Attributions: Effects on Toddlers' Sense of Self

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BABIES HAVE IMMENSE MEANING for their parents. They are the object of wishes and dreams: through the baby, parents hope to perpetuate the best of themselves and to fulfill what has remained unrealized in their own lives. Babies can also be the recipients of what is most painfully secret in the parents' psyches. When this happens, babies become the carriers of the parents' unconscious fears, impulses, and other repressed or disowned parts of themselves.

This paper focuses on a particular aspect of this phenomenon: how mothers make negative attributions on their young children and how those negative attributions are internalized by the child and become an integral part of the child's sense of self. This intimate process of communication between mother and infant represents a particularly rich area for dialogue between attachment theory and psychoanalysis. This paper has three major goals in striving toward an integration of these two theoretical approaches. One goal is to highlight the contributions of attachment theory to clinical practice through an increasing recognition of the pivotal importance of real-life events, including actual interactions with the mother, in molding the child's inner world and sense of self. A second goal is to underline the clinical relevance of the protective function served by the attachment bond. The quality of the child's primary attachment is a basic building block for infant mental health through the experience of security and trust in the

caregiver and, conversely, can lead to the early development of psychopathology when the attachment figure is perceived as a source of danger as well as the provider of protection (**Bowlby, 1969**, **1973**, **1980**; **Main, 1991**). A third goal of this paper is to expand the notion of internal working models to include not only the set of rules and expectations that forecast attachment relationships, but also the child's psychosexual level of development in the context of the parents' modulation and integration of their own impulses or drives. Such an expansion of the concept of internal working models calls for a more differentiated, specific, and individualized approach to the understanding of patterns of attachment for clinical (as compared to research) purposes. For this to happen, the traditionally psychoanalytic concepts of sexuality and aggression as primary motivating forces need to be fully incorporated into the attachment paradigm (**Lieberman, 1996**, **1997**).

Maternal Attributions in the First Year

Maternal attributions are fixed beliefs that the mother has about the child's existential core, beliefs that she perceives as objective, accurate perceptions of the child's essence. Of course, parents routinely make attributions to their children, and many of these attributions are essential for the child's healthy development (**Dix and Grusec, 1985**). When a mother sees her child as the cutest, most intelligent, most endearing being ever created, she is summoning from the depths of herself the capacity for ecstasy that allows her to put up with the inevitably annoying, exasperating, or simply tedious aspects of raising a child. These attributions are positive and adaptive, both because they give the child a feeling of being adored that serves as an antidote to the frustrations, self-doubts, and despair that he is bound to encounter and also because these positive attributions serve to counterbalance parental rage at the self-sacrifices that are needed to raise a healthy child.

Attributions can be more or less rigid and more or less attuned with reality in the sense that their content may be relatively consistent with the child's own characteristics and developmental stage or frankly bizarre and even delusional. Attributions may also be rather isolated or permeate the mother's entire perception of the child. One mother,

for example, perceived her 3-month-old daughter as so "cunning" that, according to the mother, the baby jumped from her crib to the adjacent parental bed to sneak a feeding at the breast while the mother was asleep and then jumped back to her crib. This was the only explanation the mother could find for her breasts feeling rather empty of milk when she woke up in the morning. This rather bizarre example for the attribution of "cunningness" could be very worrisome, depending on context, but in fact it remained isolated and did not affect the mother's care of her child in visibly maladaptive ways. As she explored her perception of her child's precocity in the light of her otherwise sound knowledge of developmental milestones, this mother came to realize that her attribution of cunningness to her child stemmed from a profound anxiety about not being always available to take care of her and her wish that her daughter could learn to take care of herself if necessary. This dynamic configuration could then be traced back to the severe maternal deprivation experienced by this mother while she was growing up.

Negative maternal attributions can begin with or even before the child's birth. A vivid example of a prenatal attribution involves a mother for whom unfulfilled physical and psychological hungers were a major theme. While she was pregnant, she imagined her baby as demanding and devouring every bit of energy she had, leaving her empty and depleted. When her daughter was 2 days old, she commented: "She is pretty, but she is very greedy." In keeping with her fantasies during pregnancy, this mother misinterpreted her baby daughter's healthy appetite as a sign of voraciousness and worried that there would not be enough nourishment available for the two of them.

Such early negative attributions have a powerful impact on maternal behavior. They help to determine whether and how infant behaviors are responded to, misinterpreted, or ignored. **Daniel Stern (1985)** coined the expression *selective attunement* to describe how mothers share in the subjective experiences of their infants and influence these experiences in ways that correspond to the mother's own internal agenda. By attuning to some subjective states of their babies and not to others, mothers (and fathers) inject their own fantasies, desires, fears, and prohibitions into the baby's rudimentary sense of what they are permitted to feel and what not. **Christopher Bollas (1987)** framed this process using different terms but an equally compelling image by

describing the mother as a “transformational object” who, through her actions, changes the baby's sense of self. When we think of the multiple concrete actions of the mother that transform the baby's subjective experience—from feeding and diapering to soothing a crying baby or engaging a restless baby in play—and when we think of the microscopic moment-to-moment interpretations of the baby's behavior that mothers make before they intervene (**Stern, 1985**, p. 206, calculates that, on the average, there is one maternal attunement per minute), we can really grasp the extent to which the mother's interpretations of the baby and her resulting ministrations become woven into the very texture of a baby's experience of self.

In the case of the mother who saw her 2-day-old daughter as “greedy,” this attribution of greediness had a rather straightforward behavioral expression. The mother let the baby cry for 30 to 40 minutes if the crying occurred while the mother was eating. She first finished her meal, however long it took, and only then tended to her baby. By then the child was often so overwrought and disorganized that she could not be calmed down and choked on the milk the mother tried to feed her. This was interpreted by the mother as evidence that her daughter was overly demanding and had an unrealistic expectation that she should come first.

This mother's attribution of greediness to her daughter and the behaviors through which she expressed it were creating in the child the same frantic need to eat that the mother suffered from. At a very young age, this baby was learning that hunger can be so intense and prolonged and so intertwined with feelings of frustration and abandonment that it cannot be satisfied even when food is finally available. She was also learning that the person she must depend on (i.e., her mother) could become the source of privation and suffering rather than comfort and protection. For this baby, the mother was indeed a transformational object, but one who often transformed average discomfort and bearable hunger pangs into intense agony, rather than well-being, as the baby wailed for the milk that ended up choking her before at long last filling her up.

Experiences like this are encoded at the most visceral, nonverbal levels of the child's sense of self, long before the baby is able to form a mental representation of the mother. The enduring power of these experiences may stem from the fact that maternal attributions tend not

to stop in the first year, unless there is successful therapeutic intervention or other major sources of psychological change. Sometimes the same maternal attribution is visited and revisited on the child throughout his formative years and even into adulthood, for example, a mother who said of her 40-year-old son: “He was a con artist from the day he was born.” Other times, the negative attributions take different expressions as the child's developmental acquisitions elicit different conflicts in the mother. One mother, seeing a squashed bug on her sleeping baby daughter's forehead, said: “This means that her dead father took possession of her.” The same mother believed that her daughter, now a toddler, was oversexualized (“just like her father”) because she touched her vagina. The identification of the child with her dead father remained stable, but the expression of this identification changed with the child's developmental stage.

When specific maternal attributions are a stable component of the mother—child relationship, the child incorporates these attributions into his emerging representations of the mother. Gradually, the maternal attributions come to shape the child's sense of who he is. The children come to see themselves in the ways their mothers see them, and they behave in the ways their mothers expect them to behave. The visceral memories of the first year coalesce into a mental image of who the mother is and who the child is in relation to her (**Lieberman, 1996**).

Maternal Attributions in Toddlerhood

The second and third years of life are a ripe time for eliciting negative maternal attributions because the toddler's capacity to walk alone, use language, engage in symbolic play, and be adamantly self-assertive enable him or her to become an increasingly active partner in the parent's conflicts. Even allowing for pronounced individual differences, during the first year of life, infants' relatively undifferentiated emotional functioning makes them likely to serve as “blank screens” for their parents' projections. In the first year babies are also more likely than older children to accommodate their rhythms and behavior to the parents' demands.

Toddlers, on the contrary, do not always accommodate readily unless one knows how to entice them to. They can decide on their own

when and where to go, and they can say “no” when the parent tries to stop or redirect them. In fact, a major emotional task of this age is to expand and consolidate this new autonomy without jeopardizing the feeling of security that the child derives from the parents' availability. The concept of “secure base behavior” was developed by **Mary Ainsworth (1967)** to portray the comings and goings of well-developing toddlers, who use the mother as the point of departure and move away from her in autonomous explorations when they are feeling rested, confident, and secure and then come back to her side for comfort and reassurance when tired, anxious, or uncertain.

For the toddler, the new capacity to walk alone entails a revolution in her self-concept. In this sense, locomotion represents not only a physical achievement but also a psychological milestone because, in conjunction with language, it brings about a new sense of personal will. As those who have had even minimal contact with toddlers well know, “me do it” is the motto and rallying cry of the toddler years (**Lieberman, 1993**).

This sense of personal will necessarily clashes on many occasions with the parents' agenda. At these times, the renowned negativism of toddlers may surface in full force, with the result that intractable impasses, furious screaming, and temper tantrums may follow (and not only on the toddler's part). But toddlers also have a most endearing quality of admiring adult standards and wanting to live up to them (**Kagan, 1981**). They are eager for adult approval, and they can collapse in tears when the parent frowns on them. In fact, fearing the loss of the parents' love is the salient anxiety of this age.

These developmental considerations help understand the pressure on toddlers to comply with maternal attributions, no matter how negative. Taken together, the age-appropriate wish for approval and its darker side—the fear of losing the parent's love—serve as powerful mechanisms to ensure the toddler's internalization of the mother's attributions.

Maternal Attributions and Projective Identification

The concept of projective identification provides a useful route for the reintegration of sexuality and aggression into attachment relationships

A comprehensive examination of the complex, multifaceted, and often elusive concept of projective identification as explored by numerous theoreticians of psychoanalysis is beyond the scope of this paper. For the specific purposes outlined at the outset, **Ogden's (1982)** description of projective identification is particularly relevant because it captures the essence of how maternal projections and attributions become internalized by the child.

In his book *Projective Identification and Psycho Therapeutic Technique*, **Ogden (1982)** describes projective identification as a three-part process. In the first phase, involving projection, one person attributes or projects an unwanted part of herself onto another person. The projected aspect of oneself may be a dreaded internal object, impulse, or affect state. In the second phase, the projector pressures the recipient of the projection to behave in ways that are consistent with it—in other words, to justify the projection. In the third phase, the recipient of the projection yields to the pressure and behaves in ways that are consistent with the projection.

A consistent feature of projective identification, as described since its inception in Melanie Klein's work, is that it is an unconscious mechanism occurring in fantasy, outside of the realm of language or cognition, and without any explicit link to the real-life mother. **Bion (1961)** expanded this concept by introducing the actual mother as a participant in the development of the internal life of the infant, but he viewed her primarily as a container for the infant's projective identification, in a process that he considered to be the earliest form of infant-mother communication.

Projective identification has become a central concept within psychoanalytic theory and has proven to have considerable clinical relevance. However, it is discussed primarily as a process occurring from child to parent or from patient to analyst. This paper is concerned with parental projective identification, which occurs when a parent cannot tolerate his or her own emotional experience in relation to the child and must rely on excessive projective identificatory mechanisms and fantasies, with the child serving as the repository of parental projections (Lieberman, 1992, **1997**; Seligman, in press).

Whereas projective identification describes primitive, inchoate psychic mechanisms and fantasies, the concept of attribution, originating in a vastly different theoretical paradigm, can be conceptualized

within a psychodynamic perspective as the cognitively organized manifestation of projective identification. Negative parental attributions, pressure to comply, and eventual child compliance with these attributions are cognitive, affective, and behavioral manifestations of coercive parent—child interactions. Together, parental projective identification and parental attributions represent separate, yet mutually influential, psychic levels of organization. They are equally fundamental building blocks for the interactional process that gives shape and meaning to the infant's mental representations of the self in relation to intimate others (**Silverman and Lieberman, 1999**).

A recurrent finding in the content analysis of what mothers attribute to or project onto their toddlers is the relative prevalence of aggressive and sexual themes. From a developmental perspective, it makes sense that maternal attributions to their toddlers are strongly influenced by conflicts around sex and aggression. Toddlers are just learning the power of their anger in the forms, for example, of temper tantrums, striking out, and negativism. They are also learning about their bodies, finding names for their genitals, comparing themselves with their friends and discovering the differences between boys and girls, playing with their genitals and asking their parents to do the same, and parading about delighting in their nakedness and checking to see whether their loved ones also delight in it. In these circumstances, even well-adjusted parents may occasionally find their boundaries under siege. For parents with mental health disturbances, their child's graphic enactment of problems regulating anger or unabashed sexual curiosity and experimentation present even more difficult challenges.

Although impulses or drives are not discrete entities existing in a vacuum, there are times when the maternal attributions are centered either on aggression or on sexuality. Typical examples of primarily aggressive attributions often involve single mothers of boys who have a long history of abusive relationships with their male partners, including the boy's father. These mothers tend to attribute to their sons the same violent impulses acted out by the adult males in their lives. In particular, they misinterpret age-appropriate rambunctiousness as malevolent or out-of-control aggression, and they distort the meaning of angry behaviors on their son's part as evidence that the boy has an aggressive personality core and will grow up to be violent.

These mothers can exert very direct pressure on their sons to comply with their attributions. They tease the boy until he loses control and strikes out; they call him names like “vicious,” “monster,” “devil,” and “evil,” they ignore or ridicule his signals of anxiety and vulnerability by telling him he is pretending or being manipulative; and they are consistently rough and bossy with him. Paradoxically, when their boy does strike out or becomes insolent and disobedient, the mothers are at a loss to put an effective stop to their behavior. In other words, these mothers' treatment of their sons seems unconsciously designed to provoke in their boy the very behavior that they consciously fear and loath. These mothers are giving their boys early and intensive training to become violent adult males when they grow up—just like the males they are attracted to. To the extent that this happens, we can see in these mother-son relationships the earliest substrate of domestic violence.

Just as there are attributions that are concerned with aggression, there are also attributions that are focused primarily on sexuality. To give a rather extreme example: one mother described her 22-month-old daughter as a “sexy girl who needs silk stockings” and regretted that the child's father, in her own words, “bought her straight-leg Levis instead of curved ones that can show off her femininity.”

It needs to be understood that a clear-cut attributional focus on sexuality does not mean that aggression plays no role in the relationship, and similarly, attributions focused on aggression do not mean that sexual issues never appear. Nevertheless, when attributions are fixed on one theme or the other, the child is the carrier of the mother's conflict in this particular area, and other issues can come and go more flexibly, depending on the particular developmental stage and source of stress at hand. For example, the mother who wanted silk stockings for her little girl often got very angry with her child, but she did not make inappropriate attributions around aggression in the sense that she did not see the *child* as inherently aggressive; she knew that it was *she* who was angry, not the child. When it came to sexuality, on the other hand, she saw the *child* as a sexual object and treated her accordingly. There are other cases where maternal attributions involve both sexuality and aggression, as illustrated in the clinical illustration that follows.

Clinical Illustration

This case involves a Caucasian 20-year-old single mother, Alana, and her daughter Saphire, 13 months old. They were treated at the Infant—Parent Program of the University of California San Francisco General Hospital, an infant mental health program providing infant—parent psychotherapy to infants under 3 years of age and their families in situations of abuse, neglect, and attachment disorders.

Infant—parent psychotherapy is a multimodal, psychoanalytically oriented form of treatment originally developed by **Selma Fraiberg (1980)** and based on the notion that parent—infant relationship disorders involve unresolved psychological conflicts that the parent reexperiences in relation to the baby. The baby is seen as a transference object that becomes the target of the parent's displaced or projected affect. The goal of infant-parent psychotherapy is to free the baby from engulfment in the parental conflicts, which are likened to "ghosts in the nursery" that paralyze the normative unfolding of the parent's loving emotional involvement with the child.

The hallmark of infant-parent psychotherapy is the child's presence during the sessions in order to observe and address in the moment the affective distortions originating in the parent's conflicts. Therapeutic interventions take a variety of forms depending on clinical need, and may involve any of four major modalities, including crisis intervention, emotional support, nondidactic emotional guidance, and insight-oriented interpretations linking the parent's present experience of the infant with unresolved and conflict-laden childhood experiences. A large literature on infant-parent psychotherapy documents the modifications brought about by sociological changes and by current theoretical and clinical paradigms such as attachment theory and innovations within psychoanalysis (see, for example, **Lieberman, 1991**; **Lieberman and Pawl, 1993**; **Seligman, 1994**; **Pawl and Lieberman, 1997**).

The immediate reason for Alana and Saphire's referral was the mother's intense anger at her 13-month-old daughter's refusal to continue breastfeeding. This refusal began at about 12 months of age. When Alana offered the breast, Saphire pushed it away, pinched it, or hit it. This enraged the mother so much that on several occasions she slapped Saphire's face and one time even bit her back in retaliation for the child's biting her breast. Alana said angrily that she wanted

Saphire to breastfeed until she was old enough to say in words that she wanted to stop breast feeding. To her credit, Alana was so upset by hitting Saphire that she called the child abuse hotline, which in turn referred her to the Infant-Parent Program.

As usually happens, the initial reason for referral turned out to be a very small component of the conflict between mother and child. Alana had an alternative lifestyle that included homosexual and heterosexual relationships, and she reported having sex in front of the child because it was the "natural thing to do," and she did not want Saphire, in her words, to grow up like herself, inhibited about sex. She also reported French kissing with the child and kissing the child's buttocks. In the therapist's presence, Alana often asked her daughter for a kiss. There was an urgent and sometimes dramatic quality to this request. Alana would say, for example: "Saphire, I need a kiss this very moment," or "You are so delightful, I really must kiss you right now." The child sometimes complied and other times simply shook her head in an eloquent "no." When refused, Alana often made a big show of being desperate for a kiss and begged for one. On rare occasions, she even kissed Saphire against the child's will. At these times Saphire either pushed her back or yielded with an enigmatic little smile. On one particular session, when Alana kept grabbing and kissing Saphire, the child finally yelled "no" and slapped her in the face. After this happened, the mother turned ruefully to the therapist and said: "She is so irresistible, all I want to do is kiss her."

One could say that Alana was sexually obsessed with Saphire. But she was also constantly on the verge of physically abusing her, and she often left the child alone in the house in order to put some safe distance between Saphire and herself when she feared losing control of her anger. In session after session, Alana described episodes in which she screamed at Saphire or slapped her hard. She was extremely despondent and loathed herself after such incidents. Once she confided: "I always knew that I would create a child that would hate me."

Paradoxically, Alana was consciously very protective of Saphire when other people came in contact with her daughter. Once, when taking the child for routine immunizations, she almost got into a fist fight with the nurse, who supposedly was too rough during the procedure. Every night she insisted that her boyfriend bathe Saphire, and as he took the child to the bathroom she warned him: "Don't you abuse

my child now." Yet her blindspots around appropriate protectiveness were glaring: she planned to hire an alcoholic friend of hers to provide regular childcare because he had been sexually abused while growing up and would know not to inflict such a terrible experience on a child.

Alana's sexualized behavior toward Saphire was largely egosyntonic. When both the infant-parent psychotherapist and her individual therapist (whom she saw only intermittemly) independently told her that French kissing, kissing the child's buttocks, and having sex in front of Saphire were all extremely inappropriate, Alana disagreed vehemently, complained that both therapists were straightlaced bourgeois matrons making a big deal out of nothing, and said she would stop kissing Saphire as soon as she felt sexually aroused while doing it. As for having sex in Saphire's presence, she said: "Saphire likes it." In contrast, Alana's aggressive feelings toward her daughter were invariably ego-dystonic, and she often expressed suicidal ideations after hitting Saphire.

In both kinds of situations, however, Alana believed firmly that it was Saphire who was responsible for the strong feelings she experienced toward her child. She thought that her daughter was "irresistibly seductive" as an objective trait. In her answering machine, her message said: "Hello, you have reached the household of Alana and of Saphire, the Love Goddess." We could think of this as an ostensibly positive attribution, but one that pressured the child to become excessively and precociously sexualized and could therefore be as disastrous for her mental health as a frankly negative attribution. Alana also believed that Saphire was by nature rebellious, aggressive and determined to have her own way.

Where could these attributions have originated? As treatment proceeded, we learned that Alana had struggled for many years with self-mutilating tendencies. She often cut her arm compulsively during her adolescence. That behavior had stopped, but she still stuck Q-tips deeply into her ear and poked until her ears bled. Soon after the beginning of treatment, she developed an ear infection and dizziness so severe that her doctor feared she would develop hearing loss. Alana also reported a long history of suicidal ideations and suicide attempts and explained that she had decided to become pregnant with Saphire in order not to commit suicide.

Alana had many clear memories of her childhood. Her father, whom she adored, died of syphilis when she was 5 years old. He had become demented as a result of his illness and often attacked Alana brutally, only to become loving and available when his rage subsided. When he died, Alana's mother took in male boarders who slept in Alana's room. Many of them asked her to take her clothes off and touched her all over, including her genitals. Although she denied having intercourse before age 18, she said she had an older lover at age 13 with whom she did "everything but." Alana remembered often feeling confused by the sexual feelings combined with fear and loathing that she experienced with the male boarders. She also reported that, when she told her mother about the abuse, the mother accused her of lying and forced her to apologize to the boarders. Alana's conflicts with sexuality and aggression, her confusion over appropriate boundaries, and her self-punitiveness could be readily understood in the light of this history.

How did Saphire fare in the midst of this chaotic mothering context? Rather better than one would anticipate, perhaps because of a combination of her mother's unmistakable, if distorted, love for her and the child's own very high native intelligence and resilience. Nevertheless, there was clear evidence that Saphire had begun to yield to her mother's pressure to comply with the dual set of attributions as being aggressive as well as a Love Goddess. Saphire often hit and bit her mother and pushed her away. She had started picking at her lips until they bled, much as her mother picked at her own ears. She sometimes displayed a driven sexualization in her behavior. Several times she walked down the street pointing explicitly at the crotches of male passersby, saying "penis!" in a loud voice. Her behavior during one session was particularly worrisome in this regard. Alana was telling the therapist yet again how much she liked kissing Saphire's buttocks. She added that she had promised Saphire to let the child watch a favorite television program if Saphire let her kiss her buttocks. The therapist, shocked and struggling to help the mother understand the coercive nature of her suggestion, said rather awkwardly: "What would you think if *I* told Saphire that?" Saphire, playing on her own nearby, instantly perked up, came close to the therapist, and said smilingly: "OK." When the therapist told Saphire that her buttocks

were private and she would not kiss them, Saphire looked crestfallen and averted her eyes. This exchange taught us, ominously, that Saphire was ready to trade the toddler equivalent of sexual favors to get something that she wanted and that she experienced the therapist's refusal as a narcissistic injury. Clearly, Saphire had begun to internalize her mother's exploitive and self-victimizing attitudes toward sexuality into her sense of self.

At the same time, Saphire also fought courageously to preserve areas of personal autonomy. Her aggression toward her mother occurred most often when this was the only means to fend off Alana's intrusiveness—for example, when she bit the breast that was being thrust into her mouth in spite of her clear signals, such as head aversion, pushing away, and saying "no," that she did not want it. But Saphire could also be more subtle in her efforts at preserving an internal space that was free of her mother's overpowering pressures. At 3 years, 2 months of age, after 2 years of treatment, the therapist asked her why she insisted on wearing diapers to bed even though she stayed dry during the night. Saphire answered: "If I don't wear diapers, my mom will forget I'm a little girl." This child knew that her mother was pressuring her to grow up sexually much faster then she was ready to, and she consciously looked for ways to remind her mother that she was still a little girl.

How are we to treat this kind of psychopathology in the mother—child relationship? How do we help a mother to develop more age-appropriate, less psychologically taxing perceptions of her child? And how do we help to strengthen the child's coping mechanisms so that she can better withstand the pressure to yield to the mother's negative attributions and chaotic, unpredictable patterns of relating to the child?

Clearly, there are no easy answers because the course of treatment is never predictable and because different families present different therapeutic dilemmas as well as pleasant surprises in their capacity to growth. One of the pioneering insights offered by **Fraiberg (1980)** is that a parent's emotional investment in her child can be so powerful as to allow for therapeutic progress in infant-parent psychotherapy even in situations when the parent's diagnostic profile is such that sustained improvement in traditional individual psychotherapy is believed unlikely, as is the case with the diagnoses of Borderline Personality

Disorder or Complex Post-Traumatic Stress Disorder that describe Alana's psychopathology. Indeed, Alana's love for Saphire led her to heroic efforts to change for the sake of her child. Highlights of the treatment modalities used in this case are described below.

The first job of the therapist was to remain as conscious as possible of intense countertransference reactions in order to contain her strong indignation and wishes to punish Alana for her behavior toward her child. While the maternal behaviors and attitudes were truly damaging, it was also clear that Alana was extremely vigilant to any sign of criticism, and she either got angry or withdrew from treatment for weeks when she thought the therapist disapproved of her. It was imperative for the therapist to take the time to build a secure container for the work to be done. This meant that the therapist needed to harden herself to withstand repeated assaults on her own sense of what a child needs and deserves without retaliating by assaulting the mother.

Building a secure container did not mean colluding with the mother and acquiescing with her negative attributions and the appalling behaviors that resulted from them. From the beginning, the therapist said very clearly and nonaccusingly that it was confusing and overexciting for Saphire to be kissed in the mouth and the buttocks and to witness sex between her mother and various boyfriends, that it was dangerous and scary for her to be left alone in the house, and that witnessing the mother's outbursts of physical attacks on her boyfriends and altercations with people on the street made her scared of her mother and fueled her own aggression. These remarks were said by the therapist factually, with deep concern, but without anger.

The effort to build a safe container also took a rather unorthodox turn. As we learned that the therapist's advice was not enough to change Alana's behavior, by the sixth session the therapist told Alana that she was concerned about her treatment of Saphire and would need to make a Child Protective Services referral. The therapist explained that she believed this would help by giving Alana an external reminder of the limits of what was acceptable parental behavior in raising a child. Alana took this referral rather well. She acknowledged that she was angry, but added: “You are just doing your job,” and went along quite compliantly with the investigation, which resulted in a voluntary agreement with Child Protective Services to stay in infant-parent psychotherapy and to meet regularly with the child

welfare worker. It is quite possible that Alana felt relief in getting such a clear message that there were certain boundaries that needed strict enforcement.

A second aspect of the work involved the therapist's ongoing efforts to learn more about Alana's past and about aspects of her current life outside of mothering in order to understand better the dynamics of her behavior toward Saphire. It was through tactful, but persistent, questioning that the therapist learned about the specifics of Alana's physical and sexual abuse when she was growing up, her mother's exploitation of her as a sex object for her boarders, her self-mutilating behavior, and her uncontained aggression in her everyday life. This knowledge helped to formulate the two basic hypotheses that guided the treatment. One hypothesis was that Alana needed to feel things intensely in her body for emotional experiences to feel real. The second hypothesis was that Alana had no sense of boundaries just as some people have no sense of right and wrong, because the teaching of these basic cultural constructs did not take place during the developmental period when children are ready to learn them. The corollary of this hypothesis was that now was the time to teach Alana about boundaries.

These two hypotheses informed the treatment plan. The first goal was to help Alana recognize when she was craving emotional intimacy by putting herself through extreme body experiences like picking physical fights, engaging in wild sex, or mutilating herself. The second goal was to help her recognize the ways in which sex and violence were intertwined with each other in her experience. The third goal, which was pursued through straightforward developmental guidance, was to teach Alana when what she was doing with her daughter was inappropriate and damaging, while explaining at the same time that she had no way of knowing this because of the way she was raised, and now was the time to learn it.

Saphire was present in the sessions during most of the time. Her role became increasingly more active in the course of the 2 years of treatment, as she became more verbal and able to articulate her plight. The therapist moved back and forth between the mother's and the child's experience, trying to help Alana become more aware of her impact on Saphire and at the same time explaining to Saphire, in ageappropriate

terms, her mother's efforts to come to grips with her anger and with her wishes to kiss Saphire “all the time.”

This treatment was successful in many ways. By the time Saphire was 2 years old (8 months into the treatment), Alana had stopped hitting Saphire. She also stopped having sex in front of the child and went so far as to sit on her hands in order to stop herself when the urge to grab and kiss Saphire seized her at an inappropriate time. A few months later she largely stopped having physical fights in front of Saphire, and the frequency of the fights declined altogether. By the end of treatment, when Saphire was 3½ years old, Alana had become so protective of boundaries that she took the initiative to ask for times alone with the therapist when she wanted to discuss a topic that was inappropriate for Saphire to hear. Recognizing that her problems were chronic and severe, Alana started individual psychotherapy on a regular basis to find help with her many sources of pain. But she had learned that her struggles belonged to her, not to Saphire, and that realization made a big difference for this child's mental health. Most tellingly, the message in the answering machine no longer made reference to Saphire, the Love Goddess.

Perhaps the most tangible expression of Alana's newly found ability to think of Saphire as a separate person with her own needs was her decision to enroll the child in preschool. For a long time, Alana had rejected all suggestions that Saphire might be ready for peer group experiences out of the home because she did not know how she would spend her days without Saphire to give her a sense of meaning. (It should be remembered that Alana reported that she became pregnant in order not to commit suicide.) In a masterful internal compromise, she chose for her daughter a cooperative nursery school where she needed to volunteer twice a week, and she took great pains to become a team member with the other parents in spite of her painful feeling of being an unwelcome outsider wherever she went.

Saphire adjusted well to nursery school, made friends, was liked by her teachers, and took pleasure in learning. Her aggressive behavior was mostly well contained, with occasional outbursts of quick hitting or pushing away when her autonomy was threatened by somebody else's persistent demands. Similarly, her sexualized behavior declined

markedly and seemed to be well within the normative range, although she retained a certain coquettishness, which could range from charming to stilted and manipulative, depending on how pressured she felt to please or to get something she wanted. These defensive postures did not detract from an overall spontaneity of pleasure in exploration of the interpersonal and the inanimate worlds.

Alana's negative attributions to Saphire were not addressed directly in the therapy, but they disappeared without leaving a trace. In this sense, negative maternal attributions can be considered as symptoms, to be used as guides that point out where the psychological conflict resides rather than as targets for direct intervention. On the other hand, direct attention was given to the damaging maternal behavior because Alana was able to tolerate it and because change in this area was imperative to give Saphire a more nurturing and protective experience of human relationships.

Conclusion

At a theoretical level, cases such as this illustrate the happy emerging convergence of attachment theory and psychoanalysis in expanding and enriching clinical understanding. The vicissitudes of the attachment relationship are played out in other areas of the child's functioning—in Saphire's case, sexuality and aggression—and profoundly shape the child's experience of herself and of others. In this sense, attachment theory gives us a point of view and a vocabulary that greatly enhance our appreciation for the psychological centrality of the concept of security and its origins in developmentally appropriate maternal responsiveness, so that the outer world becomes transformed into psychological reality. In this sense, attachment theory has the function of a magnifying lens, allowing us to detect the microprocesses that comprise the foundation for a sense of trust and emotional security and well-being or their reverse—suspicion, alienation, detachment, emotional emptiness, and fear.

The case of Alana and Saphire also illustrates how maternal projections of sexual and aggressive impulses affect the child's working model of attachment and the self and how impulses, affects, and fantasies are woven into the very texture of internal working models. These processes highlight the need to expand the concept of

internal working models to include aspects of impulse, drive, and affect not usually associated with the set of rules and expectations that shape and forecast attachment relationships. **Bowlby (1980)** thought of internal working models as open to change and revision under the influence of new developmental stages and new experiences. The integration of sexuality and aggression as primary motivational systems in a complex and evolving relationship with the attachment motivational system should enrich and expand the clinical usefulness of the concept. Psychoanalysis has given us a visceral appreciation for the passion and the struggle of being human that is unmatched by any other psychology to date. It provides a magnifying lens on our raw impulses, perhaps less welcome at times, but essential to use in conjunction with the lens of attachment theory if we are to attain bifocal vision.

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