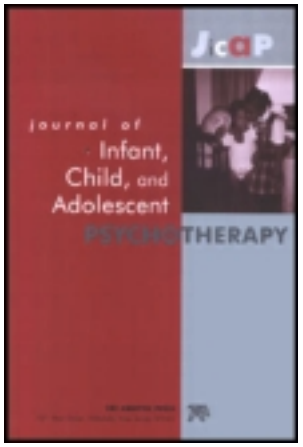

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The Development of Reflective Functioning in a Mother Traumatized by Past and Present Events: Facilitating Change in the Parent-Infant Relationship

Tricia Stern

This article presents clinical work with a woman who experienced trauma in both her childhood and adult life and who demonstrated poor reflective functioning. Treatment began during the patient's pregnancy and continued with dyadic work with mother and baby in an effort to help the patient address and reflect on past and current life stressors and to develop a healthy mother-child relationship. A review of reflective functioning precedes the case material.

This article describes the work with Natalie that began during her pregnancy with her fourth child and moved into dyadic work once the baby was born. The patient identified her reason for coming to treatment as needing help with panic attacks that she was experiencing, particularly around finding a job. At the beginning of treatment, Natalie's thinking was concrete and fragmented, and she was unable to reflect on her own feelings and behavior as well as those of others. She could not make connections between her current life and past history, nor describe her life and present situation in a way that I could easily follow. It took many months before I heard of major life events and was able to place them in a coherent context. In thinking about the work retrospectively, the treatment has helped Natalie develop reflective functioning which in turn has created change in her relationship with her baby.

Reflective functioning or mentalization is a developmental acquisition that enables individuals to understand their own mental states as well as those of others (Fonagy & Target, 1997). Through understanding what both self and other are thinking, feeling, believing, and desiring, one is better able to regulate one's own emotions and behavior as well as find another's more meaningful and predictable. Reflective functioning allows for the awareness that an individual's behavior is an expression of underlying, unobservable, changing, and dynamic intentions and emotions (Slade, 2002).

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Reflective capacity develops as a function of interpersonal experience and begins with affective attunement between parent and baby (Fonagy, Steele, Steele, Moran, & Higgit, 1991). A parent's capacity to hold in her own mind the notion that her child has feelings, desires, and intentions provides a secure base for the child to discover his own internal experience via his parent's experience (Slade, 2002). When a parent is able to link the child's mental states with the child's behavior, she then can respond empathically, which helps the child with self-regulation and creates a link for the child between mental states and behavior. As Gold (2011) observes, a baby comes to realize that "when you think about me, I understand myself." The parent's capacity to appreciate the dynamics of her own affective experience is also regulating for the parent and allows the parent to respond sensitively based on the child's intentions and feelings without being overwhelmed by her own distress (Slade, 2002; Gold).

A parent's inability to hold the child in mind this way can compromise reflective functioning for the child as an adult. Additionally, external stressors can interfere with reflective function: from a neurobiological perspective, attention is prevented from being directed inwardly toward one's own mind or that of another's (Pally, 2012) because energies are spent addressing whatever in the environment needs attention. Trauma, in particular, interferes with the development of reflective capacities because it hinders stable, coherent representations of self and other (Slade et al., 2005). As Moskowitz (2011) notes, trauma has a disruptive effect on mothers' minds and disrupts their capacity to be preoccupied, in Winnicott's sense (1956), with their infants. The typical feeling of loss of control of one's body brought on during pregnancy becomes heightened due to the trauma, particularly if the mother's body was a source of trauma, causing great difficulty in being attuned to their babies (Moskowitz; Slade et al. 2005).

Adults who have not developed a reflective capacity, particularly those who have been traumatized, suffer detrimental consequences to their own senses of self and to their roles as parents. Steele and Steele (2008) demonstrate that individuals with low reflective functioning skills often avoid the range and intensity of human feelings, leaving them with limited understanding of their own emotions and of the causes and consequences of their behavior. Such individuals experience the psychological world in terms of basic, poorly integrated states of mind. Affect regulation becomes more difficult and the social and emotional life more stressful (Fonagy, Gergely, Jurist, & Target, 2002). Bach (2001) notes how not being held in a parent's mind as a child can lead to problems with memory and profound anxieties and phobias in adulthood.

Having a diminished reflective capacity not only limits one's ability to think about one's own emotions and behavior but creates an incapacity to understand that others have minds and a reduced understanding of self-other motivations and feelings (Fonagy et al., 1991). Those with this diminished capacity lack interest in exploring the internal world of their parents and children (Steele & Steele, 2008) and can be unable to recognize their child's essential needs or physical states (Slade et al., 2005). A traumatized parent with poor reflective functioning often distorts or misattributes their child's cues and behaviors as overwhelming and provocative (Slade et al.).

Poor reflective functioning impacts the parent-child relationship and the child's regulation (Fonagy et al., 2002). If a caregiver is unable to think of her child's feelings or intentions and either misinterprets or ignores them, the infant "is left in a noxious state of disequilibrium from which he or she seeks alleviation" (Fonagy et al., 1991, p. 206). Fraiberg (1982) notes the baby is then left to regulate her affect through pathological defenses such as avoidance, freezing, fighting, or through transformation of affect.

PAST AND CURRENT HISTORY OF TRAUMA

It took many months to understand the chronology of Natalie's past as she presented a fragmented history. Her concrete thinking and the disconnected and disparate content of treatment sessions made it difficult to piece together a coherent story. Over time Natalie began to share shocking and upsetting details of her life.

Natalie was 42 years old and 5 months pregnant with her fourth child when she entered treatment. She had immigrated three and a half years earlier from South America with her husband and three children as her husband had found work in the restaurant business. Natalie wanted to find work herself and was trying to complete job applications. Her stated reason for coming to therapy was that she began experiencing panic attacks when leaving her home country and these attacks and her anxiety had increased in frequency, almost completely incapacitating her as she tried to complete job applications.

More than a year prior to starting treatment Natalie had been diagnosed with breast cancer and had a total mastectomy and reconstruction of her left breast. When she learned that women from Latin America are the second highest ethnic group to have an increased incidence of having the BRCA gene which produces a hereditary breast-ovarian cancer syndrome, Natalie was tested. She learned that she did have this gene, which she stated put her at high risk for cancer of the other breast as well as for ovarian cancer. Her doctors recommended she have a complete hysterectomy and removal of the other breast. However, Natalie desperately wanted a fourth child and became pregnant, postponing the surgery and putting her health at risk. Natalie shared these details about her health and the risks involved with the pregnancy almost incidentally; her main anxieties were the job applications and her uncertainty in finding work.

As Natalie talked over time about her husband, she presented him as emotionally removed. She stated he put a lot of pressure on her to find work and did not understand why the process was so difficult for her. Natalie shared that he had also not been a source of support to her regarding her diagnoses, treatments, and surgery.

Over the course of several months of treatment, Natalie gradually revealed more about her family of origin. Her father was, and continues to be, verbally and emotionally abusive to her mother, her maternal grandmother, her siblings, and Natalie herself. In trying to cope with her husband's constant abuse, Natalie's mother would, and still does, sleep all day and stay up at night. Natalie's youngest sibling is mentally ill, depressed, and suicidal. He continues to live with Natalie's parents, never finishing school or working.

During Natalie's pregnancy while in treatment, her doctors became concerned that Natalie had developed a tumor in her right breast. This discovery was a cause of some anxiety and allowed attention in sessions to turn to her body and soon-to-be born baby. Nevertheless, Natalie forgot to call me to let me know that the tumor was benign, saying when we spoke that it was ok and she did not want to think about it any longer. In this way, she closed herself off to her body and to the ongoing connection with me, and I felt left to hold the anxiety about her health and the coming baby.

Additionally, Natalie's amniotic fluid stayed very low throughout the pregnancy and Natalie would share this in a matter of fact way week after week and I again found myself containing the fear and anxiety about the baby's well-being. When Natalie was 36 weeks pregnant, I received a message from her stating that she was not able to make our appointment. When I called back

to propose an alternate date her oldest child told me that Natalie was at the hospital giving birth. I was not able to speak with her until a week later and when we first spoke she was worried that I was waiting for her to come to therapy and apologized for not calling me to tell me she could not come to see me. We talked about this for several minutes before I asked if she had the baby. She said she did, that she was induced because there was almost no fluid left and that she gave birth to a baby girl, Ella. Natalie said that Ella is very sweet yet not sleeping through the night.

When Natalie was pregnant her doctors had cautioned her that the outside limit to have the mastectomy of the other breast and the hysterectomy was six months postpartum. Natalie was informed that she would need to stop nursing one month prior to the surgery. Natalie delayed having the surgeries until Ella was 8 months old because she found it hard physically and emotionally to give up nursing. This decision again put her health in jeopardy, yet nursing was very important to Natalie and was the only way she felt connected and giving to her baby. There were several times in treatment during the weaning process where she would feed Ella in front of me even though she told me she was "not supposed to."

When Natalie did have the surgery it went well and no breast or ovarian cancer was found. However, Natalie learned that she was at high risk for pancreatic cancer and must be checked every six months for the rest of her life.

In coming to treatment, Natalie was dealing with multiple traumas: her abusive childhood, the loss of her country, her illness and surgeries, and the injuries to her identity as a woman and a mother. The effect of these traumas on Natalie's thinking and emotional life prevented her from focusing on her baby during pregnancy and after she gave birth.

I saw Natalie almost every week before she gave birth, and afterwards I met with Natalie and Ella together weekly with the exception of two sessions after her surgery when she came alone. Treatment stopped again for two weeks when she had reconstructive surgery five months after the mastectomy and hysterectomy.

INDIVIDUAL TREATMENT DURING PREGNANCY

Natalie exhibited many of the consequences of poor reflective functioning. When she was pregnant, she had difficulty identifying any feelings related to the many stressors in her life. She would resist my naming them. She highlighted concrete facts and pushed away emotions. She lacked an ability to talk about her own feelings of loss, anger, or disappointment at the diagnosis or to wonder about the impact on her or her children.

Natalie could not make sense of why anyone in her life acted the way they did. She was unable to understand motivations of family members, friends or people with whom she had limited interactions. Instead of thinking about feelings or motivations of others she attributed any change in friends or acquaintances to concrete facts, such as that they were American. Natalie also had a difficult time imagining her children could be affected by her cancer diagnosis, pregnancy or surgeries. She continually told me, "I really don't think they care."

Natalie also was unable to think about her own parents in a reflective way. She did not want to try to understand them and felt guilty anytime she said anything bad about them. Natalie would push away any attempt to better understand her mother's experience of living with her abusive father. Natalie said she could not even say or write the words that her father used toward her mother, her grandmother, her siblings, and herself. In the beginning of treatment, Natalie would

reject my attempts to say how hard it must have been for her, her mother, grandmother, or siblings, and she would not want to explore the impact of her father's verbal abuse on anyone. From our first session, when talking about her father, she would list the things he did or said that were hurtful but would then remark that she should not talk that way because he was very good to her and helped her out and that she needed him. In addition to not being able to explore her parents' minds, Natalie could not remember much about her childhood. She had what she called 'flashes' but could not relate a single childhood experience.

In trying to help Natalie understand her own feelings and thoughts, I realized retrospectively that I was improving her reflective capacity. The first thing that seemed to help Natalie be comfortable understanding that others have minds was helping her think about my own mind. Spezzano (2005) talks about this as the patient finding a home in the therapist's mind. From the very first session with Natalie, I showed her some of the workings of my mind. I noticed she responded with interest to comments that began with my saying, "I wonder if" or "I'm wondering." By hearing me phrase comments this way, Natalie seemed to be able to see my mind as a psychic environment or home (Spezzano, 2007), and she began to feel encouraged to think or wonder about what was going on in another's mind. By phrasing comments this way, it appeared that I was able to show Natalie that I was keeping her in my mind, an experience entirely new to her. This first experience of having another mind reflecting on her own seemed to help Natalie begin to think about her own mental state as well as that of others (Baradon, 2005) and experience herself existing in my mind as an internal object to whom I could relate (Spezzano, 2005). This change, while small, seemed evident from the first session. While Natalie initially resisted or fought what I was wondering about, she ended the first session with the comment, "I'm starting to wonder about that too." The seeds were planted for Natalie to start reflecting about herself and others. My trying to understand Natalie's thinking and communication demonstrated to Natalie my interest and concern for her and helped her clarify her own thoughts and feelings (Baradon).

This pattern in our sessions continued: I would wonder about her, her feelings as well as that of others in her life; Natalie would first resist but would end sessions with comments like, "You're trying to figure me out," "I never thought about that before," "I want to keep thinking about what you said," or "I wonder if I'm not feeling it because I'm denying something." About a month and a half into treatment, Natalie came into a session saying she was thinking about what we had discussed last session and that she was not convinced by a connection I had made. I took as a significant indication of growth that Natalie was letting me know that she was thinking about her own feelings and motivations and she had thought about something I had said a week earlier, was trying to make sense of it, and could imagine that I could handle her disagreement. As Spezzano (2005) points out, it is important for a therapist to demonstrate that she can tolerate being a 'bad object' in the patient's mind.

Whereas at the beginning of treatment Natalie would want me to tell her what to do, she now began to ask me my thoughts when she could not make sense of something and would expect us to reflect on it together. She also started to ask me why I was asking certain questions, and she wanted to know what connections I was making. By doing this together, Natalie and I co-created new scripts that allowed her to make better sense of events in her world and her thinking (Spezzano, 2005).

I tried to provide some sense of continuity and organization to Natalie's thoughts, behavior and experiences (Bach, 2001). I would note Natalie's comments from previous sessions or from her history and link them to current comments or behavior. Natalie responded strongly when I would

make these connections. She often remarked, "I can't believe you remember that" or "How do you remember that?" or "You remember everything I talk about; I don't even remember what I say." As Bach notes, by remembering Natalie and her thoughts, feelings, and experiences, I showed her that I kept her alive in my mind in a continuous way. This helped her to feel connected to her own various experiences as well as to me.

I also demonstrated to Natalie that I was a "secure base" (Bowlby, 1988) who kept her in mind in other ways, too. After each session, Natalie would ask for my card with her appointment time on it for the next week, even if it was her usual appointment time. I understood this request as Natalie needing something concrete akin to a baby's transitional object to take me and our work together with her. Providing this secure base for Natalie allowed us to better explore her feelings together and make sense of them.

In the beginning of treatment, every time Natalie shared a feeling she felt was negative, she would quickly talk herself out of it when I repeated it. About three months into treatment, I introduced the idea that it is possible to feel more than one feeling at a time, even if they are contradictory. This concept was very difficult for Natalie to accept. As a practicing Roman Catholic, she worried that if she focused on the bad feelings or if she showed fear or complained rather than concentrating on the miracle of getting pregnant, God would think that she was ungrateful and would punish her or let her die. We started talking about the difference between feeling something and acting on it. I tried to identify certain situations or experiences where she felt more than one feeling and helped her stay with the feelings. When she talked about her family of origin, I would try to name feelings I imagined she had as a child.

I also realized that Natalie used her religion as what Spezzano (2005) calls a "home for the mind," as a defense against chaos and a way to feel contained. I realized that Natalie's faith was the only container she had, and I utilized it to help her. In trying to have her understand it is possible and healthy to feel several things at once, I pointed out that one thanks God for blessings but also asks for better health, peace and understanding. This way of working seemed to allow Natalie to open herself up to her feelings without guilt or fear of being punished. Eventually she no longer denied negative feelings nor seemed to fear God as much. By connecting to Natalie's faith, I showed her that I wanted to try to understand her and I respected her beliefs.

As Natalie felt more comfortable and less afraid to express her feelings, she found it easier to remember more of her past. She began to talk more about her maternal grandmother and how important she was to her and how horrible her father had been to his mother-in-law. She told me that her whole family was in therapy because of her father when it is he who should be in therapy. She began to reflect on her mother's behavior growing up and wondered if her mother was depressed and if that was why she had her kids do everything, including make their own meals. Natalie was eventually able to share how she was hurt by both parents: by her father for how hard he is on her and by her mother for not being there to take care of her as a child and for not helping her now that she has children of her own. Natalie was able to tolerate loving her mother and being angry at her for not giving her what she needed. As treatment progressed, Natalie realized that she did not need her father financially and, more importantly, emotionally. This realization was a big step for her, one which I continued to point out to her.

Remembering and connecting to feelings led her to reflect on the behavior of others. She might begin a session by telling me about a disagreement she had with a friend, and we would think together about what she and her friend were thinking and feeling. We talked about what her

friend's motivations might have been and about not responding to the details of what the friend said but rather sharing how the experience made Natalie feel.

We also began to reflect together on Natalie's children. Natalie was projecting a lot onto her oldest child, whom she felt did not care about her, her feelings, or her cancer. I gently wondered what her son was feeling, and said I found it hard to believe he was not affected by Natalie's cancer, pregnancy, or surgeries. We also talked about different ways to discipline, and I introduced the term "firm" rather than "strict" or "tough" when talking about boundary setting. We were able to reflect what a difficult time Natalie had in creating structure and boundaries because when she did she felt that she was being harsh like her father. We began to explore the difference between being punitive and setting limits to help her children. In describing a situation involving her oldest child, Natalie stated that "he is having both good and bad feelings, and I've realized from coming here that that's ok and it's normal."

Despite significant changes in Natalie's level of anxiety and other changes, Natalie's pregnancy and the seriousness of her illness were areas where her thinking remained concrete. She continually repeated how "desperate" she was to have a fourth child yet would block any attempts by me to better understand this deep wish, especially given the great risk another pregnancy posed to her health. When I imagined her being fearful about her health, Natalie denied these feelings and only said that this pregnancy was a "miracle." The only feeling she had was that she felt blessed. She was unwilling to let herself feel any other feeling. Even when the doctor found a lump in her other breast and she was waiting for biopsy results, she continued to say she did not feel fear.

At the end of her pregnancy when faced with decreasing amniotic fluid, Natalie also did not follow her obstetrician's recommendations to rest and drink more water. Natalie could not reflect on her inability to adhere to these instructions and would only say it was difficult to slow down. Natalie would deny my wondering if she had concerns about the baby's health. She would never physically or emotionally reference the baby and could not think about the reality of the baby entering the world.

DYADIC TREATMENT WITH PATIENT AND HER BABY

Given Natalie's difficulty seeing other's minds, particularly those of her older children, and her denial of the risks associated with her pregnancy, I had concern that Natalie would not be able to keep her new baby in mind. I believed that seeing Natalie in treatment with the baby would provide opportunities to help Natalie 'see' her baby as a person with her own thoughts, feelings, and motivations. Natalie agreed to the dyadic work, although it was not clear that she understood my reasons. She mainly seemed motivated to bring Ella because she had no one to watch the baby.

Seeing mother and baby together became increasingly important as it became clear that the only connection Natalie felt able to make with Ella was through breastfeeding, and this would have to stop in a few months as she prepared for the second mastectomy and hysterectomy. Natalie only looked at or responded to Ella when it came to nursing, which she herself stated was more important for her than for Ella. There were times when Natalie was not breastfeeding where she would have Ella on her lap facing outward and I would become concerned that Ella would fall off as Natalie was not holding onto her or looking at her and Ella would wobble. Other times while holding Ella on her lap Natalie would turn her around and hang Ella upside down, continuing to

talk to me while Ella hung down. If Ella were awake and not nursing, Natalie would plop her on the floor and not engage with her. The only time of closeness and connection I observed between the two was during breastfeeding. However Natalie did not believe there would be any effect on Ella when breastfeeding ended, but said that she herself would miss it tremendously as she found it very "relaxing."

The work with Natalie and Ella together did seem to foster Natalie's reflective capacity. I tried to help Natalie see Ella as her own person with her own feelings and motivations. I always directly addressed Ella as her own person (Baradon, 2005; Norman, 2004). I said hello to both of them, asked Ella how she was, commenting on how big she was, or noticing a difference in her body, clothes, the toys she had or her development. I always said good-bye to both of them. When Ella turned 1 year old, I said "Happy Birthday" directly to her. In reflecting on the work it appears that offering myself to Ella as an interested, concerned person with whom she could engage served as a model for Natalie for how she might be with her baby (Baradon; Norman). Baradon notes that this way of interacting with a baby can help a baby regulate her emotional state when the parent is not able.

HELPING MOTHER OBSERVE AND REFLECT ON HER BABY

During our sessions, I often helped Natalie sit and observe Ella as she played and tried to help Natalie focus on what Ella was doing by reflecting back observations of their interactions (Baradon, 2005). For instance, when the two were cuddling or having a loving interaction, I would make comments about how nice it seemed for Ella to be on her mother's lap, or that it seemed to feel good for the two of them to be close.

I also tried to raise Natalie's awareness of Ella's state of mind (Baradon, 2005). I would wonder with Natalie about Ella hearing the difficult things Natalie was talking with me about, such as needing to stop breastfeeding and her upcoming surgeries. I started to ask Natalie how she imagined Ella's experience. If Natalie was talking about some of her feelings, worries, or anxieties, I would bring Ella into the conversation and help her understand what was being talked about. Norman (2004) notes that infants can grasp the emotional meaning of spoken language when there is a correspondence among words, intonation, and facial expressions. Therefore, the therapist's verbal formulations to the infant have to be sincere expressions of what the therapist imagines (Norman). By addressing babies in this way, the therapist makes meaning for both baby and mother (A. Bergman, personal communication, 2013) and helps create memories of affective states and experiences (implicit memory) which begins preverbally and affects mental functioning even though these memories cannot be consciously recalled (Norman).

In one session, when Natalie was talking about having to stop breastfeeding, she began to cry hard. I said to Ella who was 6 months old, "Mommy is talking about some very difficult and scary things, and she's upset because how she is feeding you is going to change." Despite Ella's age I continued to talk to her and wondered aloud if she heard and saw her mother upset and if it was making her worried about what was going on and what would happen. In another session, when Natalie was talking about how she worried about who would care for Ella when she was in the hospital, Ella began to cry very hard. I said to Ella, "You hear Mommy talking about big feelings and her worries for you." In a later session, Natalie was having a hard time accepting that she was important to Ella if she was not nursing. I told Ella how important her mother was to her and

that we had to help her mother understand that. I went on to tell Ella, "Mommy is saying that things will be different when she comes back from being away for a couple days. She will have to hold you differently and we will find new ways for you to be close; nothing can break your connection." By saying these things out loud I was trying to convey to Natalie the complexities of her own feelings as well as Ella's and to put Ella's feelings into words for Natalie and vice versa to help Ella better understand what was going on for her mother.

In addition to talking to Ella about her mother's sadness and the family's scary events, I also relayed positive affect and experiences to Ella. When Natalie told me that Ella was beginning to take steps at 11 months old, I said to Ella, "Mommy is saying you took some steps. Wow!" When Natalie informed me that the family was moving to a new apartment, Ella started to clap; I then clapped and said, "Yay!" and remarked that Ella seemed excited, too. When Natalie told me how active Ella was and that it was getting harder to leave the room, I said to Ella, "Mommy is telling me how busy you are and how you are really exploring your new house." When, in a session, Natalie read an email she had written to friends and family explaining the past year, including Ella's birth and the surgery, I said, "Mommy wrote such a beautiful email about the past year, with all the ups and downs."

I also helped Natalie talk to Ella about being away for several days in the hospital for her surgery. When Natalie was unsure what to say, I said to Ella, "Mommy is going away for a couple of days, but she will come back." I then spoke to Ella telling her, "Mommy is wondering how it will be for you both when she comes back after being away when she might not be able to hold you in the same way. It will be different, but you will find a way to be close to each other." When Natalie told me she was worried about Ella, I repeated this to Ella.

I would also try to help Natalie reflect on Ella's emotional and internal life by wondering with Natalie about Ella's feelings as shown in Ella's behavior either in my office or what Natalie described was happening at home (Slade, 2002). In one session, when Natalie stated that she was starting to get upset about having to stop breastfeeding, Ella made some noise, and I commented that I wondered if Ella heard us talking about the surgery and was having feelings about it. In that same session, Natalie told me how Ella got very upset and cried continuously when Natalie left the house even for a couple hours. I commented that I wondered if Ella was upset because Natalie was not there and was missing her. I pointed out that Natalie had said how much time they spend together and maybe Ella did not know where her mother was. In another session, Natalie stated how scared she was that her upcoming surgery would reveal cancer, and Ella began to cry intensely. I said to Natalie that it seemed Ella was upset about what we were talking about, just as Natalie was having feelings about stopping breastfeeding and what the surgery would find. In another session when Ella seemed to intently follow Natalie's conversation with me about her reconstructive surgery, I pointed out to Natalie that Ella seemed to be following and having feelings about it. As Slade (2002) notes, helping parents observe their child and learn to read their actions and words are at the heart of the reflective model.

By helping mother and baby in this way, I attempted to scaffold Ella's feelings and behaviors, create meaning for her and Natalie, acknowledge the importance of the other's state of mind, confirm both parent and child's sense of self and help them to understand their own mental state and to recognize feeling states (Baradon, 2005). The hope was to help Natalie make sense of what Ella was feeling, of Ella's developing mind and sense of self, distinct from Natalie's, and of the impact Natalie's actions and feelings had on Ella (Baradon).

ADDRESSING AND REFRAMING MISATTRIBUTIONS

Natalie had many "negative positions" (Baradon, 2005) about Ella that needed to be reframed and changed. Natalie had a difficult time believing there would be any connection with Ella after she stopped nursing or that she was important to Ella without it. I observed interactions between Natalie and Ella to highlight how important Natalie was to Ella. In a session when Ella sucked on Natalie's shoe and leg and Natalie talked about not feeling as special to Ella, I remarked that it seemed that Ella really wanted to be close to her mother. When Natalie said she would do it with anyone, I pointed out how she was not behaving that way with me. Similarly, when Ella was on the floor and rolled toward her mother and Natalie downplayed it, I remarked that Ella was capable of rolling both ways but wanted to be closer to her mother. After the mastectomy and hysterectomy, Natalie told me how in the middle of the night Ella would wake up and Natalie would put Ella in the same position as when she nursed until they both fell asleep together. I commented that they were finding new ways of connecting to each other. Similarly, Natalie told me that she and Ella took naps together while she held Ella. I commented that I was glad that Natalie was feeling close to Ella without nursing.

There were other times where Natalie's negative projections of Ella needed to be reframed. Many had to do with what Natalie referred to as Ella's being "messy," a "terror," and "driving her mother crazy." For instance, when, at seven months, Ella was rolling over and rolled farther than I think she wanted and looked up and cried, Natalie reacted with annoyance. I wondered with Natalie if maybe Ella rolled away from her mother and got scared and did not know how to get back to her. Another time Natalie gave Ella a closed plastic bag of Cheerios, and when Ella used her teeth to open it and the cereal went everywhere, Natalie got frustrated and remarked on the mess. I commented that it seemed Ella really wanted the Cheerios and wondered if she did not know how else to get them open. In a later session, when Natalie gave Ella a snack, I commented on how well Ella was eating it. Natalie responded by pointing to the stains on her white shirt and saying that Ella had made a mess with her hands after eating. Ella looked to me, and I told her that maybe Mommy did not realize there was some of the veggie stix on Ella's hand and that when Ella wanted to hug or be close to her mother, Mommy probably did not realize that Ella's hands were dirty.

POSITIVE RESPONSES TO TREATMENT

In working with mother and baby in this way, there seemed to be immediate and remarkable responses. Although Natalie initially questioned whether Ella could understand our conversations and what was happening at home, I explained that she could understand our tone and feelings and some of the words (Norman, 2004). At first Natalie began to hold Ella in a more nurturing, comforting position. Then Natalie began to look at Ella and say things like, "I'm going to miss you but it's going to be ok," after which she would bring Ella to her. In another session when Ella was crying, Natalie responded warmly saying, "I'm here" and pulled the stroller closer to her and looked at and spoke to Ella, who quieted down. In another session, Natalie again looked at Ella and said, "I'm going to miss you, Ella." In a session before Natalie's hysterectomy and mastectomy, Natalie informed me that she had started talking to Ella about being away and that she was telling Ella that she was going away but that she would come back. Another time, Natalie

told me that she and Ella would figure out new ways to connect with each other. A bit later, when Ella arched her back in the car seat, Natalie told Ella that she knew that she did not want to be in the seat and wanted instead to be carried; Natalie then carried her out.

In the session where Ella watched and listened intently as we discussed Natalie's reconstructive surgery and I pointed this out, Natalie said to Ella, "Wow, you really want to know." Natalie then looked at Ella and beautifully told her that she had to go away for a couple of hours to see the doctor but that she would come back. Natalie had reported that she realized Ella had been angry with her after the separation during the previous surgery and had turned away from Natalie when she came to visit her in the hospital. I thought it was positive that Natalie could see this reaction of Ella's and was not upset or offended by it. Natalie did worry that Ella would be angry after the upcoming separation for the reconstructive surgery but also realized that if she was, they could readjust.

Ella also seemed to respond to treatment. After working with mother and baby in the above-mentioned ways, Ella would often try to kiss her mother, and they would hug tightly. At the session before her mastectomy and hysterectomy, Natalie was crying almost uncontrollably with Ella on her lap. I had concern for Ella who looked to me seeming confused and unsure what to do in being exposed to the intensity of her mother's feelings. I commented that I thought Ella was probably also worried about what was happening. Ella then put her hand on her mother's cheek, and I said to them both that Ella was also scared and she seemed to be trying to make Natalie feel better but that she also needed comforting. I asked Natalie how it felt for her holding Ella in that moment and Natalie turned Ella around and gave her a kiss and told her she loved her and Ella smiled.

For the last time that Natalie breastfed Ella, she had a "goodbye party" for the two of them. She told me that she initially was going to pretend it was not the last time and would "trick" herself and Ella. She then thought about it and decided she did not want to do that. Natalie had written about what had happened, describing how she had cried and cried. According to Natalie, Ella touched her face, "as if to say 'it's ok, we're going to be ok.'" I commented how beautiful it sounded and how special it was that she and Ella shared this exchange. She told me it was so meaningful and that, amazingly, Ella, who was fed only what she usually was during this weaning process, slept through the following night. Natalie commented that it was as if Ella knew the significance of the goodbye party. Natalie stated that she wanted to thank me and felt that she was not the same person she was when she came to treatment. She said that, thanks to me, she was more in touch with her emotions and that she liked it. A year ago she said she would have run away from her feelings but now she wanted to feel them, which made everything better.

REFLECTING ON THE CLINICAL WORK WITH NATALIE AND ELLA

Both Natalie and Ella made considerable progress over the course of the treatment, and I continue to meet with them. Natalie has wanted to talk in more detail about her parents and is remembering more about her childhood and expressing her feelings about it more deeply. She has mourned who her parents are and were, their impact on her, and how she did not get the kind of parenting she deserved. Natalie is also seeing the connections between her parents' behavior and the struggles she and her siblings have had. We have spent time trying to figure out what feelings her parents have about their own childhoods and life experiences and how that has influenced their current

behavior. I continue to note how far she has come in being able to express her feelings and set more appropriate boundaries.

For many months earlier in the treatment, Natalie would be resistant any time I tried to put out toys for Ella to play with during sessions. As treatment progressed, Natalie asked to move sessions to a therapeutic playroom so Ella could play with more toys. I have interpreted this as key progress: as Natalie herself feels cared for by me, she can allow Ella to be nurtured as well.

In the playroom, Ella often engaged in dangerous behavior, such as climbing up on the tables or chairs, and I used these incidents to think with Natalie about what is going on for Ella and what makes it hard for Natalie to do something about it. Natalie has shared that when she says no or removes Ella, the baby would cry, which makes Natalie feel bad. We have been able to talk about the difference between her father's abusive behavior and her trying to set limits and boundaries to keep Ella safe. We have explored together what Ella's cries mean, which has helped Natalie realize she is not hurting Ella by saying no.

There has been much improvement and still more work and healing to be done for Natalie and Ella. Part of the focus of ongoing work will be continuing to do what Lieberman and Van Horn (2008) recommend, namely providing compassion for what the parent has endured as well as continuing to bring the baby into the work and talking about the impact on the baby's internal world. By helping Natalie better understand and heal from her childhood traumas, we are together finding new ways for Natalie to interact with her children. As Lieberman and Van Horn (2008) point out, when parents are able to remember not only frightening experiences from their childhood but also the affects associated with them, they are better able to summon protective impulses toward their child because they are consciously motivated to spare the baby the kinds of experiences they had. As Natalie continues to feel held by me, to see me as a secure base from which to explore her past and inner life, her understanding of Ella's feelings and motivations will continue to develop.

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