CHAPTER 1

Brief work with parents of infants

Isca Wittenberg

My interest in brief work began when I was asked to spend a day a week at Sussex University Student Health Service as a Student Counsellor. Having so little time available and wanting to see as many students as possible, I offered a three-session consultation to each of the young people referred to me by the doctors. It proved a wonderful learning opportunity.

I was impressed by how clearly a core problem emerged not only from what the client said, but also from his or her behaviour during the interview and how the very difficulty that had brought about the present impasse sometimes became enacted. This enabled me to observe, feel, think about, and comment on what was happening between us in the here-and-now and how this might be a way of communicating what was also going wrong in other relationships.

The interviews were mainly unstructured, but I felt free to ask questions if some statement needed clarifying. Also, unless such information emerged spontaneously, I would usually within the first session enquire about the client's family and what had prompted him or her to seek help at this particular time. I would be quite active in commenting on the feelings in the room and what seemed to be expected of me. On the basis of this, I might begin tentatively to formulate something about the nature of the underlying problem and how it might relate

to present and past experiences. A great deal of work went on in my mind between the first and second session, especially an examination of the feelings and thoughts that had been aroused in me or appeared to have been lodged in me. These gave a clue as to the nature of the emotions and anxieties that were intolerable for the client to bear and hence had been projected into me. I encouraged the student to do some homework, too—namely, to think about our conversation and bring to the next session any further thoughts that had come into his or her mind in connection with it. The second (middle) session was the one where earlier hypotheses as to the nature of the anxieties and difficulties and their possible origin could be tested and new understanding take place. In the final session, I learnt how such understanding had been used and I summarized what we together had discovered. We would explore what the ending of our contact meant to the client and whether more help might be needed and desired, or not.

When, some time later, the Adolescent Department of the Tavistock Clinic set up a Young People's Counselling Service (which offers up to four sessions), I used a very similar model and was able to tell my colleagues about the method I had found useful in doing brief work—namely, a particular way of using the transference and countertransference to highlight a problem and promoting the client's adult capacity for thinking about feelings rather than gathering the infantile self into the relationship with me. An offer of a few sessions is particularly useful in working with adolescents and young people because many of them are afraid of dependency involved in long-term treatment. Few will be able to commit themselves to the latter unless, through an initial brief encounter with it, they have a taste of what analytic understanding is about. In some cases a crisis or block in development may be alleviated by the insight gained within the four sessions.

I do not wish to overrate the benefits that derive from brief work. It is not a panacea or quick fix that can replace long-term analytic work. However, my previous experiences of brief work have convinced me that at critical points of transition in a person's life, such as having a baby or facing the problems of retirement, disability, bereavement, death, even a few interviews can be extremely useful. The new situation often produces an inner turbulence and may drive the individual urgently to address previously undigested anxieties. To be able to talk about their worries and fears, to be listened to by someone who can bear to stay with psychic pain and help them to think about their feelings in depth, may give clients some understanding of the nature of

their problem. In some cases this may lead to a realization that more ongoing help is required, but often the insight gained and the experience of being understood is enough to enable clients to manage their lives more constructively and to undo a block in their development. Brief work is most likely to be of benefit where the person coming for help is not generally disturbed but is stuck with a particular problem, especially if it is one that has come to the fore recently due to some inner or outer change.

The value of early intervention with parents and their infants

Having a baby is a most disturbing as well as a very exciting event. New parents in particular are undergoing major life changes. Up to this moment they have been a twosome, but now they need to make space for a third person. This new entrant into the couple's life radically alters the nature of their relationship, requiring them not only to care for each other as partners, but to be jointly responsible for the baby they have created. A mother is likely to harbour some fears about the kind of baby inside her, of what it might do to her body, as well as worrying whether she can provide a good-enough environment for its growth. In the last few months, the burden of carrying the baby, anxieties about the birth, and the responsibilities facing her may weigh heavily. After the baby is born, the wonder and joy at having produced a live baby have to be matched with the realities of the ongoing strain of looking after a physically and emotionally demanding little one. Not only is the actual work of taking care of a vulnerable young infant physically taxing, but the baby's communication of his/her terrors of helplessness, of falling apart, of struggling to survive will put to the test the parents' capacities to be in touch with, tolerate, and attend to such extreme primitive anxieties with sympathetic understanding. In each partner the nature of their relationships to their own father and mother and siblings as well as their infantile anxieties will be evoked. What they have internalized on the basis of their own experience of having been babies, children, and in their parents' care will deeply affect the way they perceive the new baby, how they interpret the baby's behaviour, and the way they deal with it.

While the mother is likely to be the main caretaker, the father, too, is called upon to take on a new role, helping with the care of the baby and supporting his wife with his understanding, thus parenting the mother. He will have to cope both with the jealousy that may be

evoked by the closeness of the nursing couple and with envy of the mother's ability to feed the baby from her breasts. All these upheavals, external and internal, while likely to cause distress, may also lead to a spurt of emotional growth and deep satisfaction for one or both parents. If the burden becomes too great, however, and the anxieties aroused too unbearable, temporary or even more long-term breakdown may ensue. Alternatively, past unhelpful defensive patterns of dealing with feared emotions may become re-enforced, to the detriment of the parent–child relationship.

When the Child and Family Department of the Tavistock Clinic set up an Under Fives Service offering up to five sessions to parents of children under the age of 5 years, I was keen to participate, hoping particularly to see parents of infants. Psychoanalysis as well as research in developmental psychology has shown that the foundations of mental-emotional health are laid in infancy. To offer understanding to parents burdened or unable to manage the disturbing feelings aroused by their young baby seems to be, therefore, of quite particular importance, a piece of preventative mental health work of the first order. Because of the intimate, interactive relationship between parent and baby, any upset in one is easily communicated to the other and can quickly develop into a vicious cycle of mounting distress. I hoped that an early, brief intervention (up to five sessions were offered), might alleviate an escalation of difficulties or resolve a crisis that had arisen. To witness relief, greater tolerance of the difficulties involved in being a parent, and the ascendancy of love towards the baby arising out of greater insight is a wondrous, humbling, and gratifying experience for any therapist. I have often asked myself how the little I have done could have brought about such a change. Part of the answer, I believe, lies in the fact that looking after an infant reawakens very primitive, overwhelming anxieties, and hence there is a great urgency to seek and make use of understanding. The concern for the baby and the wish to be good-enough parents further promotes working at the difficulties.

The importance of infant observation as a training tool for clinicians working with parents and infants

The study of infants, which includes detailed observation of babies within their own families for a period of some two years, has made us aware of the intricate interplay between the mental states of infant,

mother, and father. One learns at first hand about the most primitive anxieties and the defences against them, observes how adjustments and maladjustments come about, and watches character in the making. The responsiveness of mothers and fathers to the baby's needs and anxieties plays a vital role in laying the foundation for the children's emotional growth, the structuring of their personalities, and the specific vulnerabilities that they may be subject to throughout life. But the baby's endowment also plays an important part. Moreover, a lovingly responsive baby may help to pull the mother out of a depressed state, while a "difficult-to-satisfy" infant may undermine a mother's confidence in her ability to care for her baby and may precipitate a vicious cycle of persecutory behaviour between them. Infant observation also helps one to study one's own feeling responses to the triad of baby, mother, and father. We need to become aware of the strength and nature of the emotions evoked in us in order to empathize with parents and infants and not to allow prejudices and judgemental attitudes to interfere in our professional work. The following are likely to be some of the chief hazards:

1. Over-identification with the baby. There is a tendency to identify with the infantile wish never to be frustrated, to have a perfect mother. This attitude tends to show itself in being impatient when the new mother is at first clumsy in her feeding or keeps the baby waiting for a feed, expecting her to provide instant relief, be constantly available, infinitely patient, never tired, never having needs of her own. There is an assumption that all distress in the baby is due to inadequate mothering and could therefore be avoided.
2. Jealousy of the baby is often less obvious but probably always present to some degree. We all harbour an infantile wish to be nursed, fed, carried about, and given exclusive love and attention, and we may therefore feel jealous of the baby, noticing only the satisfactions rather than the distresses that are part and parcel of being an infant. Sometimes this leads to the view that the baby is being indulged too much—for instance, that the mother feeds him too long, or should not let him go to sleep at the breast.
3. Competitiveness with the mother has its roots in childhood rivalry with our own mothers and the wish to have babies of our own. It shows itself in a judgemental attitude towards the way the mother and father handle the infant and in unfounded doubts about the parents' capacity to be good caretakers. We tend too readily to be

> critical and need to be aware of an inclination to step in and rescue the baby (which is only seldom necessary). We may feel inclined to give advice rather than being supportive and understanding of the difficulties of parenting a baby twenty-four hours a day.

It is essential to be aware of such tendencies in ourselves when we engage in counselling parents. There are a number of ways of setting about this task. My own approach is based on insights gained from psychoanalytic work. I attempt to get in touch with and understand the parents' feelings, their unconscious phantasies, and the nature of the anxieties that interfere with their ability to care for the baby in the way that their more adult selves would wish to do. The work is intense and emotionally demanding. It requires of the client availability and awareness of feelings in depth and the capacity to reflect upon them anew. The therapist needs the experience of ongoing psychoanalytic work in order to be able to discern quickly the nature of the underlying anxiety and to have the conviction that it is helpful to name it and face it openly with the client. Sometimes we may have to weigh up whether the baby is in any physical danger, but usually it is the emotional development that is at stake. I am convinced that we can best help the baby by the help we offer to the infantile aspects of mother and father, thus setting a model for them of being interested in thinking about and containing infantile feelings.

The following examples will illustrate some of the stresses experienced by parents and the way I found of working with them. I find it useful to allow up to 1¼ hours for the first meeting in order for a relationship to the therapist to develop and the main problem and its history to emerge.

The Monster Baby

I was asked to see Mr and Mrs B urgently. The mother had phoned the secretary of the Counselling Service, saying that she was absolutely desperate and must talk to someone this very day because the baby's crying drove her mad. As she was speaking, the secretary could hear the baby screaming in the background. She told me: "It was such a terrible sound, it went right through me." The impact of this communication was to make me feel that something absolutely dreadful was happening and that I was going to be confronted by such a disturbed mother–baby relationship, perhaps involving violence, that it might necessitate hospitalization. I agreed to see the family that evening.

When I met Mr and Mrs B, I felt at once reassured. I found them to be a charming young couple who behaved lovingly towards each other and towards their 8-week-old baby boy, who remained asleep throughout the interview. Mrs B sat on the couch, holding the wrapped infant close to her body, while father took the chair next to mine. Mother told me that she feeds the baby frequently and plays with him afterwards, but within minutes of being put down he starts screaming and she cannot get on with anything else. Having agreed that this was difficult to bear, I asked the parents to tell me about the history of this baby. Both parents reported that there had been difficulties from the start. Mrs B had been very sick for much of the pregnancy. Then, in the last few weeks before confinement, the doctors became worried about the baby not gaining weight. Mother was eventually hospitalized, and when there were signs of foetal distress, two weeks before the baby was due, a Caesarean operation was decided upon. The baby was lying in a transverse position and had the cord around his neck. The mother was told that he was very thin because her placenta had not given him adequate nourishment. The father added: "He looked emaciated, like a concentration-camp baby—just skin and bones." They were advised that he needed to be given a lot of milk, so the mother fed him at frequent intervals. Her nipples became sore, and she became progressively more exhausted. She wondered whether he was getting enough at the breast, so she had weaned him the week before and bottle-fed him, yet he still continued to scream whenever she put him down. She mentioned that when she is not alone in the house the baby cries less, and when her mother puts him in his cot and rocks him for a while he settles and sleeps longer.

Mrs B added: "I haven't time for all that; I've got to get on with my work. I'll soon have to get back to my job, my maternity leave will be up then, and they will not give me more time off or let me work part-time. I don't want to neglect the baby and leave him all day, but my career is important to me." I said she seemed to feel that he never gave her any peace and would continue like this, and she would never be able to return to her career. Perhaps this made her want to get away from him and start work now. Her worry about the future might also have made her more tense and impatient with the baby. She asked in surprise: "Can my nervousness and my wish to get away from him really affect him? Do babies pick up such feelings?" She then spoke of feeling ashamed if he screams while they are out: "All the other mothers know what to do with their babies and how to satisfy them." Mrs B had dissolved into tears by now, crying pitifully; Mr B had moved

over to his wife, was comforting her, and had taken the baby from her. I commented that the baby made her feel a failure. Father said: "I feel the baby is trying to tell us something. We are trying to be good parents, but what is the baby feeling?" Mother added: "Does he feel we are monsters? He seems so violent when he closes his little fists and beats my breasts. Can babies be violent?" I said she had no doubt that he was very angry with her sometimes, but she felt that it was worse than that; that perhaps he was accusing her of having been a mother who had starved him when he was inside her and that he had now come to avenge himself for that.

Mother continued to cry but became very thoughtful. Towards the end of the interview, the parents asked for advice about how they should handle the baby. I said I was sure they would find their own way of comforting him, and I reminded them that they had told me that he sleeps better when mother feels supported by father's presence and also when he is rocked after being put down by Granny. This led to Mr and Mrs B speaking about their parents. They both came from broken homes. In fact, this couple had put off marrying and starting a family because they felt that having children had led to discord and the marriage break-up in their childhoods. We parted after having fixed a meeting for the following week, but I indicated that they could get in touch with me earlier if they felt this to be necessary.

As I came away from the meeting, I reflected on the fact that they had not been able to learn from the way Mrs B's mother handled the baby. Did that suggest a lack of recognition of Granny's mothering capacity, a feeling of superiority on their part in terms of their intellectual and very impressive professional achievements? Was the baby felt to be an intruder who would destroy their careers and their marital relationship? Had the pregnancy, the birth, and the baby's appearance been so terrifying that they felt guilty and utterly persecuted, convinced that either they or the baby were monsters? I suddenly realized that I was having a corresponding experience of seeing either the parents or the baby in extreme terms. Having expected to meet a hostile mother, I felt very positive towards the couple during and after the interview and sorry that their parenthood had got off to such a difficult start. Instead, I was left with a very eerie feeling about the baby. I pictured an extremely angry, unforgiving baby, the kind of child that not only shakes the parents' confidence in being able to produce a good baby but gives them such hell that they regret they ever gave birth to it. Was this baby, in fact, such a sort of monster? This phantasy

perturbed me at times throughout the week, and so I approached the second interview with much trepidation.

When I collected them from the waiting room, the couple looked more relaxed. The baby was crying but in not too distressed a way, and he quietened as soon as mother fed him. I noticed that he was scratching the bottle at first but then held onto it firmly. The parents were smiling as they told me that the situation had changed "out of all recognition. It is a complete success story." Mother said she had at first felt drained after the interview last week, but it was marvellous what had happened since. She reported that she was spending longer in putting him down and was rocking him for a while. He often slept for three hours at a time. He still awoke sometimes after a few minutes, but if she held him for a little while he would fall asleep again. She had stopped worrying about work. She said that she used to want him to fit into her schedule so that she could get on with her typing, but actually now that he was sleeping more she was able to get more work done. He was even sleeping for seven hours at night, and so she felt more rested. Father got him a little rocking chair made out of canvas, and the baby was enjoying sitting in it. Mother could put her foot on it and rock him while she continued working. "And when he smiles at me, I feel so rewarded." Father said that the baby followed him with his eyes. We talked about how they and the baby managed to keep in touch with each other in these various ways. "But," father added, "he doesn't always want to look at you. For instance, when he has been lying on his bed on his own and I come into the room, he sometimes seems deliberately to look away." A moment later, he added: "It occurs to me now, as I am telling you, that perhaps the baby is cross that we left him on his own." I said: "That may well be so—isn't it interesting to think about what baby's behaviour might mean?"

Mother burst out: "Do you really think that babies think?" She had read that it was all a matter of physical stimuli. I reminded her that she and her husband had wondered last week what the baby was trying to tell them with his crying. Perhaps, when she expected a terrifying message to come from him, it was preferable to consider him as incapable of thought. She said that he still cried piercingly when the bottle didn't come at once. He seemed to know when she put the muslin on him that food was on the way; he would look around, but it did not seem to come fast enough. She then began to reflect that when she had breastfed him, the milk had been there right away. "It's different with the bottle—perhaps he wonders whether the food will ever come." She

looked astonished at her discovery. Perhaps thoughts about his experience *in utero* crossed her mind, as it did mine. She said she knew now how to handle him and went into some detail about how she fed him, held him for some time in the position he liked best, played with him afterwards on the bed, gently put him down and rocked him. "It's all so much better," she exclaimed. She said she wanted to see how things developed with the baby before deciding what to do about her work. She wondered whether she could not, after all, persuade her colleagues to accept her back on a part-time basis. She told me that she used to be very ambitious, a "high-flyer", but added: "It's not so important any more since I find more pleasure in the baby." Father said: "It's really wonderful what has happened since last week, we are so grateful." I asked: "What do you think did happen?" Mrs B replied: "When we came I thought that either I had done something terrible to the baby, he had such a dreadful time inside me. At other times I thought that there was something very wrong and disturbed about him, something really nasty and dangerous. I thought that if he is so violent now, how would he be when he is five, ten, and fifteen!" I said that they had been afraid that he would never get better, afraid that they had produced a cruel, monstrous child, full of destructiveness.

They then told me that for years they had not really wanted to have a child, they were so happy together, so fulfilled in their work and marriage. They then realized that time was getting on and that, if they were to have children at all, they could not postpone it much longer. However, it came as a shock that Mrs B fell pregnant at once. She was just about to get promotion in her job. Mrs B said: "I suppose we were selfish, we had such a good life, just the two of us, we wondered whether the baby would put an end to all that. We wanted him to fit into our lives and not to take over. Instead, he did take over and was controlling us. I was both angry and frightened, and it all got into a vicious circle. I feel we are on a much better footing now. I feel easier, he feels happier, and I feel so happy that I can make him happy". She thought for a moment before adding: "We have been seeing much more of my parents. I have come to appreciate my mother more, we are closer now, able to share the love and worry about the baby." Both Mr and Mrs B again expressed their gratitude and said they would write to let me know how they were managing. They sent a letter two months later, which stated that the baby was happy and contented and so were they—mother was working part-time. They again expressed their appreciation of the work we had done together.

I was very touched in the second interview to witness how the parents were beginning to observe and think about the baby's behaviour and emotional experience. Why, I asked myself, had these intelligent parents not been able to do this before? What had enabled them to do so now? It seemed that, on the one hand, a division had been established in their minds between adulthood and work, which were highly regarded, and, on the other hand, babies, which were looked down upon. I may have represented for them a maternal or grand-maternal figure who was a professional woman and also had the capacity to feel for and think about infants. This may have enabled them to bring their adult, thinking capacity to be used also in the service of parenting.

Discussion

While this may be part of the picture, I believe that we have to look in greater depth at the change that took place in this couple. What is so striking about this case is the way the parents' feelings about themselves and the baby were transmitted to me in such a powerful way that I was taken over by them—first, the feeling that they were monsters, and then that their baby was a monster. Yet the interesting fact is that this did not happen in the parents' presence or in the presence of the baby. I had these thoughts about the couple before I met Mr and Mrs B, and I was obsessed with thoughts of a destructive baby before I had seen him awake. I kept on wondering about this phenomenon. It did not fit in with what we so often describe as countertransference: our emotive response to what a patient projects into us in the consulting room, in the alive encounter in the here-and-now. It made me aware of the need to extend the concept of countertransference to include what we feel is lodged in us before and after a session. With hindsight I feel it was a twofold fear of their and their baby's destructiveness which invaded me in such a powerful way before and after the first session. I think the dread of a "monster" child had its roots in the parents' unconscious fantasy of having been responsible for the break-up of both their parents' marriages after they had had children and led to the fear of having a child who, in turn, would destroy their life together. To what extent such anxiety affected the pregnancy one can only speculate, but I am certain that the newborn looking like a "concentration-camp baby" aroused the frightening fantasy in the parents of being "monsters" themselves who had inflicted such harm on the baby.

In turn, the actual behaviour of the baby, his demanding a great deal of feeding and holding and his "eerie" cry, was not felt by them to be arising due to his neediness (linked to the inadequate nourishment *in utero*), but led to the belief that he was a tyrant who wanted to punish them and control their lives forever.

So a vicious circle of persecutory anxiety was set up between baby and parents, each interaction seeming to confirm the idea that they were monsters. I believe that the parents' phantasies were so powerful that they interfered with their capacity to see, observe, and think about the reality of their baby and themselves. What I think I was able to do was to alleviate the phantasy of being, or having, a monster by pointing at the interconnectedness of the baby's persecutory anxiety, anger, and demanding-ness and their fears, guilt, and consequent feelings of persecution. The parents were able to experience me as someone who appreciated their wish to be good parents, someone who empathized with the burden of caring for a young infant and was able to tolerate and try to understand their angry and despairing feelings. This alleviated their worst anxieties and created a space to see themselves and their child in a more realistic light rather than distorted by their phantasies. Instead of being caught up in a vicious circle of persecutory phantasies and anxieties, they were able to study the baby's behaviour, think about him with understanding, and thus to parent him in a way that engendered mutual satisfaction. A safer, happier basis was thus laid for his and their development.

Unresolved mourning and its effect on the baby

The family doctor wrote as follows: "I would be grateful if you would send this family an appointment. Lisa and John, both in their early twenties, have been together for some years now. Their little boy, Robbie, died earlier this year aged 17 months, after a long illness involving many months of in-patient treatment. Lisa was heavily pregnant at the time, and Zena was born six weeks after Robert's death. Initially they seemed to be coping well with both the grief and the arrival of the new baby, but it has become apparent that the stress has become enormous and neither of them is coping. John has become rather destructive, which made Lisa leave home. She is angry with him and with the hospital. I am worried about them and how their bad feelings might affect the new baby, who is 7 months old now."

I saw the couple within a few days; they were half an hour late. Father had a round soft baby face. He was blonde; she was dark. He

wore two earrings in his left ear and looked depressed. She was pretty, with dark rings under her eyes and an angry, withdrawn expression.

They sat down on opposite sides of the room. I said that I had heard from their doctor that there had been difficulties in their relationship since their older child's death. They both said emphatically that it had nothing to do with Robbie's death, they had often quarrelled before, but they then added that recently they seemed to argue about every silly little thing. I commented that they seemed troubled by this, and I thought the fact that they had come together indicated that they were both interested in doing something about their relationship. I wondered, though, why they had arrived late. I learnt that they had had a disagreement on the way to the clinic. Lisa was angry that John had gone across to the other side of the road; she had understood this to mean that he didn't want to come. John said firmly that there was never any question of his not wanting to come.

I said that perhaps this incident showed how easily they misunderstood each other at present and that it also indicated Lisa's doubts about John. John said he got violent sometimes and hit her. Asked what made him feel violent; he replied that Lisa didn't listen to him or want to understand him. Lisa said: "But when I ask you what the matter is, you just sit there and don't answer." I said they were telling me that the communication between them had broken down and each of them felt hurt and rejected by the other. Lisa said John had been wonderful with Robbie. When I wondered whether Robbie had been a bond between them which was now broken, Lisa quickly denied this, saying she had left John once when she was six months pregnant, but they always got together again because when they were close it was wonderful. Now, however, it was worse than ever before. I could sense a great deal of anger in the room and therefore ventured that perhaps they were angry with each other because they had not been able to keep Robbie alive.

From this point onwards, Robbie was at the centre of our conversation. John said he was very angry with the hospital; it was unbelievable how many mistakes had been made. Robbie was a wonderful child, he was so proud of him. Zena was nice, Lisa said, but "ordinary—Robbie had been special". Would I like to see photographs? she asked. Lisa produced a photograph of Robbie, showing a charming blonde, blue-eyed fellow crawling in his cot, smiling and animated. Zena was dark-haired, a fat, rather solid and solemn-looking baby. I commented on Robbie's friendly smile, and John said that was how he was all the time, in spite of all he had had to go through. He was so

intelligent too. John became very animated as he spoke about Robbie, whereas Lisa showed little emotion. I spoke about John's pride in his son and then asked about the illness. They said he had seemed fine when he was born, but just when they were due to leave the hospital, the doctor had told them that Robbie had been diagnosed with aplastic anaemia and would need blood transfusions every six weeks. He was fine for the first six months, then not so well but recovered again, and in his second year began to have periods of illness. But much of the time they had thought he'd be okay. When he was 15 months old, a specialist told them that they had to be prepared for the likelihood that he had no more than two to four months to live. He was put on chemotherapy, and John said he had to keep a careful watch because the nurses often made mistakes. When I asked whether he was blaming the hospital for Robbie's death, John replied, "I can't help wondering. They moved Robbie to another room, then he just went downhill and after six days he gave up." I asked whether they also felt disappointed and angry with Robbie for giving up the struggle when they were trying everything to keep him alive. John agreed, saying, "Why, when he had fought so hard, did he have to give up just then?" I said they must have felt very helpless and as if someone must be to blame for the death.

They both said it was unfair what had happened to them. I said that perhaps their anger and blaming had got into their relationship. Lisa then said that at first they had been inseparable—they had met a lot of couples at the hospital who left their partners because of the illness of their child but "we were regarded as the ideal couple". The doctor had been worried that Lisa would reject the new baby and told John to look after her, but in fact it was John who wasn't interested in Zena, while Lisa had taken to her. "If it had been a boy," John said, "it would have been quite impossible." I said that perhaps it felt disloyal to his son to like the new baby. Turning to Lisa, I said that she seemed to find some comfort in having a healthy baby that she could help to grow, while John seemed to feel that he had lost both a son who was like him and also the closeness to her, and thus felt left out and angry. I asked about his work. He had lost his job on a building site, and then he hadn't bothered because of Robbie's illness. He would like to get back to work; it had given him satisfaction in the past, but it wasn't easy to get employment. I said the absence of work must add to his feeling helpless and doubtful about being wanted, useful, and productive. It did seem important to feel that he had a contribution to make to the family. I said I hoped they would find time to talk to each other

as they had done today, and we agreed to meet again two weeks later, after Christmas.

At the second interview I hardly recognized Lisa; she looked so much better, with red cheeks and pretty make-up. John also looked less depressed. They told me that they had had a very good Christmas. John said he had felt so much lighter when he had walked out of my room than when he had come in last time; he felt a heavy burden had been taken off them. Things between him and Lisa had been so stuck, but ever since then they had gone on talking to each other. When he felt hurt or angry, he told Lisa what it was about. Lisa agreed that the relationship was great now. John had been very caring, but she was still not sure of him. She said he seemed to need to be reassured about being loved, even when she thinks that things are going well between them. She said she was rude to him sometimes and called him stupid, but she didn't really mean it. He said that at times he felt he could not get through to Lisa, though this was less so now. I remarked on his vulnerability to feeling unwanted and unloved, and I remembered that they had told me that Lisa gets help from her mother but that John was not close to his family. It emerged that his father had died when John was a child, and that he finds he cannot communicate with his mother. I commented that it seemed he had quite a history of not feeling listened to, and that this might make him especially sensitive in relation to Lisa's availability. Lisa said: "He wants me to be his Mum much of the time, but I have got the baby to look after." I said that this might leave John feeling rather excluded, especially after the loss of Robbie. John said: "I feel such a failure with no work—and not able to save Robbie." I said that all that made him especially need and want Lisa's approval—and at that, Lisa looked across to him warmly, as if this was a really new insight for her. John brightened up. He said they had done a lot of things together recently. They had been decorating their flat. He had gone to two building sites this week to offer himself for work. I said these were very important ways of proving to himself that he had something good to contribute. Lisa had had the advantage of being reassured by her ability to feed the baby, while he had not had as much opportunity to prove to himself that he could be creative.

They then talked about Zena, and John told me that he was enjoying her more although Robbie was always part of their conversation. He now shared some of looking after Zena, whereas before he had spent almost all day watching television while Lisa was busy with the baby, and so they had hardly communicated. I said it seemed as if they now felt that not everything had come to an end with Robbie's death,

that they could invest in the new baby while keeping Robbie alive in their minds. Lisa said she could express her feelings to John more now because she was less frightened of him. There had been no hitting recently. John said he did not let himself get into such a state; he realized it was better to talk rather than to act on one's feelings. Lisa said he used to drink too much and then be violent. I asked when the drinking problem had started, and John thought it was about two years ago. I said it sounded as if that was the time they began to worry about Robbie's illness, and that television, like drink, might be a way of escaping from worry and sorrows. John said that he had gone drinking because it made him feel more alive, and I added that it was to counteract the dead feelings and depression. Having talked about these matters, they again stressed how greatly things had changed and that they really felt very close and good together. I said they seemed to have done a great deal of thinking and working things out together, and I wondered whether they wanted to carry on by themselves rather than continue to meet with me. They agreed that this is what they would like to do. I said that I hoped they would contact me if their relationship deteriorated or if they wanted to talk further with me. They both firmly shook my hand, and John gave me a big wink and smile as they went out.

It seemed to me that having a new baby had helped Lisa to invest in life again after her son's death but that, in order to cope, she was projecting her feelings of anger and sorrow into her husband. The more the father carried the anger, guilt, and depression, the more Lisa rejected him. The more she rejected him, the more John felt excluded by the closeness of mother and baby, and, in turn, he got angry to the point of violence. I was impressed by John's capacity for insight. I think that our work enabled them to verbalize their anger and depression and to come together to repair both the house and their relationship. Having faced their mourning, I hoped that the new baby could receive love in her own right, rather than being loaded with disappointment and depression and being perceived as only a second-class, "ordinary" person.

Post-natal depression

When Mrs D rang the Counselling Service saying that she wished to consult someone about difficulties over her baby's birth, our sensitive secretary gained the impression that she was severely depressed and therefore arranged for her to come to see me a few days later.

First interview

A pleasant looking woman, Mrs D immediately delved into the terrifying birth experience with Debbie. She cried throughout the interview, drying her tears with the many tissues she had brought with her. She had not expected the birth to be difficult. Contractions had been normal, but then the baby became "stuck". Neither the epidural nor the anaesthetic worked, and she was in severe pain. Eventually the baby was extracted by suction, and "it all felt like being tortured". When I commented that it sounded a very frightening experience, she nodded agreement. She had talked with many friends, who had passed it off as "just a difficult birth", not understanding how dreadful it had been. She lost a great deal of blood, was severely bruised, and required extensive stitching. The following morning she was asked to get up but fainted on the way to the bathroom. Everyone had told her that she was brave and strong, yet "I was in the most terrible pain and feeling dreadful." I said she must have been very shocked and have thought that nobody understood how awful she felt. Perhaps she might be afraid that I, too, would simply be reassuring instead of appreciating what a frightening experience she had had and that she was still feeling dreadful. I added that it sounded as if she had thought that she was dying. Mrs D began crying more copiously now, saying that she still suffered from the consequences of the birth. The episiotomy had left her not only very sore but so damaged internally that she had had to undergo a laser operation recently. She had not been able to have intercourse because it was too painful. She and her husband were close, and she had missed the sexual relationship. She said that it was all so dreadful; they had not in any way had a normal life since Debbie's birth. I commented that Debbie's arrival seemed to have disrupted everything.

Mrs D said her husband and his family, with whom they were staying, adored the baby and could not understand why she found Debbie so difficult. She herself could hardly bear to be with her. She found the baby demanding and could not stand her crying. I said she might feel that it was she, mother, that needed looking after. She agreed, saying that for weeks and months she thought, "There is this bundle that I am supposed to nurse, feed, and clean up, and I feel I cannot. I just want to turn away and do nothing." I said it seemed that she could not provide for the baby when she felt her own needs, especially her emotional needs, were not attended to. I also wondered how angry she might be with the baby whose birth had caused her so much pain and

disrupted her relationship with her husband. She replied, "I know it is irrational, but I blame the baby for all this and I don't trust myself to be alone with her." I said it sounded as if she were afraid she might hurt the baby. Mrs D cried for some minutes. She said sometimes she felt that she could not go on any more, but until now nobody had understood how she felt. Everyone had been trying to be nice, telling her how well she was doing, but that had not helped. Her husband was kind, and he was wonderful with the baby. She was glad to be out of the home much of the day and liked her work in an accountancy firm. Debbie was looked after by a minder who was good with her and had only one other child to attend to. I said she seemed to feel that this was safer for the baby and herself. Mrs D said that every time she looked at the baby she went over and over the birth experience in her mind. She added that it was good to be able to talk to me. She reiterated that she did not feel that anyone had listened to her before like this and understood how dreadful it had all been and how awful she still felt.

She asked whether she could come again soon, and we fixed another appointment four days after the initial one. I ended by saying that I thought it might be helpful to try to find times when she and the baby were more at peace, so that they could meet on some basis of pleasure, instead of distress, which was such a reminder of what agony had been involved in her birth.

Second interview

Mrs D looked a little brighter and said she was relieved to be able to come. There was one thing in particular that I had said that had been important to her. Every time she thought about the birth, she now remembered that I had said that she had thought that she would die. This summed up just how she had felt, and it was a comfort that somebody had recognized this. She had been able to look at the baby more and feel less angry, although the thoughts about the birth still went on and on in her mind. She then told me how resentful she had been last Christmas, when nearly all the presents she received had been for the baby. I said that even before the baby was born she had been afraid that the baby was robbing her of what had been hers. I asked about her family and learnt that she had a sister who was married and had two children. I wondered whether Debbie was felt to be more like a sister than a baby of her own—a rival baby who had robbed her of her mother's attention. I also referred to the fact that it was going to be Christmas now and perhaps she felt that I was giving presents and

attention to a child of my own rather than more of my time to her. She replied that she thought this Christmas might be a bit better than the last. I suggested that maybe when her needs and her painful experiences were given attention here, she was able to give more of herself to the baby. She told me that they were planning to buy a house of their own and hoped to move the following month.

Third interview

Mrs D reported that, although she was still crying when she came to see me, she was doing so much less at home. What emerged in this session was primarily that Mrs D had been very efficient and successful in her work and had thought of herself as a "superwoman". It became clear that the birth had disrupted this notion of herself as so capable and in control. I said that the delivery had thrown her back into a state of feeling helplessly dependent on others, like a small child. She seemed also to feel that these others had inflicted the pain and suffering on her on purpose, like torturers.

Fourth interview

Mrs D reported that she felt much better. They had moved, and she felt very pleased to be in her own home rather than staying with her in-laws. She now had more space and freedom. Debbie was crawling up and down the corridor. I commented that there seemed to be a feeling of more space for both of them, that she and the baby could be near, yet not too close to each other. Mrs D talked of her love of gardening and hoped that Debbie might enjoy sharing this activity with her. She sounded altogether more hopeful. I agreed to Mrs D's wish that the fifth and last interview should take place after Debbie's birthday, a day she was dreading.

Fifth interview

Mrs D immediately started crying but said she had not done so for some time. It was good to have a home of their own, the sexual relationship with her husband had returned to normal, and she was enjoying Debbie. She mentioned that the baby was becoming very independent, was developing well, and had begun to sleep through the night. Mrs D looked proud as she told me that everyone finds her delightful. The baby-minder had commented that Debbie seemed so

much better these days. She was no longer restless and fretful. Mrs D thought this might relate to her feeling less upset and more at ease with the baby. I said the move and the birthday were quite a big event, marking the fact that they had all survived this very difficult first year. She seemed to have begun to enjoy her family. She said her husband had been thinking about another addition to the family, but she was in no hurry to have another baby. It was nice, though, to see Debbie settling down to toys, and she liked playing with her. I asked about the birthday, and Mrs D said it had all gone very well, and a good time had been had by everyone. They had invited friends, and Mrs D had made a big birthday cake.

Then she started to cry as she told me that she had been terribly upset by a dream she had had the night after Debbie's birthday. In the dream, *she had seen the baby sitting inside the gas oven they had recently acquired. The baby was trapped and screaming, but she had just stood by looking on and did nothing*. Mrs D cried heartrendingly, saying she was still terribly upset about the dream, it was so awful. I said what felt awful was that the dream showed her murderous feelings towards the baby, allowing it to be tortured. I thought the birthday had once more aroused her anger at the terrible birth experience. I reminded her that at one point we had talked about Debbie feeling more like a baby sister/younger sibling to her than her baby. Perhaps the birthday had brought up in Mrs D early childhood feelings about her own mother's baby who was to stew in mother's stomach, to have no life, so that it should not rob Mrs D of her mother's attention. Maybe she felt that such hidden early feelings were the reason for her having such a punishing labour when she had thought that the baby might kill her. I recognized that she was feeling dreadful and very miserable about such murderous phantasies. I thought that alongside such thoughts she also felt very sorry for the baby, who was trapped inside and whom she had not been able to help to get out. This too must have made her feel helpless at the time of baby's birth. I thought that she was able to deal better with her feelings during the daytime and that these thoughts had now become contained within a dream.

Perhaps, as this was our last meeting, she might also feel angry with me, as if I were a mother who now replaced her with the next baby. Mrs D gathered herself together and told me the interviews had been extremely important to her. "I don't know what would have happened if I had not had this opportunity come and talk to you," she said; "I feel I might have hurt the baby," and after a pause she added, "or committed suicide." We talked about whether it was appropriate

for this to be the last time we met. Having given it some thought, Mrs D said she felt it was. We agreed that if she continued to be worried, she would contact me. I also suggested that when she became pregnant again, this might well be a time when she would wish to have further help. Mrs D asked me to write to her new doctor. She wanted me to explain about the birth and about her depression. She wished the doctor to know that she had been to the Counselling Service and that if she got depressed again this was the kind of help she wanted, rather than to be sent off to a psychiatric hospital or treated with antidepressant drugs.

Comment

We see that Mrs D's experience of giving birth to a baby not only was felt as an attack on her body, but shattered the omnipotent image she had of herself as a "superwoman". This resulted in a life-and-death struggle between the strict internal voice, which demanded that she be perfect, and the rage with her child who had forced her to confront her vulnerability and her negative feelings about mother's babies. It was hard for me to decide during the course of the fifth interview whether it was safe for this to be our last meeting. But I trusted Mrs D neither to act on her feelings not to push them out of her mind, but to seek further help if necessary. I think it is important to remember that uncertainty about what has been achieved and worry about the future are always present and are integral elements of the burden of anxiety carried in brief counselling work. It is essential that enough trust has developed during the course of the intervention for the client to feel that one is truly interested and concerned and therefore available to be contacted again when needed.

Conclusion

I hope that the examples presented here in a brief form convey something of the variety of problems parents brought and the kind of interaction that took place between us. The comments show some of my reflections at the time of seeing the parents as well as subsequently.

I have found working with parents of infants to be deeply moving and rewarding. One becomes aware of how prone parents are to feeling inadequate, helpless, persecuted, enraged, depressed, and guilty. When there is no one to unburden themselves to, these emotions escalate, and anxiety quickly becomes overwhelming. It seems, therefore,

important to provide a readily available counselling service, where parents can talk over their difficulties without being given reassurance, offered facile solutions, or infantilized by an expert. I think the clients I saw experienced me as someone genuinely interested in helping them to understand themselves as well as their babies, someone who respected their adult strivings to be good parents while helping them to examine the more infantile and destructive feelings that interfered with their task.

I set out with no rigid technique in mind and found myself working a little differently with every case. My experience of infant observation and psychoanalytic work helped me to be able to listen, to encourage the exploration of the roots of the current anxiety, to stay with psychic pain, and to believe in the emotional strength derived from facing the truth. It always seemed to me that I was doing very little, and I was astounded at the dramatic improvement that often resulted. Of course, many questions remain unanswered, and the degree of long-term benefit the client derived is uncertain. Yet I have no doubt that in many instances a dynamic shift did in fact occur. In speculating about the reason for this, I would suggest that the clients were locked into an unhelpful pattern of relating, feeling persecuted and being persecuting. Conversations with me opened up a new channel of communication between destructive and loving aspects of themselves, between their infant and adult selves, and this led to a better understanding between husband and wife, between parent and baby. As a result, hope was restored, and a benign circle of interaction emerged, which produced satisfaction and in turn increased the parents' confidence in their capacity to look after their babies and help them develop.

It seems to me appropriate to work briefly with parents so as not to encourage dependency and to avoid the danger of disturbing the new intimate relationship developing between parents and their offspring. On the other hand, it may be important to offer ongoing help where the parent has little internal containment or external support. Long-term help is likely to be essential where destructive feelings towards the infant dominate, and this may be the case if the parent has had a deprived childhood or been abused. There is another group of parents who, while they may be helped in their relationship with their baby, may indicate their need for therapy for a wider range of problems and can be encouraged to refer themselves to the appropriate agency.

The parents I have worked with on a brief basis, although they experienced anger and at times hatred towards each other or their babies, showed great concern and were primarily worried lest their

negative feelings would take over. While it may be wise to be cautious about what may be expected from a few interviews, I suspect there are many parents who could use such an opportunity to develop their own resources to understand themselves in their struggle to find a better relationship with their babies and thus lay a sounder basis for their emotional growth.

Because they are in the midst of an enormous change in their lives, feelings are stirred up in the depth, alive to be worked with and seeking to be understood. It is always a surprise to me how even a little help given at this early stage can go a long way, and that this can prevent problems getting established and becoming a serious interference in the relationship between the couple and their baby. The countertransference is bound to be strong, as our own baby-feelings, as well as those associated with us being mothers or fathers, are stirred up by this work. Hopefully, we can develop an attitude of being able to listen and trying to understand the emotions and fantasies about the parents themselves and their baby as they are presented to us. Our client may fear that we will be like the interfering and criticizing parental figures in their external or internal world; alternatively, they may turn to us in the hope that we have some magical solutions to offer. While I am aware of such transference phenomena, I tend not to interpret them when dealing with parents of infants unless they present an obstacle to the work, because it seems to me unhelpful to encourage infantile dependency at a point in a couple's lives when they are being called upon to be at their most adult. It is essential, however, that we do not fit in with the parents' fantasy of being all-knowing, nor that should we only consider the baby. It is our task to encourage the adult part of the parents to look themselves at the primitive anxieties that have been stirred up by having a baby, so that they can test them against the reality and thus enable their worst fears to be modulated. It is a privilege to be allowed to play a small part in such a process, one that fills those of us who work in this field with a deep sense of joy.

Note

This chapter is a modified version of two earlier publications: I. Wittenberg, "Brief Work with Parents of Infants", in: R. Szur (Ed.), *Extending Horizons* (London: Karnac, 1991), pp. 80–107; and I. Wittenberg, "Brief Therapeutic Work with Parents of Infants", in: F. Grier (Ed.), *Brief Encounters with Couples* (London: Karnac, 2001), pp. 69–85.