Maternal Conflicts Activated by the Child's

Separation-Individuation: A Maturational Opportunity

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ABSTRACT

The mother's emotional availability during the crucial developmental phase of separation-individuation is limited by her own unresolved separation problems. The biological and psychological upheavals of pregnancy and birth result in regression and a loosening of her defenses. As a result, her early conflicts and memories are powerfully reactivated, and are more readily accessible to a "second chance" at working through. Further, her conflicts related to repressed aggression are exposed, because of the integral relationship between developmental fixation and internalized rage. Case vignettes illustrate how the mothers growth in treatment were enhanced by the surfacing of early traumatic memories and feelings, particularly that of aggression, the result both of projection onto, and identification with, the child.

INTRODUCTION

The maturational tasks of the separation-individuation phase are daunting for both the child and the mother. The mother's task in bringing about an emotionally valid separation is to provide a holding environment, to resonate emotionally with her child. This task is further complicated by the mother's conflicts with her repressed aggression. The child, in order to individuate, needs to develop a solid sense of his own competence, and expand his trust in others, and have relative comfort with his own aggression. Both must, ultimately, disengage. When the mother is frightened by her unconscious (though normal) murderousness, she has to ensure that she hasn't killed the child by keeping a close eye on him, thereby thwarting separation.

Mahler (1968), originator of the term "separation-individuation," studied its permutations by making careful observations of mother-child pairs. She asserted that the process entails the development of a "differentiated object representation." Mahler says that separation-individuation may require from six to thirty months, and that it has multiple components: "…maturational and developmental, autonomous and conflictual, intrapsychic and environmental"... (p. 220)

She continues:

> The concept of separation, in this sense, means differentiation of the self from the symbiotic object as an intrapsychic process...During the course of the normal separation-individuation process, the predominance of pleasure in separate functioning, in an atmosphere in which the mother is emotionally available, enables the child to overcome that measure of separation anxiety that makes its appearance at that point of the separation-individuation phase at which a differentiated object representation, separate from the self, gradually enters consciousness. (pp. 220-221)

Margolis (1994) underscores the importance of the separation-individuation phase, noting that it is crucial for the child because it makes possible the establishment of the self and the development of ego boundaries:

> With the process of separation-individuation, which began when symbiosis had reached its peak, self and object representations take on ever sharper outlines. The ego,

> nurtured by the acquisition of multiple functions and identifications, evolves and stabilizes its boundaries. Separation-individuation may be viewed as a complex process of transition in personality development from symbiotic oneness to total self and object disengagement. (p. 150)

Regarding the role of aggression, Margolis explains that

> The course of normal maturation described this far is subject at any point to distortion by excessive frustration experienced by the child at the hands of the mothering object, and by unexpressed aggression. In those cases destined to develop narcissistic disorders, the child concludes that expression of rage toward the other is counterproductive and even dangerous. He internalized the rage to spare the object, burdening the immature ego with large quantities of unneutralized aggression. (p. 150)

The internalized rage can result in fixation, arresting, at least to some degree, separation. Nelson [1957], as cited in Margolis (1994) further elucidates this process: "(the negativistic defense pattern) is representative of a preverbal insulation barrier activated to protect the organism against overstimulation." (p. 222) "But what was once normal negation has been transformed, under the impact of unwholesome interactions with the mother, into a posture of 'malignant No' in Lichtenstein's [1977] phrase." (Margolis, 1994, p. 222)

On the other side of the equation is the mother, stranded as she is in her own development and varying levels of freedom with or inhibition of her own aggression. Her ability to manage her aggression comfortably sets the stage for an easier course of separation between mother and child, but when this is not the case, difficulties ensue. Goldberg (1997) comments that

> It is the job of every mother to make the commitment to take her child's raw energy of wanting to kill her—the murder behind the normal developmental narcissism—and to turn this into something wonderful, in to a splendid act of metaphorical murder. And every mother must make the commitment to take her own raw energy of wanting to kill her child and to turn this into something wonderful, into another splendid act of metaphorical murder. In short, it is the mother's job to help her child to break the most unbreakable of bonds, to separate with

> as little pain as possible and with as much joy as possible. (pp. 160-161)

TREATMENT OF MOTHERS WITH UNRESOLVED SEPARATION-INDIVIDUATION CONFLICTS

The woman who was unable to complete the separation-individuation phase of her own childhood faces extra difficulties in dealing with the challenges of separating from her toddler. Her emotional availability is influenced by early childhood trauma: the loss of a parent or sibling; a hospitalization; abandonment; the birth of a sibling, and by unresolved separation-individuation struggles. Early memories for these emotionally conflictual events, usually preconscious or unconscious, are triggered by the mother's proximity to and identification with her child. Transference of these contents to the child becomes much more likely when they remain hidden from the mother's awareness.

PREGNANCY AND PARTURITION

The processes of conception, pregnancy and birth generate powerful transference and countertransference feelings in the woman and in her analyst. Clinicians have observed extreme regression during pregnancy, regression that may continue through the baby's pre-oedipal years. Blos (1985) describes the observations of Bibring, who studied pregnant women in an obstetrical clinic, and who was:

> ...startled to find that an extraordinarily high number of patients were diagnosed as "borderline." Deciding that this diagnosis was not plausible, she entertained the idea that the observations more accurately reflected the changing state of the maternal psychic structure during pregnancy. (p. 52)

Benedek (1959) writes of the regression that compromised the maternal psyche:

> Each phase of motherhood -- pregnancy, lactation, and also the preparation for these during the progesterone

> phase of each sexual cycle -- is accompanied by a regression to the oral phase of development ... (these regressions) bring about a repetition of intrapsychic processes which originate in the mother-child relationship during her infancy. (p. 394)

Solnit and Stark (1961) describe the same events, emphasizing drive-defense operations in the mother's psyche:

> The study of pregnancy...reveals a loosening up of defenses in the more direct, and at times more threatening, access to unconscious representations, wishes and scars (fixations). In a normal pregnancy, labor and delivery, there are psychological rearrangements and achievements necessary for the developmental advances leading to early motherhood. (p. 524)

This phenomenon is similar to the psychological and chemical changes of adolescence that activate conflicts having to do with separation. And they also offer a second chance for resolution.

RESHAPING THE TREATMENT PARTNERSHIP

A review of the literature dealing with maternal depression and anxiety in relation to separation-individuation conflicts produced many citations describing the child's struggles and the mother's response to them. However, few detail the reasons for difficulties in the mother-infant dyad from the mother's perspective.

What prevents a mother from resonating with her child at this crucial time? Even in a lengthy transference analysis the specific early childhood basis of a mother's inadequate responses to her individuating child may not surface.

However, Pappenheim (1952) and Fraiberg (1980) discovered that when the toddler is present in the treatment room, and the mother is projecting her own infantile memories and feelings onto her child as he plays or cries or moves toward and away from her, the maternal introject can be fully reactivated, and the details of the patient's conflicts made visible*, in vivo*. Even if the child is not present, unexamined issues in a woman's analysis may emerge full-blown as she is confronted by her positive and negative feelings for her own child.

Blos (1985) describes the mother's regression as "ego-syntonic," a "normal" and "necessary" developmental phase:

> Thus, with each pregnancy and birth, especially the first, but not limited to it, there is an ego-syntonic regression which is an essential, normal, and necessary part of motherhood as a developmental phase. This regression in both drive and ego contributes to the flexibility of the psychic structures, the heightened capacity to rework old conflicts, and eventually, the psychic growth of mother and infant. Our clinical data suggest that the heightened capacity for regression, greater access to childhood memories, unconscious wishes, conflicts and fixations, and loosening of defenses outlasts the physical and endocrinological changes of biological pregnancy and the postpartum period. (p. 52)

Blos (1985) further observes that this "loosening of defenses" might continue for as long as 18 months:

> This psychic openness is sustained for many months and begins to attenuate only during the middle of the young toddler's second year. Normally and gradually, it seems, this period of psychic flexibility is brought to a close by the toddler's increasing awareness of his or her own psychological separateness and the mother's recognition that this has occurred. (p. 53)

Benedek (1959) noted that a woman's normal mothering responsibilities play a role in the resolution of her early conflicts:

> Since motherliness involves the repetition and working through of the primary, oral conflicts with the mother's own mother, the healthy, normal process of mothering allows for resolution of those conflicts, i.e., for intrapsychic "reconciliation" with the mother. Thus motherhood facilitates the psychosexual development toward completion. (p. 396)

CASE STUDIES:

The following examples from the literature and from my practice are illustrative.

The child as dog

> *Blos (1985) describes the treatment of a mother unable to connect with her toddler. The little girl, of course, also was not developing an attachment. Prior analytic work had made it clear that the mother's mother had always been very detached -- she had greater concern for her dogs than for her children. At one point, the patient was observed throwing a doll toward her daughter and saying "go get it." Blos concluded that, identifying with her mother, the woman was actually behaving as if her child were a dog (p.50) Perhaps, also, the mother fantasized unconsciously that she, as a child, would have been better off as a dog*

An analyst provided with the opportunity to watch the mother's treatment of her child could only have made such an observation: having both mother and child in the treatment room brings the unresolved conflicts of the mother's childhood into her awareness, giving the treatment more leverage.

The effects of early physical and psychological isolation

My work with Mrs. A, who has been severely depressed since infancy, also demonstrates the activation of early conflicts as a result of motherhood.

> *Mrs. A came to this country from Eastern Europe as a teenager. When she was six months old, she developed a life-threatening blood infection that required immediate medical care. Her mother rushed her to the hospital. Hospitalized for more than a month, my patient had infrequent contacts with her very narcissistic, psychotic and anorexic mother. When Mrs. A's mother came to the hospital to visit her, she found her daughter limp and losing weight with what may have been incipient marasmus. The mother took her out of the hospital.*
>
> *Mrs. A had been told that as an infant, she had had a sleep problem until she was in the hospital, but that it had remitted at that point in her life. I suspect that she simply had given up trying to connect with the mother; that she had gone into an anaclitic depression.*
>
> *When she was two, the first of two siblings was born. Mrs. A remembers being in the room with her brother at night, and whenever the baby cried she got up and gave him his pacifier.*

Another sibling was born when she was four. Overwhelmed by loneliness and longing, she would run down to her parents' room in a far part of the house. Denied admittance to her parents' bed, she would sleep on the floor on a towel. She experienced it as "cold and hard."

Her mother's unavailability, exacerbated by the fact that there were two other siblings very close in age, in addition to the hospital trauma at six months, seriously reduced the care she received from infancy onward.

Mrs. A was hospitalized for depression, anorexia and bulimia as an adolescent, and has had suicidal ideation since then and on and off during this treatment.

Mrs. A became pregnant after a very brief (i.e., inadequate) discussion of her plan in treatment. I was only able to glean from her that she was in a rush. During Mrs. A's pregnancy, when she and her husband were planning a vacation, they argued over the question of what should be done with her cats: she couldn't tolerate the idea of her pets bring cooped up in a little cage at the veterinarian's. Her feelings were so intense on the matter that it led me to hypothesize that she was re-experiencing her own feelings of being alone in a barred hospital crib, activated by the pregnancy..

Subsequently, Mrs. A gave birth to a boy. She became actively suicidal after the birth; her plan to jump from the seventeenth floor of her apartment building only changed after I told her husband, at her request, that they needed to hire a baby nurse to give the overwhelmed Mrs. A some help. She was unable to assert her needs herself.

The new baby displayed considerable separation anxiety, especially at night. Through the age of three, he had extreme sleep problems: he would insist that his mother lie next to him in bed before he could go to sleep. He would take her head and forcibly turn it to face him so he could look into her eyes as he was dozing off. Even before the child was born she could not contemplate the idea of his having his own room, and she continued to keep him in the room with her "just in case" he might become unbearably lonely. Her association was to what she must have felt when she was alone in the hospital as well as during all of her childhood years. As a result, mother and child were in a troubled merger with each other.

Mrs. A has brought her son into her session, and most of the time the child played very nicely on his own with his trucks and other toys. However, at some point he became aware that he hadn't had enough of his mother, and he pulled her onto the floor so that they could play with the trucks together, manipulating her whole body -- trunk, arms and head -- in a very forcible way to make her an extension of him in his play. Thus, her inability to separate from her mother, whom she could not get enough of, infiltrated the relationship with her own three-year-old, who could not get enough of her.

Mrs. A told me that her son at one point said he hates her, and that this is the basis of her conclusion that he really doesn't need her, and hence she doesn't really need to be his mother, to take full responsibility for him. She did not know that his rejecting words were the passing feelings of a small child -- that he really does need her. Mrs. A continues to complain in her sessions about her child's clinging while producing many memories of her mother's neglect, e.g., locking up food, turning her care over to the maid while her mother went to the beach. She herself did not have the opportunity to cling, much less attach.

In the transference, she demonstrates her own unmet dependency needs by frequently asking for advice about how to get her child to sleep, or what to do to prevent his becoming depressed, which she anticipates (sometimes eagerly, it seems to me). Her expectation of his incipient lifetime depression became a repetitive litany after the birth of her second child, a girl. (This pregnancy was a complete surprise to me; there had been no discussion of it at all--with her husband, or me.) Her concern about the boy's depression came up at around the seventh month of the new sibling's life. Mrs. A expressed a powerful drive to leave the baby to return to work in the baby's sixth month, while the baby was still nursing and would not accept a bottle from the babysitter or father. Mrs. A was in tremendous conflict about this, experiencing, on the one hand, rage, revulsion and exhaustion around the baby's needs and a wish to escape to work, and on the other hand, overwhelming guilt as she knew the baby would be traumatized if she left suddenly (as she had been left). Nevertheless, she wanted to take action.

When she asked my advice about what to do, I reacted based upon my concern about the crisis brewing to repeat history through her child and responded, with all the rage I had built up (actually, toward her, for having had these children impulsively,

without discussion with me, setting out to ruin their lives, and complaining to me about the consequences): "Is that what your mother did to you --threw you in the hospital and walked away, saying, 'Who cares about her, she might as well be dead, she's too much trouble!' Looks like your mother is still running the show today!"[1] *-- Mrs. A responded, "She wanted me dead before I went into the hospital; she drugged me to get me to sleep; she couldn't be bothered." Then, she decided reluctantly, "Well, maybe I shouldn't leave-- but I can't stand her constantly needing to be held." After more discussion and ventilation I complimented her for persevering with all this adversity and difficulty and for having produced a happy baby who did not have a sleep problem. She decided to stay home. The combination of the analyst's modeling enjoyment of aggressive feelings, the patient's internalizing this attitude toward the feelings, and her increased ability to experience and vent these feelings may have helped her not to act on them by abortively distancing herself from her child.*

The issue regarding her son's potential depression began. (Was she alluding to herself- the frustration incurred and anger at me for interfering in her plan to leave home?) She took him to a child psychologist convenient to her (she had moved to a location several hours from my office; sessions were on the phone), to evaluate his "depression." The therapist pronounced the boy to be happy and healthy after each session with him. She was dissatisfied with this and repeated to me her fear. I invited her to bring him in to my office.

According to her, his problem manifested only between the two of them. Only in her presence, and nowhere else would he hit himself or say he was "stupid." She hypothesized he was protecting her from his anger at her for having the baby. At my suggestion, she brought in a doll, which could be decapitated. She had attempted to do play therapy with him and the doll (representing the new baby), but felt it hadn't worked. So she watched while he and I played with the doll and yelled at it, calling it a "stupid baby" and pulling it apart. Mrs. A giggled frequently during this time of yelling. After the session, there was a dramatic shift. Mrs. A reported, "It amazes me. The baby wakes up; she's ready to go. I don't get it. The only thing I look forward to is coffee. I look at Laura and Michael [her children] in amazement-- they're social and nondepressed; it amazes me, because I'm so the opposite. They're very active. I could just lie around, read and sleep. If only I could harness some of their

energy." For the first time she was able to see the children as separate from her.

A core countertransference resistance in this treatment has been my need to give advice, problem solve, and otherwise initiate my agenda, rather than wait for the contact and reflect questions. Waiting and reflecting has the result of (1) allowing for more frustration and less gratification, (2) leaving room for the negative transference to build and the patient to verbalize negative feelings toward the analyst, (3) reducing the depression, and (4) promoting the patient's autonomy. It has been extremely difficult to maintain the discipline to do this consistently. I understand this to be because I have avoided placing myself squarely in the path of the voluminous preverbal rage I know this patient has, and because I also know she left her previous therapist in a fit of rage. The potential for her leaving rather than talking has been discussed, but not enough to maintain the viability of treatment.

Spotnitz and Meadow (1976) point out that for the therapist,

> how much easier it is to stifle the emotion by giving a gratifying communication that relieves the patient in his suffering or to act mechanically with the patient in order to avoid his own depths of feeling. Avoidance is far simpler than working through emotional stress in which the very person of the analyst is the subject of attack. The analyst's ability to tolerate his own and the patient's frustration and negative feelings, the patient's total devotion to an all-powerful object, and his own positive and protective feelings aroused during sessions, without trying to "make things better" is the carefully-trained talent about which Reik wrote. (p. 135)

Although Mrs. A continues to describe herself as quite depressed, her affect in the above session was more lively, and the repetitive content has changed. Also, she now perceives the children as having their own personalities. She could not destroy the doll with feelings in the room with me or at home working with her son. Nor was she able to discharge criticism directly to me, so it may be that she got some vicarious enjoyment watching the demolition of the doll (she would love to kill her younger sibling, her children, her mother, me, herself).

MRS. G: A maladaptive need to rescue

The serious effects that the mother's unresolved separation-individuation issues have on the child are seen in the treatment of Mrs. G.

> *Mrs. G, daughter of a chronically depressed, emotionally unavailable mother who ultimately committed suicide, was forced to deal with her unresolved separation issues when they interfered with the emotional maturation of her daughter. In the eighth month of pregnancy, Mrs. G became pre-eclamptic, and an emergency Caesarian was necessary to save her life. The procedure posed a real threat to the infant's survival: she weighed a mere four-and-a-half pounds, her lungs were not fully developed, and one lung quickly collapsed. She required immediate transfer to the neonatal intensive care unit, where a tube was inserted into the infant's chest to aid her breathing. Mother and infant were for the most part separated for eight days, although visits were made during the day. Mrs. G was present on three occasions when the infant's monitor signaled that she had stopped breathing. Fortunately, these episodes were short-lived.*
>
> *Separation problems manifested themselves on both sides. The child was plagued by sleep problems: she awakened frequently during her first three years. Both mother and daughter had great difficulties dealing with their anxieties when the child entered preschool. While Mrs. G had been working in treatment on her separation problems, a striking breakthrough occurred when the little girl was seven: she was about to take a week long school trip during which the school prohibited parent-child contacts. This was mother and daughter's first major separation since that neonatal week in the hospital.*
>
> *Mrs. G developed severe anxiety and enervating guilt a month before the trip, and anticipated that during the child's absence she would have the feeling that her child had ceased to exist. Disturbed by her feelings, she studied them in treatment, and realized they were triggered by the separation. The anxiety generated by her child's prospective absence concealed feelings of abandonment, rage and guilt having to do with her own mother's suicide. The separation anxiety was exacerbated by the experience that Mrs. G had murdered her child, transferring early murderous wishes (and early magical thinking) toward her own mother in the past to her daughter in the present.*

New, regressive behaviors erupted in the child: she became physically ill on the school trip, and when she came home, she regressed to infancy, wanting a pacifier and a wheelchair. She would ask to go to her "real home" inside her mother's tummy, and revisited her sleep problem every night as well as having tantrums every morning, not wanting to go to school because it had suddenly become "too hard."

Another way in which Mrs. G's separation-individuation difficulties with her mother were enacted in her relationship with her daughter was seen in her inability to assert herself by setting self-protective limits for the child. This deprived the child of the holding environment she needed, causing her to became increasingly provocative and out-of-control. Mrs. G's response was to become murderously angry with her daughter. The emotional pain evoked by the physical separation of the daughter's school trip, the murderous feelings she was struggling with, and the knowledge that the child was on a self-destructive path, led her to redouble her efforts to use her treatment effectively. She discovered on both an emotional and an intellectual level that in childhood she believed that when she said "no" to her mother, or asserted her normal separation needs, she could drive her mother into deep depression. The feelings, behaviors and expectations generated during her traumatic years trying to save her suicidal mother, transferred to her daughter, had rendered her incapable of separating from the child. Specifically, she was able to get in touch with and verbalize in treatment the volcanic rage associated with her needy, depressed, demanding, suicidal (homicidal) mother, enabling the patient to separate from the toxic introject.

The diminishment of the transference enabled her to begin to set appropriate limits. This fostered the child's separation from her, enabling the daughter to progress with her struggles to individuate. The child became more cooperative, converting her self-destructive impulses into self-protective ones. The relationship became mutually loving, and maturation could immediately be seen in the daughter: she was able to leave her mother's orbit and set up her own projects comfortably, creatively and self-sufficiently during a family vacation.

These case vignettes illustrate the exacerbation of separation-individuation problems between a mother and her child by the mother's transfer of unresolved separation-individuation issues with her own mother. Fortunately, they were amenable to treatment.

SELF ESTEEM FEEDBACK LOOP

The feedback loop that exists between mother and child allows both to gain ego reinforcement. When the mother is able to comfort the baby, and to see herself as “a good mother” it allows the child to internalize positive feelings, seeing himself/herself as “a good baby.” On the other hand, when the mother must deal with a colicky baby or one with whom she is temperamentally mismatched, or who has important medical problems that lead the mother to have feelings of inadequacy, she may be unable to soothe the baby. This leaves her feeling like a bad mother.

In reaction, the child may develop a bad mother introject and feel like “a bad baby.” This can seriously affect the way that mother and child negotiate the shoals of separation-individuation. The ensuing guilt increases the mother's difficulties in separating from the baby by interfering with her ability to provide fully adequate nurturance. If the mother did not negotiate her own separation-individuation process well, she may mistake her child for her own mother and be unwilling to separate. She has the unending need to pursue the unavailable or frustrating object to get what was not gotten in early childhood. This dynamic is true of both the above cases.

Benedek observes that the mother's regression “stirs up... the preverbal memories of the oral-dependent phase of her own development,” and that the anxieties produced by the unresolved conflicts from that period of her life may cause her to become “the 'bad, frustrating mother' of her child as well as the 'bad, frustrating infant' of her mother again.” Only “through the thriving of her child” can the mother re-establish her emotional stability, Benedek concludes. (p. 396)

Fraiberg (1975) explains that:

> The presence of pathological figures in the parental past will not, in itself, predict identification with [the morbid] figures [of the parent’s early childhood] and the passing on of morbid experience to one's own children. (p. 419)

What does lead to this destructive handing down, Fraiberg concluded, is identification with the aggressor. She characterizes this as “a pathological identification with the dangerous and assaultive enemies of the ego” (p. 419). Further, Fraiberg believes that memory of childhood abuse, tyranny and desertion is not sufficient to produce a repetition. The essential additional element is the inability to remember the events with the full charge of the intense associated feelings.

CONCLUSION

When the mother's unresolved separation-individuation issues are revived in her child's current separation-individuation struggles, it is likely that new memories and feelings will emerge, greatly enhancing analytic progress. The problems resulting from a lifetime of inhibited aggression will also be activated as child and mother evoke in each other the feelings of murder and co-murderousness that no other dyad can do. The discovery and expression of these feelings in the safety of the analytic setting lays the groundwork for success, giving the mother a powerful opportunity for healing and maturation. Her growth will then allow for the child's growth, arresting the intergenerational transmission of pathology, and thereby changing the legacy of the future.

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